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 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Sunrise Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on record review, interview and policy review, the facility failed to ensure six of seven residents (Resident (R) 1, R7, R47, R55, R77, and R391), and their representatives, reviewed for facility initiated emergent hospital transfer, from a total sample of 24 residents, were provided with written transfer/discharge notice that stated the reason for transfer, the place of transfer, and how to appeal the transfer. This failure has the potential to affect the resident and their Resident Representative (RR) by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. Findings include: Review of the facility policy titled Transfer and Discharge (including AMA), reviewed/revised 07/15/23, showed: Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except as initiated by resident, necessary for the health and safety of resident or other individuals are endangered, or as otherwise permitted by applicable law. Policy Explanation and Compliance guidelines: . 3. The facility may initiate transfers or discharges in the following limited circumstances: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in facility. 7. Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). b. Notify resident and/or resident representative. i. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer. j. Provide transfer notice as soon as practicable to resident and representative. (continued on next page)

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

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

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	1. Review of R47's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE], readmission on 03/11/24, with medical diagnoses that included hemiplegia and hemiparesis following cerebral infarct, aphasia, shoulder muscle wasting and atrophy, weakness, and congestive heart failure. Review of R47's quarterly Minimum Data Set (MDS) from the EMR MDS tab, assessment reference date (ARD) 02/08/24 showed a Brief Interview for Mental Status (BIMS) score of nine out of a possible 15, indicative of moderate cognitive impairment. Review of the EMR MDS tab showed discharge return anticipated assessments (DCRA) with reference dates of 12/07/23 and 12/20/23. Review of R47's EMR Progress Notes tab showed: 12/07/23 at 7:41 PM Health Status Note- Resident was sent out to [hospital] via [company name] ambulance at 1640 due to increased edema, weakness, and slurred speech, writer updated [RR name] and [practitioner name]. 12/20/23 at 1:00 PM Health Status Note- Resident became unresponsive with decreased HR/BP [heartrate and blood pressure] and labored breathing, 911 was called and resident was transported to [hospital], resident was seen by NP [Nurse Practitioner], and DON [Director of Nursing] at time of incident. [RR] called by writer to inform of transfer to hospital. Review of the facility provided Wisconsin Bed Hold and Notice of Transfer for 12/07/23 and 12/20/23 showed a facility employee contacted someone not named on the form, by phone, regarding the transfers. 2. Review of R55's Admission Record from the EMR Profile tab showed a facility admitted [DATE], readmission on 12/06/23, with medical diagnoses that included chronic obstructive pulmonary disease (COPD), weakness, bilateral shoulder muscle wasting and atrophy, type II diabetes, chronic respiratory failure with hypoxia, hypertensive heart disease with heart failure, osteoarthritis, and congestive heart failure (CHF). During an interview on 04/02/24 at 9:46 AM, R55 stated she had not been to the hospital recently, the last time was in November due to her carbon dioxide levels being too high. R55 stated she was not conscious when she left and the hospital told her why she was there. When asked if she was provided with a written letter of transfer or bed hold policy, R55 stated no. In the survey software, R55 showed a MDS trigger for investigation due to four plus rehospitalization s. Review of R55's EMR MDS tab showed DCRA with reference dates of 07/02/23, 09/12/23, 09/20/23, and 12/03/23. Review of R55's EMR Progress Notes tab showed: 12/03/23 at 8:22 PM Change of Condition.Recommendations: Transport to Hospital for evaluation and treatment. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	09/21/23 at 6:51 AM Health Status Note- Resident asked to be sent out to the hospital @ [at] 10:50 PM, . 09/12/23 at 8:22 PM Transfer to Hospital Summary. 07/02/23 at 10:00 AM Health Status Note- Sent out to [hospital name] for AMS [altered mental status]and respiratory distress. Review of the facility provided Wisconsin Bed Hold and Notice of Transfer for 07/02/23, 09/12/23, 09/20/23, and 12/03/23 showed an unnamed person was notified by telephone of R55's transfers. The 09/20/23 notice showed the unnamed person was notified by phone on 09/13/23. During a follow up interview on 04/04/24 at 8:56 AM, R55 reviewed the four Wisconsin Bed Hold and Notice of Transfer forms; R55 reviewed them. When asked if she had received these written notices, R55 stated she had been unconscious when she left (clarified, all four times). When asked if anyone provided them once she awoke or if they were available upon return to the facility, she stated, No, the numbers [clarified the daily charges for bed hold] would have stuck out in my head. No, I've not seen these forms before. In an interview on 04/03/24 at 12:45 PM regarding the provision of written notice, the Administrator stated there was no documentation that the resident received a transfer/discharge notice upon transfer as the notices were called [to RR] afterwards. At 12:58 PM, the Administrator paraphrased from the regulation 'in writing and in a language/form they understand' and confirmed this was not being done. During an interview on 04/04/24 at 10:34 AM regarding the provision of written notice of transfer provision to the resident and RR, the Director of Nursing (DON) stated for emergent transfers, the Administrator takes care of that with the bed holds. When asked if that was done in writing, the DON responded, I was under the wrong impression [about written]. 42037 3. R77 was admitted to the facility on [DATE]. R77 was hospitalized on [DATE] and was readmitted to the facility on [DATE]. On 4/3/24 at 3:15 PM, Surveyor requested evidence that a bed hold and transfer notice was provided to R77 and to R77's responsible party when R77 was hospitalized on [DATE]. On 4/4/24 at 8:05 AM, the facility provided copies of the North Shore Healthcare Wisconsin Bed Hold and Notice of Transfer forms dated 2/8/24. Surveyor noted that a signature was not obtained from R77 or their representative on the transport section. Below the signature line is a section If unable to obtain a signature above: Facility Representative ________ (name) confirms that the resident and known family or legal representative was given notice on _____(date). They were notified by: phone, hand delivered or mail. For this notice the NHA-A is the name who gave notice and the date given is 2/29/24. Of the three options given for notification methods, phone is checked on the form. (continued on next page)

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F 0623

Level of Harm - Potential for minimal harm

Residents Affected - Many

On 4/4/24 at 10:40 AM, Surveyor interviewed NHA-A regarding the facility's procedure for bed hold and transfer notices. NHA-A confirmed that no transfer paperwork is given to the resident or representative only a phone update of the transfer after they go out. Surveyor shared concern that bed hold and transfer notices are not being given to residents or their responsible parties in a written language that they understand. NHA-A told Surveyor that they will be changing their bed hold and transfer procedure to ensure residents and their representatives receive written notice of bed hold and transfer.

4.) R7 was readmitted to the facility on [DATE] after being hospitalized on [DATE]. R7 is responsible for self.

On 4/2/2024, the Surveyor reviewed R7's electronic medical record which indicated R7 was transferred to the hospital on 2/28/2024 and was admitted to (name of hospital) with a urinary tract infection and acute kidney injury. R7 returned to same room in the facility on 3/4/2024.

Surveyor requested evidence from the facility that notice of bed hold and transfer was provided to R7 and to R7's responsible party when R7 was hospitalized on [DATE]. The facility provided copies of the North Shore Healthcare Wisconsin Bed Hold and Notice of Transfer forms dated 2/29/2024. Surveyor noted that a signature was not obtained from R7 or their representative on the transport section. Below the signature line is a section If unable to obtain a signature above: Facility Representative ________ (name) confirms that the resident and known family or legal representative was given notice on _____(date). They were notified by: phone, hand delivered or mail. For this notice the NHA (Nursing Home Administrator)-A is the name who gave notice and the date given is 2/29/24. Of the three options given for notification methods phone is checked on the form.

On 04/04/24 at 08:57 AM Surveyor spoke with R7 and asked if paperwork is given to them when sent out to hospital, R7 stated they don't remember any, that papers stay with transporter.

On 04/04/24 at 09:22 AM Surveyor spoke with Registered Nurse (RN)-C and asked if there is an emergent transfer needed is any paperwork given to the resident related to the transfer? RN-C stated that none is given directly to the resident, pertinent medical paperwork is printed then handed directly to the Paramedics.

On 4/4/24 at 10:40 AM Surveyor interviewed NHA-A regarding the process of paperwork for transfer notice. NHA-A confirmed that no transfer paperwork is given to the resident or representative only a phone update of the transfer after they go out. Surveyor shared that this is a concern and NHA-A stated they are fixing the problem already.

5. R1 was readmitted to the facility on [DATE] after being hospitalized on [DATE]. R1 is responsible for self.

On 4/2/2024 at 10:31 am, the Surveyor reviewed R1's electronic medical record which indicated R1 was transferred to the hospital on 3/16/2024 and admitted to (name of hospital) with sepsis secondary to a urinary tract infection. R1 returned to same room in the facility on 3/18/2024.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Surveyor requested evidence from the facility that notice of bed hold and transfer was provided to R1 and to R1's responsible party when R1 was hospitalized on [DATE]. The facility provided copies of the North Shore Healthcare Wisconsin Bed Hold and Notice of Transfer forms dated 3/18/2024. Surveyor noted that a signature was not obtained from R1 or their representative on the transport section. Below the signature line is a section If unable to obtain a signature above: Facility Representative ________ (name) confirms that the resident and known family or legal representative was given notice on _____(date). They were notified by: phone, hand delivered or mail. For this notice the NHA (Nursing Home Administrator)-A is the name who gave notice and the date given is 2/29/24. Of the three options given for notification methods phone is checked on the form. On 04/04/24 at 09:22 AM Surveyor spoke with Registered Nurse (RN)-C and asked if there is an emergent transfer needed is any paperwork given to the resident related to the transfer? RN-C stated that none is given directly to the resident, pertinent medical paperwork is printed then handed directly to the Paramedics. On 4/4/24 at 10:40 AM Surveyor interviewed NHA-A regarding the process of paperwork for transfer notice. NHA-A confirmed that no transfer paperwork is given to the resident or representative only a phone update of the transfer after they go out. Surveyor shared that this is a concern and NHA-A stated they are fixing the problem already. 6. R391 was readmitted to the facility on [DATE] after being hospitalized on [DATE]. R391 has a guardian assigned. On 4/2/2024 at 11:38 am, the Surveyor reviewed R391's electronic medical record which indicated R391 was transferred to the hospital on 2/13/2024 and admitted to (name of hospital) with aspiration pneumonia and sepsis. R391 returned to same room in the facility on 2/19/2024. Surveyor requested evidence from the facility that notice of bed hold and transfer was provided to R391 and to R391's responsible party when R391 was hospitalized on [DATE]. The facility provided copies of the North Shore Healthcare Wisconsin Bed Hold and Notice of Transfer forms dated 2/14/2024. Surveyor noted that a signature was not obtained from R391 or their representative on the transport section. Below the signature line is a section If unable to obtain a signature above: Facility Representative ________ (name) confirms that the resident and known family or legal representative was given notice on _____(date). They were notified by: phone, hand delivered or mail. For this notice the NHA (Nursing Home Administrator)-A is the name who gave notice and the date given is 2/14/24. Of the three options given for notification methods phone is checked on the form. On 04/04/24 at 09:22 AM Surveyor spoke with Registered Nurse (RN)-C and asked if there is an emergent transfer needed is any paperwork given to the resident related to the transfer? RN-C stated that none is given directly to the resident, pertinent medical paperwork is printed then handed directly to the Paramedics. On 4/4/24 at 10:40 AM Surveyor interviewed NHA-A regarding the process of paperwork for transfer notice. NHA-A confirmed that no transfer paperwork is given to the resident or representative only a phone update of the transfer after they go out. Surveyor shared that this is a concern and NHA-A stated they are fixing the problem already. 49011

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not ensure that 1 out of 1 residents reviewed (R141) who went out on therapeutic leave, were able to return to the facility based on following a written policy permitting residents to return after they are finished with a therapeutic leave. Findings include: R141 was originally admitted to the facility on [DATE] and discharged on [DATE]. R141 is responsible for herself. The admission contract was signed on 8/25/23 by R141. R141 was admitted using Anthem BC/BC levels. On 1/1/24, the primary payor source was changed to Medicaid. Medicaid was the payor source up to 2/2/24. A review of the last quarterly MDS, dated [DATE] indicates that R141 has a BIMS of 15 (cognitively intact) . Section Q04000- discharge plan- Is active discharge planning already occurring for the resident to return to the community?- No Surveyor conducted a review of R141's Individual Plan of Care. Resident (R141) shows potential for discharge, date initiated 8/24/23. Interventions include: o Will be discharged to home when clinical and rehabilitation goals are met. o Arrange transportation for discharge as needed. o Complete a post discharge plan. Provide copy and review with resident and/or representative. o Investigate need for special equipment, home health services, lifeline, outpatient therapy, physical follow up, resources, etc. Make referrals as needed. 11/8/2023 at 3:37 p.m., Social Services Note Text: Writer spoke with resident (R141) regarding insurance cut. Resident has a LCD of today 11/09/2023. Resident does have T19 and Business Office Manager (BOM)- D stated she can attempt to get auth but there's a chance she won't be able to. Writer informed resident of this. Resident stated she would like to stay at the facility rather than discharge because her husband is looking for a new apartment for them. Writer explained that if resident stays past today and BOM-D does not get auth she will be private pay. Resident expressed her understanding. Writer attempted to call resident's husband per her request but there was no answer and writer unable to leave a message. No questions or concerns at this time (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/27/2023 at 09:26 a.m., Social Services Note Late Entry: Care conference held on 12/27/2023. Resident(R141) and writer both present. R141's husband present via phone. R141 had a discharge date of [DATE]. R141's husband stated he still has not found a place for him and his wife to go. He is currently staying at the VA hospital. Husband and resident asked if R141 can remain at Sunrise temporarily until alternate placement is found. Writer confirmed BOM- D and R141 will switch to her Medicaid benefit as of 12/31/2023. R141 will remain at Sunrise for now and discharge planning is canceled. Writer also spoke with R141 regarding room change. R141 stated she is okay with switching rooms. R141 enjoys attending activities and socializing with other residents. R141 enjoys when her husband visits as well. R141 is no longer on therapy due to being at baseline. R141 is pleasant and stated she has no additional questions or concerns at this time. 2/2/2024 at 1:12p.m., General Note Text: R141 left with husband OOP (out on pass) via (name of transport) and is staying the weekend and plans to return on Monday to the facility. All medications sent with and divided up when to take them. R141 is in stable condition on leaving facility. 2/5/2024 at 10:07a.m., General Note Late Entry: Note Text: Writer received a call from (name of transport) that husband refused transport ride for R141 to return to facility as planned. Writer called resident's cell phone due to husband's going straight to VM (voicemail) . Husband answered R141's phone and stated, he was not ready for her to come back and would like to come pick up her medication for another day. Writer inquires regarding R141 returning, and husband requested that writer schedule (name of transport) to pick R141 up from hotel at 12pm. Transportation has been confirmed and husband stated R141 will return to the facility on ,d+[DATE]. 2/6/2024 at 2:14 p.m., General Note Text: R141 was supposed to return to facility today via (name of transport). Writer confirmed with transport that a driver did arrive for pick up, but R141 and husband did not come to the van. Writer LM for R141 to inquire on return to facility. 2/6/2024 at 2:44p.m., General Note Text: Staff remains not able to get ahold of R141 despite 2 attempts for transport and message left. 2/6/2024 at 2:44 p.m., COMMUNICATION - with R141 Note Text: R141 went out on leave on Friday 2/2 with her husband. We arranged a return ride for her on Monday 2/5 and they turned the ride away and asked for 1 more day. The SW arranged for a pick up on 2/6 at 12pm and when (name of transport) arrived neither R141 or her husband answered the call. The SW attempted to call both parties with no response. I reached out to VPS (Vice Present of Success) and she stated that if the patient is not back by 1159 pm tonight, we will not be taking R141 back. Social Worker- E, Social Worker- F and Director of Nursing (DON)- B and writer (BOM- D) called R141 and received her voicemail. A message was left letting R141 know the above information and I provided my cell phone number so they can return my call. 2/7/2024 at 08:45 a.m., General Note Text: Write received no call back on her cell phone from R141 or her husband. R141 did not return over night and no messages have been left at the facility. At this time, R141's bed is no longer on hold. (Writer is BOM- D) (continued on next page)

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F 0626

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

2/7/2024 at 10:28 a.m., COMMUNICATION - with Family/NOK/POA Note Text: received a call on my cell phone from R141's husband. He was very upset and yelling at me and would not allow me to say much. He stated that we did not give R141 notice, and he was informed we attempted to call R141 & him multiple times and got no response. He then stated the pt. phone was not working; however, he called my cell phone and the only way he could have gotten my number is by listening to the VM that was left on the patients phone yesterday (2/6). I re-stated that R141 no longer has a bed at Sunrise and that the lack of communication yesterday was the reason as it seemed as if she had discharged . I informed him that her belongings were packed up and labeled and are at the front desk. He again began to yell and not allow me to speak to i informed him that unless he was going to allow me to speak to the pt. i would be hanging up. He again got nasty on the phone so i said goodbye and hung up the phone. (Writer BOM- D)

2/7/2024 at 10:33 a.m. COMMUNICATION - with Family/NOK/POA Note Text: during this phone call the call was on speaker phone and SW- E, DON- B and Nurse Practitioner were all witness to the conversation. (Writer BOM- D)

On 04/04/24 at 09:56a.m., Surveyor interviewed BOM- D in regard to R141 being told she could not come back to the facility on [DATE]. BOM- D stated that the reason she initially got involved is that she was the Administrator in charge that weekend.

R141 was supposed to come back on that Monday and Social Services and Nursing tried to reach out to see what was going on. We has set up transportation and R141 either ignored or sent the driver away. BOM- D stated she reached out to the Corporate VPS (Vice Present of Success) for guidance on what to do next. BOM- D stated she was told that if R141 does not return to the facility by 11:59 p.m. on 2/6/24 or does not return the phone calls, then she cannot come back. BOM- D confirmed that R141's husband did call back and she let him know that they have been trying to reach both of them. We couldn't reach her, we really thought she wasn't coming back. BOM- D stated the husband was just yelling at me and said he had not turned away the transportation. Surveyor asked BOM- D if R141 was on a bed hold while she was out of the facility. BOM- D stated that being out on pass was not considered a bed hold. It was her husband she was out with,and R141 was not considered to be in danger when she didn't return on 2/6/24. BOM- D stated it was if R141 discharged herself because she didn't come back. BOM- D confirmed that R141 was never offered a bedhold. BOM- D stated R141 only asked to go out on pass for over the weekend and was going to return on Monday. BOM- D did confirm that they spoke with R141's husband and agreed he could come to facility to pick up additional medication for R141 to stay out on pass 1 additional day. R141's husband did come and pick up extra medications. Surveyor asked why then was R141 told she could not come back after 1 additional day of being out on pass. BOM- D stated it seemed like she wanted to discharge. Surveyor then asked was there a discharge plan in place? BOM- D stated she was not sure and could not confirm exactly where R141 was discharging to because she knew that R141 and her husband did not have an apartment yet to return to.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 10:00 a.m., Surveyor interviewed Administrator A regarding R141 not being allowed to return to the facility on [DATE]. Administrator- A stated that we all knew R141 didn't want to be here, and she wanted to be home with her husband. Administrator- A stated I wasn't here; I was on vacation so I don't know what basis was used for the time and date she would be discharged if she didn't return. Administrator- A stated that she knew BOM- D had called twice and left 2 messages for her to return, he didn't call back so that is why we said if you don't return by this time on this date you are discharged . Surveyor asked if you considered this to be AMA (against medical advice)? BOM -D said no, R141 wanted to leave. Surveyor stated could you have given R141 another chance/ date to return to the facility? BOM-D said it was corporate that decided this. Surveyor asked for anything in writing that this is the policy for out on pass and no return. No additional information had been provided. On 04/04/24 at 10:40a.m., Surveyor interviewed Administrator- A again about R141's discharge. Administrator- A stated that she does understand what it looks like. I spoke with the [NAME] Present of Success, and she vaguely recalls situation. I do understand that it appears we didn't give notice. I don't even know if he ever came and got her things. We don't have a policy on someone going out on Therapeutic Leave. I don't believe we have a discharge summary; she never came back. Surveyor spoke with Administrator- A that this would not have been considered a safe discharge as they did not have place to live yet. Administrator- A stated she knew that the husband had gotten evicted. Administrator- A confirmed R141 had not been back tot he facility to pick up her belongings and the facility has had no further contact. Administrator- A confirmed the facility does not have a policy regarding bedhold or therapeutic leave.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on observation, record review, interview, and facility policy review, the facility failed to ensure that alternatives to bed rails were attempted prior to the use of bed rails, failed to document reasons for failure of alternatives, and failed to advise residents and/or Resident Representatives (RR) of the risks and/or benefits of rail use with informed consent signed prior to the installation of bed rails for two of four residents (Resident (R) 47 and R53) reviewed for bed rail use. This failure had the potential for the resident, or the RR to be uninformed of the risks associated with bed rail use and could put the residents at risk for injury or entrapment. Findings include: Review of the facility policy titled, Proper Use of Side Rails, reviewed/revised 09/23/22 showed: . Policy Explanation and Compliance Guidelines: 1. In conjunction with review of resident's comprehensive assessment, the Side Rail Assessment will be completed in the electronic medical record. 2. The facility will attempt to use alternatives prior to using side/bed rails. Consider referral to therapy for bed mobility assessment. The alternatives provided shall be appropriate for the intended use of the rail. Alternatives include, but are not limited to: a. Lowering the bed b. Concave (perimeter) mattress c. Patient helper (i.e., trapeze) 3. If after an attempted alternative to side/bed rails has been made, and the alternatives do not meet the resident's needs, the facility shall: a. Evaluate the alternatives and document how these alternatives failed to meet the resident's assessed needs. If there is no appropriate alternative, document reason. b. Assess the resident for risks of entrapment! and other risks associated with the use of side/bed rails. The following are examples of potential risks: i. Accident hazards (i.e., falls, entrapment, injuries sustained from attempts to climb over, around, between, or through the rails) (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Barrier from safely getting out of bed iii. Physical restraint (i.e., hinders from independently getting out of bed or performing routine activities) iv. Decline in function, such as muscle functioning/balance v. Skin integrity issues vi. Decline in other areas of daily living, such as using the bathroom, continence, eating, hydration, walking, and mobility vii. Negative psychosocial outcomes, such as altered self-esteem, feelings of isolation, or agitation/anxiety . d. Document the medical diagnosis, condition, symptom, or functional reason for the use of the side/bed rail. 1. During an interview on 04/02/24 at 10:40 AM, R47 was observed to have bilateral assist bars and a low air loss air mattress. When asked, R47 stated he uses the assist bars to roll over, but when asked if he had been advised of the risks and benefits of having the bars, R47 responded with a hesitant yes. Review of R47's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE], readmission on 03/11/24, with medical diagnoses that included hemiplegia and hemiparesis following cerebral infarct, aphasia, shoulder muscle wasting and atrophy, weakness, and congestive heart failure. Review of R47's quarterly Minimum Data Set (MDS) from the EMR MDS tab, assessment reference date (ARD) 02/08/24 showed a Brief Interview for Mental Status (BIMS) score of 09 out of a possible 15, indicative of moderate cognitive impairment. Review of R47's Care Plan from the EMR Care Plan tab showed a focus for ADL [Activities of Daily Living] self-care deficit as evidenced by weakness related to: paralysis, R [Right] sided weakness. Pertinent interventions noted were Bed Mobility - Assist of 1 [staff] Do not roll onto R should without support Bilat [Bilateral] enabler bars to aid with mobility. Review of R47's Side Rail Assessment from the EMR Assessments tab showed an assessment completed on 03/25/24 that did not document any attempted alternatives, documented in the relevant box as N/A, to bed rails or why any alternates attempted failed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 04/02/24 at 1:17 PM, R53 was noted to have one assist rail on the bed. When asked if she used it, she stated, Yes, along with the mattress frame (and demonstrated how she reached over to grab the mattress bed frame. When asked if she had been advised of the risks and benefits of bed rails, R53 stated, I never had a discussion. It was there when I came to the bed. I just assumed it was for helping to push/pull me in the bed. Review of R53's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included bilateral shoulder muscle wasting and atrophy, weakness, type II diabetes, and post-polio syndrome. Review of R53's admission MDS with an ARD of 02/29/24 showed a BIMS score of 11 out of a possible 15, indicative of a moderate cognitive deficit. Review of R53's initial Side Rail Assessment, dated 03/25/24, showed in the section for alternatives to rails attempted N/A and did not document the failure of any alternatives possibly attempted. Review of R53's Care Plan from the EMR Care Plan tab showed an ADL self care deficit as evidenced by weakness related to: Recent hospitalization with buttocks burn, Dm2 [type II diabetes], CAD [coronary artery disease] with an intervention added on 02/23/24 for Bed Mobility: Assist of 1. Review of the physician orders from the EMR Orders tab showed on 03/26/24: R enabler bar to aid with mobility. During an interview on 04/04/24 at 10:26 AM the Director of Nursing (DON) stated We are looking at entrapment, if the resident is able to grab the rail - I personally watch to ensure if they are sliding they can grab the rail. When asked about her expectation for bed rail use, the DON responded, Ultimately we would like them to not have them [rails] but if the resident wants them we will attempt an alternate prior to placing the side rails.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42037 Based on observation, interview, and record review, the facility did not ensure medications were labeled and stored in accordance with facility policy and procedures for 2 of 4 medication carts reviewed for medication storage and 1 of 3 medications rooms reviewed for medication storage. The facility did not ensure expired medications were properly removed from facility stock. * R84, R40, R13, R85, R7, & R1 had medications stored in medication carts with no dates listed as to when medication had been opened, including ophthalmic and liquid medications. Four ophthalmic medications and one liquid medication were noted by Surveyor with no names or open dates on the first floor medication cart. One expired stock medication was noted on the first floor medication cart. Two ophthalmic medications were noted by Surveyor with no names or open dates on the second floor medication cart. Two expired stock medications were noted on the second floor medication cart. Six expired medications were found in the first floor medication room. Findings include: The facility policy titled Medication Storage, dated January 2024 states: .Outdated, contaminated discontinued or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy. 1. On 4/4/24 at 10:15 AM, Surveyor observed the first floor medication room. Surveyor noted three bottles of cranberry supplements, one with an expiration date of 12/2023 and two bottles with an expiration date of 2/2024. Surveyor noted twelve doses of acetaminophen suppositories with an expiration date of 12/2022. Surveyor noted one bottle of calcium supplement with an expiration date of 2/2023. Surveyor noted two bottles of Senna laxative syrup with an expiration date of 3/2024. Surveyor observed one saline laxative enema with an expiration date of 3/2024. Surveyor observed one bottle of Melatonin medication with an expiration date of 3/2024. 2. On 4/4/24 at 10:30 AM, Surveyor observed the first floor low side medication cart. Surveyor noted R84's brimondine eye drops and dorzolamide-timolol eye drops open in medication cart without a listed open date. Surveyor noted R40's simrinza eye drops open in medication cart without a listed open date. Surveyor noted R13's timolol eye drops open in medication cart without an listed open date. Surveyor noted R85's nystatin suspension bottle open in medication cart without a listed open date. Surveyor noted one bottle of melatonin supplement in medication cart with an expiration date of 07/2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 4/4/24 at 10:45 AM, Surveyor observed the second floor low side medication cart. Surveyor noted R7's lantanoprost eye drops open in medication cart without a listed open date. Surveyor noted R1's lantanoprost eye drops open in medication cart without a listed open date. Surveyor noted one bottle of naproxen sodium in medication cart with an expiration date of 3/2024. Surveyor noted one bottle of aspirin in medication cart with an expiration date of 2/2024. Surveyor observed the 2nd drawer of the second floor low side medication cart. Surveyor noted bottles of liquid acetaminophen, chlorohexidine gluconate, Prostat protein supplement and liquid Keppra medication open without open dates. Surveyor noted medication bottles were unbagged and stuck to the bottom of the 2nd drawer of the medication cart with a sticky substance. On 4/4/24 at 11:35 AM, Surveyor met with NHA (Nursing Home Administrator)-A to share concerns related to expired medications in first floor medication room, unmarked and expired medications in the first floor low side medication cart and unmarked and expired medications and lack of cleanliness to second floor lowside medication cart. Surveyor requested facility's Medication Storage policy. No additional information was provided by facility related to Medication Storage at this time.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on interview, record review, and review of manufacturer's instructions, the facility failed to ensure bed frames and bed rails, if present, were inspected and maintained per the Manufacturer's Instructions for Use (MIFU) to minimize the risks of bed malfunction or resident injury for four of four residents (Resident (R)46, R47, R53, and R55). This failure had the potential to affect all 94 residents in the facility using a bed. Findings include: Review of the facility policy titled Bed Maintenance and Inspections Policy, implemented 06/16/22, showed: Policy: It is the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify and avoid areas of possible entrapment. Policy Explanation and Compliance Guidelines: 1. The Maintenance Director, or designee, is responsible for keeping records of bed inspections and maintenance. 2. Bed frames, mattresses, and bed rails will be maintained, including the manufacturer for each. The Maintenance Director shall be notified of any new equipment brought into the facility. 3. The Maintenance Director shall review each manufacturer's recommendations and requirements for maintenance and bed inspections, and shall establish a maintenance and inspection schedule accordingly. 7. If bed equipment is found to be outside of the manufacturer's requirements for any reason, the facility will perform maintenance to the bed equipment or remove from use. Following a review of R46, R47, R53, and R55 for bed rail use after observations, a request for bed maintenance and/or inspection records for the facility beds. Review of the quarterly TELS (TELS(R) Platform is a software designed to help senior living operators and maintenance teams drive efficacy and cost saving) reports, dated 06/02/23, 09/05/23 12/05/23, and 03/06/24, provided by Maintenance Director revealed, : Logbook Documentation. Beds - Electric: Bed rail safety audit and entrapment audit . Inspect and document safety checks following the attached Safety Grid. Follow the guidance below. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inspect connectors on rails and tighten as necessary. Remove any burs or rough edges to prevent injury. Also inspect cranks if applicable. Check for missing or faulty screws At a minimum, the bed system must be inspected and audited at least annually. In addition to the annual audit, the bed system must be inspected and tested if any changes to the care plan are made for the Resident or if any hardware changes are made to the bed system. This audit is meant to be a cooperative venture between all Departments that interact with the bed system or the Resident. This could include Maintenance, Housekeeping, Nursing and even extend to the Resident's Family. Housekeeping is around the beds in most cases numerous times a day. Housekeeping will be in the rooms changing linens or making up the beds and can notify Maintenance and Nursing if anything is damaged or missing from the bed system. It is best to track any deficiencies with a work order that can be tied back to the unique identifier for the bed system. Maintenance typically is responsible for testing and auditing the bed systems to verify that the hardware is still in safe, functioning condition. Again, any deficiencies need to be tracked with a work order that can tie back to the bed system's unique identifier. TELS QR tags work great for this. Nursing works with the Resident's, Doctors and Family members to determine if rails are necessary. In most cases, if you remove the rails, you remove (or lessen) the risk of entrapment. Nursing should do an evaluation of the Resident that would include observing the Resident's ability moving about and transferring in/out of the bed. All attempts should be made, and documented, by Nursing to show that rails are necessary, if all other alternatives failed to assist the Resident. If rails are ultimately installed to the bed system, Nursing needs to work with Maintenance to ensure the rails are not creating a 'restraint' issue. If the rail prevents the Resident from being able to get out or move about the bed, it is considered a restraint. A restraint is defined as any manual method, physical or mechanical device, equipment or material that meets all of the following criteria: . Is attached or adjacent to the Resident's body . Cannot be removed easily by the Resident; and . Restricts the Resident's freedom of movement or normal access to his/her body There are seven entrapment zones that have been identified by the FDA - only four of the zones are defined with measureable [sic] dimensions. It is recommended when verifying your compliance with the measurements of the four zones to use the entrapment testing tool and test the bed system for entrapment anytime there is a change to the bed system (bed, mattress, rail, accessories, etc). In an interview 04/03/24 at 10:38 AM regarding bed maintenance/inspections, the Maintenance Director stated, there was no documentation of the bed rail inspections. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/03/24 at 3:19 PM a request for documentation of which beds were reviewed with the quarterly TELS reports provided, the Maintenance Director stated, That is all that is in there [TELS]. When asked to clarify if there was documentation as to which beds were inspected, the Maintenance Director responded, I just look at the unoccupied beds. When asked about occupied beds, the Maintenance Director stated, When a resident leaves, I look at the bed, but nothing is put in TELS. Review of the facility provided bed MIFUs showed: Joerns Bed Frames UltraCare XT recommendations for months inspections on page 13 showed: Preventative Maintenance To ensure maximum life of your product, follow all warnings and cautions in the User Manual and maintain your bed with care, as outlined below. The maintenance required will be dictated by your bed's usage and care - a thorough inspection should be conducted monthly. To Maximize Service Life . 4. After initial week of use, check all threaded fasteners for looseness, and make sure all pins are in their normal location and fastened securely. Check monthly for loose bolts, nuts, pins and other retaining hardware. Tighten any loose hardware, [sic] and contact Joerns Healthcare to order any appropriate service parts. 5. Make sure each inspection includes the underside of the bed frame and mattress support platform. 6. Visually inspect the bed frame and accessories for any cracking, bending, or hole enlargement. If found, contact Joerns Technical Support at [phone number], remove the bed from service immediately, and replace the affected parts. 7. Check wiring for proper connections and damage (fraying, kinking, or deterioration). Report any damage to Joerns Technical Support at [phone number] 8. Check actuators for correct mounting at attachment points and ensure all related pins are mounted securely and properly to the bed frame. Actuators are not serviceable, but are replaceable if required. 9. Lubricate pivot point, pins and bolts as required. The recommended lubricant is Joerns-approved grease [product number], available from Joerns Technical Support at [phone number]. If any discrepancies are noted during inspection, they must be corrected before continuing bed frame use. Review of the second Joerns MIFU for the EasyCare Bed Platform Model ECS, on page 15, 4. monthly check for loose bolts, nuts, pins and other retaining hardware. Tighten any loose hardware, and contact Joerns HC [Healthcare] to order any appropriate parts. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Make sure each inspection includes the underside of the bed frame and mattress support platform. 6. Visually inspect the bed frame and accessories for any cracking, bending, or hole enlargement. If found, contact . 7. Check wiring for proper connections and damage (fraying, kinking, or deterioration.) Report any damage to . 8. Check actuators for correct mounting at attachment points and ensure all related pins are mounted securely and properly to the bed frame. Actuators are not serviceable, but are replaceable if required. 9. Lubricate pivot point, pins and bolts as required. The recommended lubricant is Joerns-approved grease.