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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525493 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/19/2025 |
| NAME OF PROVIDER OR SUPPLIER Sunrise Health Services | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855</p> <p>Based on record review and interviews, the facility did not ensure staff were qualified to provide CPR (cardiopulmonary resuscitation) and where not aware of licensed staffs' CPR certification status. This was observed with 1(R3) of 1 residents who required CPR in the facility.</p> <p>-R3 was observed non-responsive by facility staff and had prior written wishes to have CPR performed. The facility did not ensure Licensed Practical Nurse (LPN)- G was certified to perform CPR. LPN-G was the first to respond to R3's unresponsive, pulseless change of condition.</p> <p>Findings include:</p> <p>The facility's policy and procedure titled Cardiopulmonary Resuscitation, dated [DATE] documents: .</p> <p>3. CPR certified staff will be available at all times.</p> <p>4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstrations to obtain certification or recertification is also acceptable.</p> <p>R3's medical record documents in the Progress Note (PN) on [DATE], at 10:40 AM , a late entry on [DATE], by Unit Manager (UM)-D which documents Staff went into room around 0745 (7:45 AM) to get Resident ready for breakfast. Resident was unresponsive with no pulse code blue called. Full code, CPR initiated by 2 nurses. 911 called. AED (automated external defibrillator) obtained as paramedics entered building. Paramedics took over compressions. Health history given to Paramedics. Husband called to update. Resident (sic) stated he was on his way and hung up the phone. MD (Medical Doctor) called and updated on situation. Resident was pronounced deceased around 0900 (9:00 AM).</p> <p>R3 was admitted to the facility on [DATE] and had an order to have CPR performed in the event of an emergency.</p> <p>On [DATE], at 10:50 AM, Surveyor interviewed UM-D. UM-D stated they did not participate in the performance of CPR on R3. The CPR was already being performed by Licensed Practical Nurse (LPN)-G and LPN-F. UM-D stated they just documented the summary of the event and was not present when it occurred.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On [DATE], at 10:00 AM, Surveyor interviewed Director of Nurses (DON) - B. DON-B stated they reviewed the summary of R3's CPR event and did not discover any concerns. Surveyor requested a list of facility staff that are CPR certified.</p> <p>On [DATE], at 3:35 PM, Surveyor interviewed Scheduler- L. Scheduler-L stated the Human Resource (HR) staff track CPR certification for staff. Scheduler-L stated HR will let them know if a staff member was not CPR certified. Scheduler - L stated she does not know what staff are CPR certified in the facility.</p> <p>On [DATE], at 8:25 AM, Surveyor interviewed DON-B. DON-B stated the HR staff left employment last week and they are still trying to locate CPR certifications for staff.</p> <p>On [DATE], at 9:14 AM, Surveyor interviewed DON-B and LPN-F. DON-B stated the staff involved with R3's CPR event had CPR certification, except LPN-G. LPN-F showed Surveyor their CPR certification, via their personal phone. The DON-B was in the process of gathering facility staff CPR certifications.</p> <p>On [DATE], at 9:26 AM, Surveyor interviewed LPN-G. LPN-G stated their CPR certification expired in 2023 and they have been meaning to get the recertification completed.</p> <p>Surveyor notes LPN-G assisted in performing CPR on R3, and was not currently certified to do so, when the event occurred.</p> <p>Surveyor notes R3's 911 fire department report related to the CPR event on [DATE] documents the following: Bystander: CPR was being performed of low quality and the arrest was not witnessed.</p> <p>On [DATE], at 12:42 PM, Surveyor interviewed the Assistant Fire Chief (AFC) - K via phone. AFC-K stated when low quality CPR is documented it means a component of CPR was not observed to be done correctly. AFC-K stated their staff took over the CPR and R3 remained in asytle (no pulse). R3 passed away.</p> <p>On [DATE], at 9:45 PM, Surveyor met with Nursing Home Administrator (NHA) - A, [NAME] President of Success (VPS) - C, and DON-B, regarding R3's CPR event. The VPS-C stated there were other certified staff in the facility during R3's CPR event. Surveyor shared concerns regarding LPN-G performing a component of CPR on R3 and was not currently certified.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51014</p> <p>Based on interview and record review, the Facility did not ensure 1 (R1) of 2 residents reviewed received care and treatment in accordance with goals for care, including identifying risk factors and implementing interventions to address the risk factors.</p> <p>The Facility did not recognize or assess the risk factor of R1's knee brace frequently slipping out of place, implement interventions to address the risk factors, and assess the effectiveness of the interventions thus placing R1 at increased risk for poor healing. R1's surgical repair of the left patella (kneecap) failed. R1's orthopedic surgeon identified the failure likely occurred due to the fact R1's immobilizer was often not in the correct position.</p> <p>Findings include:</p> <p>The Facility policy, entitled, Use of Assistive Devices, dated 9/19/22, documents, in part</p> <p>. The purpose of this policy is to provide a process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity .</p> <p>Policy Explanation and Compliance Guidelines: . 3. The facility will provide assistive devices or obtain referral to specialist, for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement. 4. Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices. This may include education or therapy sessions for training on the use of the device, set up assistance, supervision, or physical assistance as needed.</p> <p>5. Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device. 6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modification to the plan of care will be made as needed.</p> <p>R1 was admitted to the facility on [DATE] with diagnoses that include displaced transverse fracture of left patella, subsequent encounter for closed fracture with routine healing, and Parkinson's disease without dyskinesia without mention of fluctuations.</p> <p>R1's MDS (Minimum Data Set) comprehensive admission assessment, dated 1/8/25, documents R1 has a BIMS (Brief Interview for Mental Status) score of 11, indicating moderate cognitive impairment, a PHQ-9 (Patient Health Questionnaire) score of 0, indicating no depressive symptoms, and no indicators of psychosis including no hallucinations or delusions, use of both wheelchair and walker. R1's toileting, showering/bathing, lower body dressing, all require substantial maximum assistance.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R1's CAA (Care Area Assessment), dated 1/8/25, documents, ADL (Assistance with Daily Living) function CAA triggered secondary to assistance required in ADL's, transfers, and ambulation. Contributing factors include further ADL decline, falls, incontinence, skin breakdown, and pain. Care plan will be initiated/reviewed to improve/maintain current ADL status and functional ability, maintain continence status, decrease pain, and decrease risk of falls and skin breakdown.</p> <p>R1's Care Plan, dated 1/13/25, documents, Focus: ADL, self-care deficits evidenced by weakness related to left fracture of patella with ORIF (Open Reduction and Internal Fixation), history of falls and Parkinson's disease. Interventions include, ambulation/locomotion assist of 2 with device, bathing/showering, assist of 1, bed mobility, assist of 1, personal hygiene, assist of 1, toileting, assist of 1, and transfer, assist of 2. Focus: At risk of loss of range of motion r/t (related to) left patella. Goal: Will tolerate application of splint/orthotic device when worn. Interventions include, apply device immobilizer to LLE (left lower extremity). May take off for care. Monitor skin each shift.</p> <p>R1's Physician orders, dated 1/2/25, documented, PT (Physical Therapy) evaluation and treat as indicated, LLE (Left Lower Extremity) weight bearing as tolerated, keep in knee immobilizer at all times. May remove for skin checks every shift and PRN (as needed).</p> <p>R1's Physician order, dated, 1/4/25, documented, Cyclobenzaprine 5 mg (milligrams) daily for muscle spasms.</p> <p>R1's Hospital After Visit Summary, dated 1/2/25, documents in part .YOU (sic) are the most important factor in your recovery. Follow your instructions carefully, take your medications as prescribed, talk with your doctor/provider if you have any questions or if you have problems getting or taking your medications, follow up with your doctor/provider as instructed, and contact your doctor/provider for health care concerns. Call your Surgeons office if you have: a temperature greater than 101.0F, Increasing pain or numbness at the incision or on your operated leg, increasing redness or drainage of the wound, You WILL (sic) be swollen 4-6 weeks after surgery; however, swelling that continues to get worse to your surgical leg or the opposite leg and is accompanied by discomfort or redness should be reported.</p> <p>Activity: You may place as much weight as you can tolerate to your operative leg. Wear your immobilizer AT ALL TIMES (sic).</p> <p>R1's Facility Physical Therapy Treatment Encounter Note dated 1/3/25, documented by Physical Therapist (PT)-V in part .Tremors noted secondary to Parkinson's which impacted mobility and stability throughout session. PT performed SPT (Stand, Pivot, Transfer) with 2 WW (Two Wheel Walker) and minimal assistance into wheelchair. Readjusted extension brace and educated patient on brace positioning.</p> <p>R1's, x-ray exam dated 1/16/25, documented findings to include, two screws have been placed at the site of the mid patellar fracture. There is persistent diastases of at least 10 mm (millimeters) posterior and 3.3 cm (centimeters) anteriorly which is slightly improved from the previous study. Skin staples are in place. Small amount of joint fluid is noted. Impression to include, interval surgical change of the left patella. Persistent diastases.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/11/25, at 8:10 am, Surveyor interviewed, PT -V, who stated, there is a circle whole in the immobilizer that needs to be kept centered to the knee. R1 was fit with a generic immobilizer based on his height and weight which was determined and fitted at the hospital prior to discharge. Immobilizers can slip when a resident moves around a lot. R1 was very active. R1 had many transfers with toileting, to and from wheelchair and was always wheeling around the facility and going to activities. Before R1 would get out of bed, either PT or another staff member would adjust the immobilizer if it slipped. PT-V stated they did have concerns regarding the immobilizer because R1 had a lot of spasms in his legs and, rigidity and restlessness and it is going to move.</p> <p>On 3/11/25, at 9:50 am, Surveyor interviewed Certified Nursing Assistant (CNA)-R, who stated, she mostly sees immobilizer's out of place after a resident has been sleeping. When this happens, she just straightens it up.</p> <p>On 3/11/25, at 9:53 am, Surveyor interviewed Registered Nurse (RN)-T who stated, the immobilizer opening should be kept at the knee cap. Immobilizer's cannot be too tight as skin break down can occur. RN-T stated R1 always had his immobilizer twisted to the side or sliding because of all his movement. He moved and rolled around a lot in bed which displaced his immobilizer. R1 would sometimes hang one leg off the bed or both legs.</p> <p>On 3/11/25, at 10:04 am, Surveyor interviewed, PT-V, who stated, there is nothing PT can do if R1 moves around a lot at night. R1 always keeps his immobilizer on but staff cannot readjust all night long if it becomes displaced. If R1 puts his call light on, staff will come to readjust it. PT-V stated in their professional opinion, R1 should have had a cast rather than an immobilizer as he would not have the problem with continual slipping, but it is not in her scope of practice to question what the surgeon orders. PT-V stated, on R1 s first day of PT on 1/3/25 that he had tremors due to Parkinson's disease that impacted his stability. PT-V states she reeducated R1 on importance of keeping brace in position.</p> <p>On 3/11/25, at 12:43 pm, Surveyor interviewed, RN-T, who stated when R1's immobilizer would slip out of place, she did not notify anyone. I am not going to notify anyone if an immobilizer needs to be adjusted. I just do it. R1 is of sound mind and has a lot of movement so expected to be readjusting. When asked if she ever updated surgeon or unit manager of R1's immobilizer slipping, RN-T stated, No, I just adjust.</p> <p>On 3/11/25, at 11:14 am, Surveyor interviewed, PTA (Physical Therapy Assistant)-W, along with PT-V. PTA-W stated R1's movement is lots of jerking in his legs. PTA-W stated, generic immobilizers have lots of give and have some degree of movement. She stated, she did not call the surgeon with any updates regarding the immobilizer slipping because it was R1's normal movement that was causing it to slip and R1 was not moving enough to warrant concern. PT-V stated, she followed the physician orders and did not question his directive. PT-V stated, she had an example of time when she did call a surgeon regarding another resident's immobilizer that did not fit well and requested a custom immobilizer, but this was for a resident who would be wearing one long term and R1 would not have an immobilizer long term. PT-V stated she would frequently adjust R1's immobilizer while he was in the hallways. PT-V states everyone was always readjusting R1's immobilizer.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/12/25, at 9:22 am, Surveyor interviewed Director of Nursing (DON)-B, who stated when she first met R1 on 1/3/25 he was, kicking like a horse, like wild. R1 was in his room, and she could see him kicking from the hallway. DON-B entered R1 's room and asked if he was ok and R1 stated his leg involuntary kicks quite often because of his Parkinson's disease. DON-B contacted the NP, (Nurse Practitioner) to see if she could get a muscle relaxer for R1 and on 1/4/25, Cyclobenzaprine 5 mg was ordered. DON-B stated she asked R1 if the muscle relaxer was helping, and R1 said it was and it decreased his spasms. DON-B stated the surgeon clearly knew how the immobilizer fit and knew R1 tremored. DON-B stated she questioned in her head, did they not notice his tremors? DON-B stated she did not notify R1 of her concerns regarding surgeon's order for the immobilizer nor did she contact the surgeon.</p> <p>On 3/12/25, at 9:25 am, Surveyor interviewed Licensed Practical Nurse (LPN)- G, who stated when she makes a check mark on the TAR for R1, she is indicating she has verified the immobilizer is on R1's left leg. LPN-G stated if the immobilizer is not placed correctly, she will just adjust it and then check off on the TAR.</p> <p>On 3/12/25, at 3:05 pm, Surveyor notified Nursing Home Administrator (NHA)-A and DON-B of the concern facility staff did not identified the risk factor of R1's immobilizers continuously slipping and how it would impact R1's recovery and healing. The facility staff did not implement interventions to address the risk factors nor did staff speak to R1's orthopedic surgeon or provider regarding the continual slipping of R1's immobilizer which negatively impacted R1's healing.</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on observation, interview, and record review, the facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 1 (R2) of 1 resident reviewed for pressure injuries.</p> <p>* R2 was admitted to the facility 1/20/25 without any pressure injuries. Upon admission R2 was identified as being at high risk for pressure injury development. The facility did not develop a potential for skin integrity care plan and R2's care plans do not address repositioning or offloading R2's feet/heels. The endocrine system care plan initiated 1/24/25 includes an intervention of: inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness. This intervention was not implemented as diabetic orders were not ordered for R2. On 2/28/25, R2 was identified with unstageable pressure injuries on the right lateral ankle and right heel and suspected deep tissue injury on the right inner ankle and top of the right foot. Treatments for these pressure injuries were not ordered until 3/2/25, two days later, and R2's March TAR (Treatment Administration Record) is not checked and initialed as being completed on 3/2/25 and 3/3/25. During the survey, observations were made of R2 not wearing Prevalon boots and/or R2's heels were not being offloaded.</p> <p>The facility's failure to provide care to prevent the development of pressure injuries and promote the healing of pressure injuries and the failure to develop and/or update resident's pressure injury care plans created a finding of Immediate Jeopardy (IJ) that began on 1/20/25.</p> <p>Surveyor notified Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, [NAME] President of Success (VPS)-C, and Unit Manager (UM)-D of the immediate jeopardy on 3/13/25 at 2:23 p.m. The immediate jeopardy was removed on 3/13/25. The deficient practice continues at a scope and severity of D (potential for harm/isolated) as the facility continues to implement its action plan.</p> <p>Findings include:</p> <p>The facility's policy titled, Pressure Injuries and Non pressure Injuries and reviewed/revised 7/20/22 documents under policy: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. The following protocols should guide prevention and treatment efforts, unless specified by a physician otherwise.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Documented under Policy Explanation and Compliance Guidelines: c. Initiate the baseline plan of care related to current skin status and skin risk level. (The comprehensive care plan will be developed within seven days of the completion of the comprehensive assessment - see below for additional information related to the comprehensive care plan). When determining skin risk status and appropriate interventions, consider the following: i. Braden Scale Score. ii. Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; iii. Drugs such as steroids that may affect healing; iv. Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency; v. Resident declination of some aspects of care and treatment; vi. Cognitive impairment; vii. Use of splints/braces or presence of a cast; viii. Presence of a medical device(s) such as an indwelling catheter, trach, nasal cannula, or CPAP (Continuous Positive Airway Pressure)/BiPAP (Bilevel Positive Airway Pressure) mask; ix. The need or request to elevate the HOB (head of bed); x. Exposure of skin to urinary and fecal incontinence; xi. Under nutrition, malnutrition, and hydration deficits; and xii. The presence of a previously healed PU (Pressure Ulcer)/PI (Pressure Injury). The history of any healed PU/PI, its origin, treatment, its stages [if known] is important assessment information since areas of healed Stage 3 or 4 PU/PIs are more likely to have recurrent breakdown.</p> <p>Documented under Care Planning: A Comprehensive Skin Integrity Care Plan is based on resident history, review of Skin Assessment, Braden Scale Scoring, Nutritional Assessments, resident and family interviews, and staff observations. Consider the areas of risk, as well as overall risk assessment score of the Braden Scale. Communicate identified risk factors and interventions to direct care staff . 2. Develop interventions based on individual Risk Factors including, but not limited to, weight, presence of edema, overall health status/comorbidities, use of medical devices, presence of acute infection, end of life/hospice, resident choice/preferences, or medications that may impact healing.</p> <p>R2 was admitted to the facility on [DATE] with diagnoses to include fracture of right femur, Diabetes Mellitus, Chronic Kidney Disease Stage 5, Peripheral Vascular Disease, Depressive Disorder, Anxiety Disorder, and Restless Leg Syndrome. R2's Power of Attorney for healthcare was activated on 1/29/25.</p> <p>Staff communicate with R2 by writing their question or what they are going to do on a whiteboard.</p> <p>R2's Braden assessment dated [DATE] has a score of 12. A score of 10 to 12 is high risk for development of a pressure injury.</p> <p>R2 was admitted with a right leg immobilizer with orders dated 1/21/25 of Immobilizer to right lower extremity at all times, may remove for skin checks Q (every) shift and PRN (as needed).</p> <p>R2's care plan documents endocrine system related to DM (diabetes mellitus) 2 initiated and revised on 1/24/25 includes an intervention of: Inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness. Initiated 1/24/25.</p> <p>Surveyor reviewed R2's January 2025, February 2025, and March 2025 MAR/TAR (Medication Administration Record/Treatment Administration Record). There is no evidence staff were inspecting R2's feet daily for open areas, sores, pressure areas, blisters, edema, or redness on these MARs/TARs.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>The facility did not develop a potential for skin integrity care plan upon admission. A potential for skin integrity care plan was not developed until 3/10/25, after R2 developed multiple pressure injuries.</p> <p>R2's ADL (Activities Daily Living) self-care deficit initiated 1/20/25 and revised 1/21/25 does not include an intervention for repositioning.</p> <p>R2's admission MDS (Minimum Data Set) with an assessment reference date of 1/26/25 has a BIMS (Brief Interview for Mental Status) score of 11 which indicates moderate cognitive impairment. R2 is assessed as requiring supervision or touching assistance for eating, substantial/maximum assistance to roll left and right, and is dependent for toileting hygiene, chair/bed to chair transfer, and toilet transfer. R2 is always incontinent of urine and occasionally incontinent of bowel. R2 is at risk for pressure injury development and is assessed as not having any pressure injuries.</p> <p>R2's pressure ulcer/injury CAA (care area assessment) dated 1/29/25 documents under analysis of findings for nature of the problem/condition: Pressure Ulcers CAA triggered secondary to potential for pressure ulcers. Contributing factors include ADL/functional/mobility impairment and incontinence. Risk factors include pain, development of PU/skin condition, and fluid deficit risk. A licensed nurse assesses skin each week and puts proper interventions in place to prevent skin breakdown. Skin is also assessed by caregivers with each bath and each time the resident is dressed. The physician is to be notified of any abnormal findings and treatment orders are obtained. The dietitian is monitoring her food and fluid intake, and implementing dietary interventions, as necessary. Caregivers assist with repositioning at least every two hours and as needed for comfort. Care plan will be initiated or reviewed to improve or maintain current ADL status and functional ability, maintain continence status, prevent pain, and decrease pressure ulcer/fluid deficit risk. Location of documentation: see NN (nurses notes)/Braden/TAR for the look back period. Resident has increased risk for skin impairment related to increased need for help with ADL such as bed mobility which can decrease blood flow and increase pressure leading to wounds.</p> <p>Documented under care plan considerations for describe impact of this problem/need on the resident and your rationale for care plan decision is the same wording as under analysis of findings for nature of the problem/condition.</p> <p>R2's Braden assessment dated [DATE] has a score of 14 which indicates moderate risk for the development of pressure injuries.</p> <p>R2's physical medicine and rehabilitation note dated 2/7/25 under history of present illness documents: Patient seen and examined. History provided partially via nursing staff and pt (patient) family. Has some improvement of appetite today. No pain today. She has been intermittent up in her chair participating in therapy. Daughter is concerned her brace on her R (right) leg is too long and irritating her skin both proximally and distally - padding has helped some. I did then reach put [sic] (out) to the orthopedic clinic and they recommend that she come out and visit for them to assess her splint and decide her weight bearing status. Her family and primary team were informed.</p> <p>R2's Braden assessment dated [DATE] has a score of 15 which indicates at risk for the development of pressure injuries.</p> <p>On 2/24/25, R2 went to an orthopedic appointment and R2's immobilizer was discontinued.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>R2's nurses note dated 2/28/25, at 11:38 a.m., and written by Unit Manager (UM)-D documents: Writer was called to resident's room by floor nurse. Daughter reported an area on resident's R (right) ankle. RN (Registered Nurse) and writer went in to assess. Found 4 DTIs (deep tissue injury). Resident has no description d/t (due to) cognition. Daughter stated she thought it was from the immobilizer but that was discontinued 2/24/25 and wound NP (nurse practitioner) saw resident on 2/25/25 and assessed R (right) hip incision OA (open area), assessed feet and circulation, no wounds were present. Writer and RN measured and assessed wound. NP here and aware. New treatment orders ordered and performed. POA (Power of Attorney) in agreement for wound NP to follow wounds. Prevalon boots when in bed ordered and put on Resident today.</p> <p>Pressure Injury #1</p> <p>R2's pressure injury weekly tracker dated 2/28/25 for pressure injury, acquired in house is indicated. Under location for site documents: 47) Right ankle (outer), type is pressure, under units of measure: centimeters for length is 1.9, width 1.5, and depth 0.1. Stage is documented as Unstageable. Tissue type is 100% necrotic. Drainage is none. Documented under additional interventions/plans: Prevalon boots when in bed order obtained, applied today during assessment and treatment. NP notified and treatment ordered. POA aware. Air mattress ordered.</p> <p>R2's physician order with an order date of 3/2/25 documents wound care: Betadine R outer ankle and R heel, cover with Mepilex QD (every day) and PRN (as needed). Surveyor notes this order is 2 days after R2's pressure injury was identified, and the treatment is not checked and initialed as being completed on 3/2/25 and 3/3/25.</p> <p>On 2/28/25, the resident has a Stage IV (4) pressure ulcer to R outer ankle. Care plan developed and revised on 3/4/25 with documented interventions all initiated on 2/28/25 of: Administer medication as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/position requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. If the resident refuses treatment, confer with the resident, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance. Document alternative methods. Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length x width x depth), stage. Obtain and monitor lab/diagnostic as ordered. Report results to MD and follow up as indicated. Prevalon boots on when in bed. On 3/5/25, an intervention of: the resident requires Air Mattress: Check function and setting every shift. Settings are 150, was initiated.</p> <p>Pressure Injury #2</p> <p>R2's pressure injury weekly tracker dated 2/28/25 for pressure injury acquired in house with date acquired documents 2/28/25. Under location for site documents: 49) Right heel, type is Pressure, and units of measure: centimeters for length is 4.5, width 1.5. Stage is Unstageable. Tissue type is 100% necrotic. Drainage is none. Under additional interventions/plans documents: Prevalon boots when in bed order obtained, applied today during assessment and treatment. NP notified and treatment ordered. POA aware. Air mattress ordered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>R2's physician order with an order date of 3/2/24 documents wound care: Betadine R outer ankle and R heel, cover with Mepilex QD (every day) and PRN (as needed). This order is 2 days after R2's pressure injury was identified, and the treatment is not checked and initialed as being completed on 3/2/25 and 3/3/25.</p> <p>On 2/28/25, the resident has an unstageable pressure ulcer to R heel care plan developed and revised on 3/4/25 with documented interventions all initiated on 2/28/25 of: Administer medication as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/position requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. If the resident refuses treatment, confer with the resident, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance. Document alternative methods. Inform the resident/family/caregivers of any new area of skin breakdown. Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length x width x depth), stage. Obtain and monitor lab/diagnostic as ordered. Report results to MD and follow up as indicated.</p> <p>Pressure Injury #3</p> <p>R2's pressure injury weekly tracker dated 2/28/25 for pressure injury acquired in house with date acquired documents 2/28/25. Under location for site documents: 45) Right ankle (inner), type is Pressure and units of measure: centimeters for length 0.7 and width 0.8. Under Stage documents Suspected Deep Tissue Injury. Skin is 100% purple. Drainage is none. Under additional interventions/plans documents: Prevalon boots when in bed order obtained, applied today during assessment and treatment. NP notified and treatment ordered. POA aware. Air mattress ordered.</p> <p>R2's physician order with an order date of 3/2/25 documents: Skin prep to R inner ankle and top of R foot QD (every day) at bedtime. This order is 2 days after R2's pressure injury was identified, and the treatment is not checked and initialed as being completed on 3/2/25 and 3/3/25.</p> <p>On 2/28/25, the resident has a DTI R inner ankle care plan developed and revised on 3/4/25 with documented interventions all initiated on 2/28/25 of: Administer medication as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. If the resident refuses treatment, confer with the resident, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance. Document alternative methods. Inform the resident/family/caregivers of any new area of skin breakdown. Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection wound size (length x width x depth), stage. Obtain and monitor lab/diagnostic as ordered. Report results to MD and follow up as indicated.</p> <p>Pressure Injury #4</p> <p>R2's pressure injury weekly tracker dated 2/28/25 for pressure injury acquired in house is indicated with date acquired 2/28/25. Under location for site documents: Other (specify) Top of R foot, type is Pressure, and units of measure: centimeters for length 1.0 and width 0.5. Stage documents Suspected Deep Tissue Injury. Drainage is none. Under additional interventions/plans documents: Prevalon boots when in bed order obtained, applied today during assessment and treatment. NP notified and treatment ordered. POA aware. Air mattress ordered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>R2's physician order with an order date of 3/2/25 documents: Skin prep to R inner ankle and top of R foot QD (every day) at bedtime. This order is 2 days after R2's pressure injury was identified, and the treatment is not checked and initialed as being completed on 3/2/25 and 3/3/25.</p> <p>On 2/28/25, the resident has a DTI top of R foot care plan developed with documented interventions all initiated on 2/28/25 of: Administer medication as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. If the resident refuses treatment, confer with the resident, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance. Document alternative methods. Inform the resident/family/caregivers of any new area of skin breakdown. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.</p> <p>Pressure Injury #5</p> <p>R2's nurses notes dated 3/4/25 at 12:11 p.m. and written by Unit Manager (UM)-D documents: During wound rounds with wound NP found new Unstageable DTI of the right toe. Wound NP measured and assessed. Treatment ordered and in place. POA aware. In house NP aware. Prevalon boots in place in bed.</p> <p>Wound NP-Q's assessment dated [DATE] for Stage 4 pressure wound of the right lateral ankle for wound size documents: 2.4 x 1.8 x not measurable cm (centimeters). Thick adherent black necrotic tissue (eschar) 80% and Slough 20%. Under additional note documents: Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis prior to this point. This wound has now revealed itself to be a Stage 4 pressure injury. This is not a wound deterioration.</p> <p>Wound NP-Q's assessment dated [DATE] for Unstageable DTI of the right heel for wound size documents: 4.4 x 4.1 x not measurable. Skin is intact with purple/maroon discoloration.</p> <p>Wound NP-Q's assessment dated [DATE] for Unstageable DTI of right medial ankle for wound size documents: 1.0 x 0.9 x not measurable. Skin is intact with purple/maroon discoloration.</p> <p>Wound NP-Q's assessment dated [DATE] for Unstageable DTI of right dorsal foot for wound size documents: 2.2 x 1.4 x not measurable. Skin is intact with purple/maroon discoloration.</p> <p>Wound NP-Q's assessment dated [DATE] for Unstageable DTI of right toe for wound size documents: 0.4 x 0.8 x not measurable. Skin is intact with purple/maroon discoloration.</p> <p>On 3/4/25, the facility developed and revised the resident's DTI pressure ulcer R toe care plan with all interventions initiated on 3/4/25 of: Administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Frequent repositioning. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>The facility's pressure injury weekly tracker dated 3/4/25 assessment of R2's right ankle (outer), right ankle (inner), top of R foot, and right toe document the same stage, measurements and description of wound bed as Wound NP-Q's assessment. The assessment of R2's right heel has the same measurements, but the stage and tissue type are different than Wound NP-Q. The facility's assessment documents the stage as Unstageable and tissue type 100% necrotic tissue.</p> <p>R2's nurses note dated 3/11/25 at 13:45 (1:45 p.m.) and written by UM-D documents: Wound rounds done with wound NP, exposed hardware from a previous surgery to R ankle exposed. MD updated. [First name] POA updated talked about referral to orthopedics per POA family decided on comfort care for resident and keeping her comfortable. Will be pursuing Hospice at home. MD aware.</p> <p>On 3/10/25 at 9:49 a.m., Surveyor observed R2 in bed on her back with the head of the bed elevated and R2's breakfast tray on the over bed table. Surveyor observed R2 has eaten 100% of her breakfast which was on the plate. Surveyor observed R2 has bare feet and R2's heels are resting directly on the mattress. R2's heels are not being offloaded and R2 is not wearing Prevalon boots according to R2's plan of care.</p> <p>On 3/10/25 at 10:01 a.m., Surveyor observed Certified Nursing Assistant (CNA)-R enter R2's room. CNA-R covered R2 with a sheet and blanket and then left R2's room. During this observation Surveyor noted CNA-R did not offer to put on R2's Prevalon boots and did not offload R2's heels.</p> <p>On 3/10/25 at 10:19 a.m., Surveyor observed R2's POA in the room. R2 continues to be in bed on her back with her heels not offloaded and R2 is not wearing Prevalon boots. During conversation with R2's POA, Surveyor was informed they aren't here 24/7 but she is at the facility during the week from around 9:00 a.m. to about 6:00 p.m. and after she leaves other family members come, and they also come on the weekend. Surveyor inquired how often staff changes R2. R2's POA informed Surveyor they are supposed to every two hours but if we are here we change her, sometimes we are here all morning and they, (referring to staff,) aren't in. At 10:34 a.m., R2's POA checked R2's incontinence product stating, she's pretty wet. At 10:37 a.m., R2's POA put the call light on, and CNA-R responded. From 10:39 a.m. to 10:48 a.m. Surveyor observed CNA-R wash R2 and provide continence cares to R2. During this observation at 10:46 a.m., CNA-R placed a pillow under R2's lower right leg, then removed and folded the pillow in half and placed under R2's right leg. Surveyor observed the right heel is being offloaded but the left heel is resting directly on the mattress.</p> <p>On 3/10/25 at 2:11 p.m., Surveyor observed R2 in bed on her back with the head of the bed elevated sleeping with R2's POA at the bedside. Surveyor observed R2 is not wearing Prevalon boots. R2's heels are resting directly on the mattress; the right foot is bare and the left foot has a slipper/sock on.</p> <p>On 3/10/25 at 3:21 p.m., Surveyor observed R2 continues to be in bed on her back with the head of the bed elevated and R2's POA at the bedside. R2 is still not wearing the Prevalon boots and R2's heels are resting directly on the mattress.</p> <p>On 3/11/25 at 7:49 a.m., Surveyor observed R2 in bed on her back with the head of the bed elevated. Surveyor observed R2 is not wearing the Prevalon boots as they are in the chair. R2's heels are not being offloaded.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 3/11/25 at 7:50 a.m., Surveyor observed CNA-R enter R2's room. CNA-R wrote on the white board asking R2 if she was ready to get washed up. CNA-R raised the height of the bed. Surveyor asked CNA-R if Surveyor could see R2's feet. Surveyor observed R2 has bare feet and R2's heels are resting directly on the mattress. CNA-R then placed a pillow under R2's lower legs but R2's heels are resting directly on the pillow and are not being offloaded. CNA-R did not offer to place R2's Prevalon boots on. CNA-R wrote on the white board can I get you up. R2 responded no. CNA-R lowered the height of the bed and left R2's room.</p> <p>On 3/11/25 at 8:00 a.m., Surveyor asked Licensed Practical Nurse (LPN)-G if she is doing treatments today. LPN-G replied, I don't have to do them today, its wound care day, the wound nurse will do them. Surveyor asked LPN-G how R2 developed the pressure injuries. LPN-G informed Surveyor she didn't know and explained she's not over here, (referring to R2's unit,) often.</p> <p>On 3/11/25 at 9:09 a.m., Surveyor observed CNA-R enter R2's room with her breakfast tray, which CNA-R placed on the over bed table and left R2's room. R2 is in bed with the head of the bed elevated and a family member in the room. R2's heels are not being offloaded and R2 is not wearing the Prevalon boots.</p> <p>On 3/11/25 at 9:12 a.m., Surveyor asked CNA-R if she has to assist R2 with eating. CNA-R replied, she can eat herself. Surveyor asked CNA-R if R2 has any pain. CNA-R replied in the right leg, she won't let you put anything on her leg.</p> <p>On 3/11/25 at 10:17 a.m., Surveyor spoke with CNA-U on the telephone regarding R2. CNA-U informed Surveyor she takes care of R2 daily along with CNA-R. Surveyor asked CNA-U if she has observed any pressure injuries on R2's feet. CNA-U stated, I'm the one that discovered the sore on the bottom of her foot when I took socks off. Surveyor asked CNA-U if she remembers when this was. CNA-U replied, last week or the week before, can't remember the exact date. Surveyor asked if she reported this to anyone. CNA-U informed Surveyor she believes [first name of RN-I] was on the floor and UM-D was there. CNA-U informed Surveyor she told UM-D first as RN-I was talking to someone. Surveyor asked CNA-U before the pressure injury had developed did she take off R2's socks when doing cares. CNA-U replied we try to, but she screams out, there could be days when we did not remove the socks because she was in too much pain. Surveyor asked when R2 was in pain did she report this to the nurse. CNA-U informed Surveyor she reported each time to the nurse. CNA-U informed Surveyor R2 did start to wear the boots after the area developed.</p> <p>On 3/11/25 at 10:56 a.m., Surveyor observed R2 in bed on her back with the head of the bed elevated. There is a pillow under R2's right leg, length wise and R2's right heel on the pillow. R2's left heel is on the mattress. Surveyor observed R2's heels are not being offloaded and R2 is not wearing Prevalon boots.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 3/11/25 at 11:18 a.m., Surveyor observed wound rounds for R2 with Wound NP-Q and UM-D. Surveyor observed R2's wound supplies are on the over bed table. Wound NP-Q removed the dressing from R2's right knee (surgical) and right ankle. Wound NP-Q then measured R2's wounds, stating the measurements out loud. Surveyor noted the following measurements: The right knee (surgical) 1.8 x 1.2, right outer ankle 2.4 x 1.7 with hardware exposed. Surveyor observed Wound NP-Q did not measure the depth of the right outer ankle. Right heel 2 x 3.7, right medial ankle 1.8 and right dorsal foot blanching 2.5 x 1.5. During this observation, Wound NP-Q did not measure R2's right toe and did not describe the wound bed of any R2's pressure injuries. After measuring, Wound NP-Q left R2's room to document and UM-D did the treatment to R2's surgical wound and R2's pressure injuries according to physician orders. During this observation at 11:32 a.m., UM-D informed Surveyor she was going to skin prep the right heel. Surveyor asked UM-D if R2's right heel pressure injury is 100% necrotic. UM-D replied yes. At 11:38 a.m. after UM-D completed the treatment for all R2's pressure injuries, UM-D stated, I know the daughter took the boots off, but I need to find them. UM-D removed her gloves and cleansed her hands. Surveyor noted as of this time, R2's daughter has not been at the facility. UM-D located R2's Prevalon boots and placed them on R2. Surveyor asked UM-D how staff know R2 is supposed to be wearing the boots. UM-D replied, it's on the Kardex. UM-D lowered R2's bed down low, placed the call light in reach, and left R2's room.</p> <p>On 3/11/25 at 1:41 p.m., Surveyor observed R2 in bed on her back, wearing Prevalon boots, and a family friend is sitting next to R2's bed in a chair.</p> <p>On 3/11/25 at 2:27 p.m., Surveyor interviewed Wound NP-Q regarding R2. Wound NP-Q informed Surveyor 2/25/25 was her first consult with R2 as she was a new orthopedic patient. Surveyor asked Wound NP-Q when she saw R2 on 2/25/25 did she assess R2's feet. Wound NP-Q replied yes, the lower leg and feet. Surveyor asked Wound NP-Q if she observed any skin impairment areas. Wound NP-Q replied on the dorsal foot, 1st and 2nd toe had little area and believes this was all that was noted at the time. Surveyor asked Wound NP-Q how a treatment is ordered if she is not at the facility. Wound NP-Q informed Surveyor they notify her via phone, she will give a treatment order and then will assess the next week. Surveyor asked Wound NP-Q today during wound rounds why didn't she measure the depth for the right outer ankle. Wound NP-Q informed Surveyor it looked exactly the same, so she left it at the same depth. Surveyor inquired about description of the wound bed. Wound NP-Q informed Surveyor she charts them in her computer and after wound rounds she manually synchs and uploads into PCC (pointclickcare). Surveyor asked Wound NP-Q how she thought R2 developed these pressure injuries. Wound NP-Q informed Surveyor it's probably a mix of pressure, in so much pain, not willing to have cares done, repositioning, and stated to Surveyor you saw today when you touch her leg. Wound NP-Q also informed Surveyor R2 was not eating well. Wound NP-Q informed Surveyor they did order Prevalon boots after they developed.</p> <p>After Surveyor met with Wound NP-Q, Surveyor reviewed Wound NP-Q's initial wound evaluation dated 2/25/25. For examination of right lower extremities documents foot warm, no edema. Wound present. See focused wound exam below. There is no documentation regarding this wound, on Wound NP-Q's evaluation.</p> <p>On 3/12/25 at 9:09 a.m., Surveyor observed R2 eating breakfast in bed on her back with the head of the bed elevated. R2 has yellow gripper socks on her feet, R2's heels are resting directly on the mattress, and R2 is not wearing Prevalon boots. Surveyor observed the Prevalon boots are in a chair.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 3/12/25 at 9:11 a.m., Surveyor observed CNA-S enter R2's room, CNA-S informed Surveyor she usually works upstairs and was floated down. CNA-S asked R2 if she was done eating. R2 yelled I can't hear you. Surveyor informed CNA-S she has to write on the white board as R2 can't hear her. CNA-S stated they didn't even tell me that. CNA-S then wrote on the communication board if she was done eating and then if she needed anything. CNA-S removed the over bed table, which was across R2, lowered the leg portion and the head of bed and lowered the height of the bed. CNA-S then wrote on the communication board can I put a pillow on your side. CNA-S lowered the head of the bed down so the bed was flat, raised the height of the bed, and assisted R2 with rolling on her right side. CNA-S placed a pillow under R2's left side, covered R2, raised the head of the bed and lowered the bed back down. Surveyor observed R2's heels are not being offloaded and CNA-S did not offer to place R2's Prevalon boots on.</p> <p>On 3/12/25 at 9:23 a.m., Surveyor asked CNA-S if she has provided incontinence cares to R2 this morning. CNA-S informed Surveyor R2 was one of the first residents she washed up and changed. Surveyor asked CNA-S why R2 was not wearing Prevalon boots according to her care plan. CNA-S informed Surveyor R2 takes them off and then stated, I don't know if she is supposed to wear them.<b [TRUNCATED]</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391</p> <p>Based on observation, interview, and record review the facility did not ensure 1 (R5) of 4 residents reviewed for accidents received adequate supervision and assistance devices to prevent future accidents.</p> <p>On 11/20/24, at 1:37 PM, R5 had an unwitnessed fall (UWF) while toileting. R5 was assessed to requires partial/moderate assistance for toilet transferring. R5 was left alone while toileting and had an UWF while attempting to self-transfer.</p> <p>Findings include:</p> <p>The facility's policy titled, Fall Prevention and Management Guidelines dated 11/8/22, last reviewed on 7/18/24, documents: .</p> <p>4. Suggested standard interventions may include: .</p> <p>g. Complete a fall risk assessment quarterly, post-fall, and as with a significant change of condition.</p> <p>7. When any resident experiences a fall, the facility will:</p> <p>a. Complete a post-fall assessment and review:</p> <p>4. Resident and/or witness statements regarding fall</p> <p>f. Obtain witness statements from other staff with possible knowledge or relevant information.</p> <p>R5 is an [AGE] year-old resident who was admitted to the facility on [DATE]. R5's diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle wasting and atrophy, dysphagia following cerebral infarction, dementia with anxiety, and history of traumatic fracture.</p> <p>R5's Quarterly Minimum Data Set (MDS) completed on 9/29/24 documents R5 has a history of falls, is frequently incontinent of urine, requires substantial/maximal assistance with toileting hygiene, transfers, and rolling left to right. R5 was documented as having a Brief Interview for Mental Status (BIMS) score of 3, indicating R5 has severe cognitive impairment.</p> <p>R5's Falls Care Area Assessment (CAA) on the 6/29/24 Admission MDS documents the following:</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Falls CAA triggered secondary to impaired gait and mobility and level of assistance required with transfers. Contributing factors include history of falls prior to admission, weakness and physical limitations affecting balance, gait, strength, and muscle endurance. Risk factors include falls and other major/minor injuries related to falls. The care plan will be initiated/reviewed to improve/maintain current physical function as it relates to ADLs, gait stability, strength and endurance, mobility, decrease fall risk and minimize injury related to falls.</p> <p>R5's Urinary Incontinence CAA on the 6/29/24 Admission MDS documents the following:</p> <p>Urinary Incontinence CAA triggered secondary to always incontinent of bladder and dependence of staff for incontinent care. Contributing factors include weakness, impaired mobility, and cognitive loss. Risk factors include skin breakdown, falls, and recurrent Urinary Tract Infections (UTI)s. Care plan will be initiated/reviewed to maintain check and change for incontinent episodes, reduction of pressure ulcer and fall risk, and reduce the risk for UTI.</p> <p>R5's Cognitive Loss/Dementia CAA on the 6/29/24 Admission MDS documents the following: Resident does not have a diagnosis of dementia or cognitive loss. Surveyor notes R5 was documented as having a BIMS of 3 (severe cognitive impairment) on the Admission MDS dated [DATE].</p> <p>R5's care plan, dated 6/23/24, documents:</p> <p>R5 is at risk for falls due to history of falls, weakness, limited mobility, Type 2 Diabetes, hemiplegia, hemiparesis, and ventricular premature depolarization, dated 6/29/24.</p> <p>Interventions include:</p> <p>Ensure R5 is wearing appropriate footwear including shoes or gripper socks, dated 6/25/24.</p> <p>Have commonly used articles within reach, dated 6/25/24.</p> <p>Medications as ordered, dated 6/25/24.</p> <p>Provide assistance to transfer and ambulate as needed (PRN), dated 6/25/24.</p> <p>Reinforce the need to call for assistance, dated 6/25/24.</p> <p>R5 is to not be left alone if toileting. Offer toileting every two to three hours, dated 11/24/24.</p> <p>Therapy evaluation and treatment as ordered, dated 6/25/24.</p> <p>R5's Kardex documents R5 requires assistance of 1 with toileting and assistance of 1 with a gait belt for mobility.</p> <p>On 3/10/25, at 9:57 AM, Surveyor observed R5 in the common room with four other residents. R5 was observed to be watching TV. R5 was dressed in personal clothing, appears comfortable, has slippers on both feet, and is sitting in a manual wheelchair. R5 was observed to have her hair pulled back in a braid with socks on both feet and feet in a dependent position.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/10/25, at 10:11 AM, Surveyor observed R5's room which had a low bed, personal belongings on the side table, call light laying on the bed, and Prevalon boots on the chair across the room. R5 was in the common area at the time of R5's room observation.</p> <p>On 3/10/25, 11:51 AM, Surveyor interviewed R5 who was sitting in her wheelchair in the common area. R5 denied concerns with Surveyor and appeared comfortable. Surveyor observed socks and shoes on both feet with multiple staff members present in the common area assisting other residents.</p> <p>On 3/10/25, at 11:53 AM, Surveyor interviewed Certified Nursing Assistant (CNA)- M who states she knows when residents are at risk for falls when she sees a low bed and will also look in the computer. CNA- M states she will call the nurse right away if a resident has a fall. CNA- M will also give report to the oncoming CNA with any recent fall or change in condition. CNA- M states staff will monitor residents more closely if they are a fall risk.</p> <p>On 3/10/25, at 3:03 PM, Surveyor asked Director of Nursing (DON)- B where Fall Risk Assessments are found in the Electronic Medical Record (EMR). DON- B states Fall Risk Assessments are completed on the admission and quarterly evaluations. DON- B states Fall Risks Assessments are included on the Admission Evaluation assessment and Quarterly Clinical Review assessments.</p> <p>Surveyor notes the following Fall Risk Assessments:</p> <p>*Admission Evaluation dated 6/23/24, documents the following:</p> <p>R5 has had a fall in the last 30 days. R5 is not at risk for falls.</p> <p>Surveyor notes R5 is documented as not being at risk for falls, even though R5's Admission MDS dated [DATE], documents R5 having a fall prior to admission.</p> <p>*Quarterly Clinical Review dated 9/26/24, documents the following:</p> <p>R5 uses a standard wheelchair, has no falls in the last 0-6 months, is frequently incontinent of bladder and is at risk for falls. R5 requires assistance of 1 staff member for toileting and transfers.</p> <p>Surveyor notes R5 is noted as having no falls in the last 0-6 months, even though R5's Admission MDS dated [DATE], documents R5 having a fall prior to admission.</p> <p>*Quarterly Clinical Review dated 12/28/24, documents the following:</p> <p>R5 uses a standard wheelchair, has no falls in the last 0-6 months, is frequently incontinent of bladder, and is not at risk for falls.</p> <p>Surveyor notes R5 is noted as having no falls in the last 0-6 months with documentation of R5 sustaining an UWF on 11/20/24. Surveyor notes R5 is documented as not being at risk for falls.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Surveyor reviewed the facility Fall Investigation for R5's UWF on 11/20/24, which documents Licensed Practical Nurse (LPN)- N heard R5 yelling for help and upon entering the room LPN- N noted R5 laying on her back on the bathroom floor. R5's wheelchair was located on her left side and R5 stated she was done using the bathroom and trying to get back into her chair. The facility fall investigation indicates the CNA placed R5 on the toilet and told R5 to pull the call light when she was done toileting. The CNA left the bathroom and left R5 alone on the toilet. R5 stated she slid down and did not hit her head. LPN- N notified the facility provider, unit manager, and R5's family. Surveyor notes R5 was documented as having gripper socks on at the time of her fall. The root cause was determined to be R5 self-transferring from the toilet. The fall investigation included when the resident was last seen, which was by the CNA who placed her on the toilet prior to her unwitnessed fall. Neuro checks were completed with no concerns noted. Care plan interventions to include R5 is not to be left alone if toileting and to offer toileting every two to three hours, were updated on R5's care plan. Surveyor notes R5 requires assistance of one with toileting and transfers and the CNA left R5 alone on the toilet. Surveyor notes R5 as having a low BIMS score indicating severe cognitive impairment at the time of the UWF. Surveyor notes there is no post fall assessment completed after R5's 11/20/24 UWF.</p> <p>On 3/11/25, at 8:54 AM, Surveyor interviewed Registered Nurse (RN)- O who states he will look at the Kardex or Care Plan to determine if a resident is at risk for falls. RN- O states staff on the 2nd floor also know the residents well as they are long term care, and the 2nd floor doesn't have a big turnover of residents.</p> <p>On 3/11/25, at 10:18 AM, Surveyor interviewed LPN- N who indicates staff will get a set of vitals with every resident that has a fall along with neuro checks, if the resident hits their head or the fall is unwitnessed. LPN- N states an RN assessment is completed after a resident fall. Staff will complete a post fall assessment, notify the unit manager, DON, family, and MD. LPN- N recalls the CNA put R5 on the toilet and left R5 on the toilet instructing them to press the call light when they were done using the bathroom. LPN- N heard R5's roommate yelling for help. LPN- N entered the room and found R5 lying on her back in the bathroom. LPN- N indicates she notified the unit manager right away who performed an assessment, got vitals, and performed neuro checks. LPN- N states R5 indicated she was attempting to go to the bathroom and self-transferring herself back to the wheelchair which was later determined as the root cause.</p> <p>On 3/11/25, at 12:46 PM, Surveyor interviewed Unit Manager (UM)- D who states Fall Assessments are completed on Admission and Quarterly. UM- D states Fall Risks assessments completed on admission are included on the Admission Evaluation assessment and Quarterly Fall Risk Assessments are included in the Quarterly Clinical Review assessments. Surveyor asked how a resident is determined to be a fall risk. UM- D states she usually puts everyone at risk for falls. Surveyor asked how staff know whether to check the resident as being at risk or not being at risk for falls. UM- D states there is no numbering scale on the Admission and Quarterly Assessments to help the staff determine if the resident is at a risk for falls. Surveyor notified UM- D that R5's 6/23/24 Admission Evaluation and 12/28/24 Quarterly Clinical Review both indicate R5 was not at risk for falls even though R5 experienced a fall prior to admission and in the facility on 11/20/24. Surveyor also notified UM- D of concerns with R5 being left alone while toileting on 11/20/24 and having an UWF. Surveyor notified UM- D that R5 was documented as having severe cognitive impairment and requiring assistance of 1 for toileting transfers and was left alone. Surveyor also notified UM- D of concerns with no post fall assessment being completed after R5's 11/20/24 UWF. UM- D acknowledges these concerns.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/11/25, at 3:04 PM, Surveyor notified Nursing Home Administrator (NHA)- A, DON- B, [NAME] President of Success (VPS)- C, and UM- D of concerns with R5 being left alone while toileting and having an UWF on 11/20/24. Surveyor reviewed that R5 was documented as having severe cognitive impairment and assistance of 1 for toileting transfers at the time of her fall. Surveyor noted the following to NHA- A, DON- B, VPS- C, and UM - D:</p> <p>*R5 was documented as not being at risk for falls on her Admission Evaluation dated 6/23/24, even though she was documented as having a fall in the last 30 days prior to her admission.</p> <p>*R5 was documented as not having falls in the last 0-6 months on her Quarterly Clinical Review dated 9/26/24.</p> <p>*R5 was documented as not having falls in the last 0-6 months and is not at risk for falls on her Quarterly Clinical Review dated 12/28/24, even though R5 had an UWF at the facility on 11/20/24.</p> <p>*R5 did not have a post fall assessment completed, which is noted in the facility policy.</p> <p>NHA- A, DON- B, VPS- C, and UM - D acknowledge these concerns.</p> |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>20483</p> <p>Based on interview and record review the facility did not provide pharmaceutical services to meet the needs of each resident for 1 (R2) of 4 Residents.</p> <p>* R2's order from nephrology on 1/31/25 for Sodium Bicarbonate 1300 mg (milligrams) three times a day was never picked up by the facility. On 3/11/25 Surveyor observed R2's morning medication in a medication cup with pudding & crushed medication on an over bed table. Family Friend (FF)-P informed Surveyor the nurse left the medication and she will give R2 the medication.</p> <p>Findings include:</p> <p>The facility's policy titled, Medication Administration and dated 1/25 under policy documents Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Under procedures documents 5. The person who prepares the dose for administration is the person who administers the dose.</p> <p>R2's diagnoses includes chronic kidney disease, diabetes mellitus, depressive disorder, anxiety disorder, and restless leg syndrome.</p> <p>* R2's physician order dated 1/20/25 documents Sodium Bicarbonate Oral Tablet 650 mg (milligram) (Sodium Bicarbonate (Antacid)) Give 1 tablet by mouth two times a day for heartburn.</p> <p>R2's nephrology note dated 1/31/25 documents: Her renal function as measured by GFR (glomerular filtration rate) is about the same (8-10 ml/min (milliliter per minute)). Her bicarb is much lower. From the ER (emergency room) note from 1/22/25 she was on sodium bicarb 650 BID (twice daily). Previously she was on 1300 mg BID Potassium mildly increased but OK. I would suggest increasing the bicarb to 1300 TID (three times daily). Under medication list at end of visit as of 1/31/25 with a start date of 1/31/25 documents sodium bicarbonate 650 mg tablet. Take 2 tablets (1,300 mg total) by mouth 3 times daily. Oral Notes to Pharmacy: Dose increase.</p> <p>R2's nurses note dated 1/31/25, at 13:46 (1:46 p.m.), written by Licensed Practical Nurse (LPN)-J documents Received call from [first name] who's with resident nephrologist. [First name] call with prescription update increase, sodium bicarbonate to 1300mg (milligram) 3X (three times) a day. Prescription is being fax over to facility. Resident nurse for today has been notified of this and is aware.</p> <p>Surveyor reviewed R2's physician orders and February 2025 MAR (medication administration record) and noted the facility never picked up R2' sodium bicarbonate 1300 mg three times a day dated 1/31/25. The facility continued to administer sodium bicarbonate 650 mg twice a day until 2/7/25 when R2's sodium bicarbonate order was changed to 1300 mg twice a day.</p> <p>(continued on next page)</p> |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/11/25, at 1:03 p.m., Surveyor asked Unit Manager (UM)-D why the facility did not pick up R2's sodium bicarbonate order on 1/31/25 to increase the dosage to 1300 mg three times a day. UM-D replied I didn't get that one, we should of put it in. UM-D informed Surveyor she doesn't know why it wasn't put in correctly and if she had noticed it she would of changed the order and notified the doctor. UM-D informed Surveyor typically she gets the papers when a resident goes out and transcribes the orders. UM-D informed Surveyor she doesn't know why the [first name of LPN-J] didn't transcribe it correctly.</p> <p>* R2's admission MDS (minimum data set) with an assessment reference date of 1/26/25 has a BIMS (brief interview mental status) score of 11 which indicates moderate cognitive impairment.</p> <p>On 3/11/25, at 10:56 a.m., Surveyor observed R2 in bed on her back with the head of the bed elevated. Family Friend (FF)-P was sitting in a chair next to R2's bed. Surveyor observed on the over bed table is a medication cup containing vanilla pudding with crushed medication. FF-P informed Surveyor the nurse came in and gave [first name of R2] pain pills. FF-P informed Surveyor the nurse left the other medication and FF-P stated I will give it to her. FF-P stated to Surveyor I'm her lucky charm, she will take it, referring to the medication, for me. FF-P informed Surveyor the nurse will be back in.</p> <p>Surveyor reviewed R2's physician orders and noted the following medications are administered in the morning for R2: Allopurinol 300 mg, Aspirin EC (enteric coated) 81 mg, Citalopram Hydrobromide 15 mg, Co Q-10 100 mg, Folic Acid 0.8 mg, Pantoprazole Sodium 40 mg, Rosuvastatin Calcium 10 mg, Vitamin D3 25 mcg (microgram) 2 tablets, Doxycycline Hyclate 100 mg, Metoprolol Tartrate 25 mg, Acetaminophen 650 mg, & Sodium Bicarbonate 1950 mg.</p> <p>Surveyor reviewed R2's medical record and did not note any education provided to family and/or family friend regarding administering R2's medication to R2. There is no care plan regarding family and/or family friend administering R2's medication.</p> <p>On 3/11/25, at 11:45 a.m., Surveyor asked Licensed Practical Nurse (LPN)-G if R2's family or family friend give R2 her medication. LPN-G replied sometimes they do. LPN-G informed Surveyor they, family, won't accept the fact R2 tells us no. They say just leave it and we'll give it. R2 has been refusing to take her medication. They can usually get her to take it but it takes awhile. Surveyor informed LPN-G the reason Surveyor is asking is because Surveyor observed a medication cup with pudding & crushed medication left on the over bed table. LPN-G informed Surveyor yes she left it, went back in later and took the medication cup as R2 didn't take the medication.</p> <p>On 3/11/25, at 3:07 p.m., Surveyor asked Director of Nursing (DON)-B if a resident's medication should be left with family or family friend to be administered. DON-B replied no. Surveyor informed DON-B of the observation with R2's morning medication being left for FF-P to give R2 the medication. Surveyor spoke with LPN-G who informed Surveyor the medication has been left in the past for family and/or family friend to give R2 her medication.</p> <p>No additional information was provided to Surveyor as to why R2's sodium bicarbonate order was not picked up by the facility and why R2's morning medication on 3/11/25 was left for FF-P to give R2 her medication.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525493 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/19/2025 |
| NAME OF PROVIDER OR SUPPLIER Sunrise Health Services | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>38829</p> <p>Based on interview and record review, the facility did not ensure 7 of 7 facility staff chosen at random received behavioral health training. Dietary Aide (DA)-DD, Licensed Practical Nurse (LPN)-EE, Certified Nursing Assistants(CNA) CNA-X, CNA-Y, CNA-Z, CNA-AA, CNA-BB did not receive behavioral health training. In addition, contracted employee, Speech Language Pathologist (SLP)-CC did not receive behavioral health training.</p> <p>This practice had the potential to affect all Residents with a psychiatric diagnosis and/or behavioral health issues in the facility.</p> <p>The facility did not provide staff with the required behavioral health training for the following staff: CNA-X, CNA-Y, CNA-Z, CNA-AA, CNA-BB, DA-DD, LPN-EE, and SLP-CC.</p> <p>Findings Include:</p> <p>The facility was unable to provide a facility policy and procedure for training requirements for all staff either employed at the facility or contracted.</p> <p>The facility's assessment last reviewed 8/5/24, documents:</p> <p>The facility documents a facility training program which includes orientation and ongoing training for all new and existing staff and for individuals providing services under contractual arrangement. The assessment lists various training topics to meet regulatory requirements. Surveyor notes that behavioral health is not listed as a training topic.</p> <p>However, according to the facility assessment:</p> <p>.c. Training and skills unique to Resident population:</p> <p>Each employee is educated on the below topics upon hire and on an as needed basis during the duration of employment.</p> <p>-Caring for Residents with mental and psychosocial disorders, as well as Residents with history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions.</p> <p>.Services provided such as behavioral health</p> <p>-Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities.</p> <p>The facility assessment documents that the facility has an average of 57% (34-146) Residents with a psychiatric diagnosis.</p> <p>(continued on next page)</p> | | |

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| <p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 3/19/25, at 10:51 AM, Surveyor randomly selected 7 facility staff and 1 contracted employee for review. Surveyor reviewed the employee records DA-DD, LPN-EE, CNA-X, CNA-Y, CNA-Z, CNA-AA and CNA-BB, and SLP-CC. The facility was unable to provide documentation that DA-DD, LPN-EE, CNA-X, CNA-Y, CNA-Z, CNA-AA, CNA-BB, and SLP-CC received the required effective behavioral health training within the year based on hire date.</p> <p>DA-DD - date of hire 3/10/24</p> <p>LPN-EE - date of hire 12/28/23</p> <p>SLP - date of hire 2/1/23</p> <p>CNA-X - date of hire 10/22/19</p> <p>CNA-Y - date of hire 3/13/23</p> <p>CNA-Z - date of hire 3/1/23</p> <p>CNA-AA - date of hire 3/6/24</p> <p>CNA-BB - date of hire 2/9/23</p> <p>On 3/19/25, at 1:12 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to DA-DD, LPN-EE, CNA-X, CNA-Y, CNA-Z, CNA-AA, CNA-BB, and SLP-CC not having the required behavioral health training. NHA-A explained that monitoring of the required trainings was human resources responsibility, but human resources is no longer employed at the facility and NHA-A took over monitoring of the trainings a couple of months ago. NHA-A informed Surveyor that the corporation chooses what training topics staff are required to receive. Surveyor asked NHA-A to define 57% Residents with a psychiatric diagnosis. NHA-A explained that would be 57% of 88 Residents have a psychiatric diagnosis.</p> <p>On 3/19/25, at 2:07 PM, NHA-A confirmed the facility does not have a formal behavioral health training to address the needs of Residents with a psychiatric diagnosis and/or behavioral health behaviors. NHA-A provided the following documentation of the number of Residents with the following diagnoses:</p> <ul style="list-style-type: none"> -Anxiety-41 -Bipolar-8 -Mood Disorder-1 -Schizoaffective-5 -Schizophrenia-6 -Depression-26 -Developmental Disorder-1 <p>(continued on next page)</p> | | |

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| <p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 3/19/25, at 3:15 PM, Surveyor shared the concern that DA-DD, LPN-EE, CNA-X, CNA-Y, CNA-Z, CNA-AA, CNA-BB, and SLP-CC did not receive the required behavioral health training to help facilitate staff to address the mental, psychosocial, psychiatric, and behavioral needs of Residents with a psychiatric diagnosis and/or behaviors with NHA-A, Director of Nursing (DON)-B, and [NAME] President of Success (VPS)-C. No further information was provided at this time.</p> <p>On 3/19/25, at 4:54 PM, Surveyor was provided additional information documenting an inservice on abuse. Documentation states that Residents displaying aggressive behaviors should have extra supervision, to offer diversional activities, and to report to a supervisor. However, there is no documentation that staff were provided specific training on the various psychiatric diagnoses that Residents in the facility have along with specific interventions based on the conditions listed in the facility assessment.</p> |