STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Scandia Village	10560 Applewood Rd Sister Bay, WI 54234

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 47248 Based on staff interview and record review, the facility did not ensure a resident or their representative was informed and consented to the risks and benefits of care and the treatment for 2 residents (R) (R16 and R20) of 5 sampled residents. R16 was prescribed Seroquel (an antipsychotic medication), Lexapro (an antidepressant medication), Depakote (an anticonvulsant/mood stabilizing medication), Paxil (an antidepressant medication), Buspar (an anti-anxiety medication), and Namenda (a cognition-enhancing medication). R16's medical record did not contain current consents for the medications. R20 was prescribed Seroquel, Depakote, Paxil, Namenda, and Exelon (a cognition-enhancing medication). R20's medical record did not contain current consents for the medications. Findings include: On 4/24/24 at 11:00 AM, Surveyor requested the facility's Resident Rights policy from Regional Consultant (RC)-C who indicated the facility followed state and federal laws regarding resident rights. The facility's Psychotropic Medication Use policy indicates: Residents, families and/or their representatives are involved in the medication management process .Residents and/or their representatives have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/resident representative the risks related to not taking the medication as well as appropriate alternatives. 1. On 4/22/24, Surveyor reviewed R16's medical record which indicated R16 had an activated power of attorney(POA) and was prescribed Seroquel, Lexapro, Depakote, Paxil, Buspar, and Namenda. R16's medical record contained the following informed consents for medication: ~Depakote, signed 6/11/22 ~Lexapro, signed 10/9/21 ~Namenda, signed 10/9/21 ~Seroquel, signed 10/6/20 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~Buspar, signed 6/11/22 The informed consent for medication forms contained the following information: dose and when to be given, alternative mode of treatment or in addition to the medication, probable consequences of not receiving the proposed medication, possible side effects, warnings and cautions including rare side effects and overall health, and a signature for the informed consent that indicated the resident/resident representative has the right to refuse to consent to medication and can withdraw consent at any time. The forms indicated questions can be discussed and answered with the interdisciplinary team, medications may not be discontinued immediately, the resident/resident representative has a right to request a review of the record at any time and a legal right to file a compliant if they feel the resident's rights were inappropriately restricted. The form also indicated the resident/resident representative permits a dosage change within the anticipated dosage range without signing another consent, and understands the use, potential risks and benefits, and alternative treatments. The form indicated the consent was for a period effective immediately, but not to exceed fifteen months from the date of the signature. On 4/22/24 at 10:53 AM, Surveyor interviewed R16's POA who indicated they did not sign recent medication consents for R16. R16's POA stated they signed medication consent forms when R16 was admitted to the facility. R16's POA did not currently know what medications R16 was prescribed. 2. On 4/22/24, Surveyor reviewed R20's medical record which indicated R20 had an activated POA and was prescribed Seroquel, Depakote, Paxil, Namenda, and Exelon. R20's medical record contained the following informed consents for medication: ~Depakote, signed 4/15/22 ~Paxil, signed 4/15/22 ~Namenda, signed 4/15/22 ~Seroquel, signed 4/15/22 ~Exelon, signed 4/15/22 On 4/22/24 at 3:00 PM, Surveyor requested current medication consent forms for R16 and R20 from RC-C. On 4/24/24 at 10:30 AM, RC-C provided Surveyor with R16 and R20's medication consent forms. Surveyor reviewed the forms and indicated the consent forms were not signed within the 15 month time frame. RC-C confirmed the facility did not obtain and review medication consent forms with resident representatives and stated the facility had turnover in Social Services and a part-time Social Services Director who worked remotely. RC-C stated RC-C would continue to look for current signed informed consent for medication forms for R16 and R20 which were not provided to Surveyor as of this writing.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not ensure 2 residents (R) (R12 and R22) of 2 residents reviewed for hospitalization received a transfer notice that included the date of the transfer, the reason for the transfer, the location of the transfer, and appeal rights. In addition, the facility did not notify the Ombudsman of the transfers. R12 was transferred to the hospital on 6/3/23. R12 was not provided with a written transfer notice and the Ombudsman was not notified of the transfer. R22 was transferred to the hospital on 11/17/23. R22 was not provided with a written transfer notice and the Ombudsman was not notified of the transfer. Findings include: The facility's Transfer Agreement policy, with an effective date of 8/1/17, indicates: Whenever the attending physician of a patient implements an order that a transfer of a patient from the facility to the hospital is medically necessary and appropriate, the facility shall transfer the patient .as promptly as possible .The facility shall arrange for safe transportation of the patient and be responsible for notification of the transfer. 1. On 4/22/24, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] with diagnoses including heart failure, pathological fracture, venous insufficiency, and polyneuropathy. R12's Minimum Data Set (MDS) assessment, dated 3/4/24, contained a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R12 had moderately impaired cognition. On 6/3/23, R12 had redness and pain in the right leg from knee to foot. R12 was transferred and admitted to the hospital for evaluation and treatment. R12's medical record did not contain a written transfer notice or indicate the Ombudsman was notified of the transfer. From 4/22/24 through 4/24/24, Surveyor requested a copy of R12's written transfer notice and Ombudsman notification which was not provided. On 4/23/24 at 12:28 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who was not aware of facility's transfer agreement policy. On 4/24/24 at 12:50 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed the facility did not provide a written transfer notice when R12 was transferred to the hospital. 45942 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/22/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty walking, and long-term anticoagulant (blood thinner) use. R22's MDS assessment, dated 8/28/23, contained a BIMS score of 15 out of 15 which indicated R22 had intact cognition. On 11/17/23, R22 sustained a laceration to the head during an unwitnessed fall and was transported to the hospital for evaluation and treatment. R22's medical record did not contain a written transfer notice or indicate the Ombudsman was notified of the transfer. From 4/22/24 to 4/24/24, Surveyor requested a copy of R22's written transfer notice and Ombudsman notification. On 4/23/24 at 12:28 PM, Surveyor interviewed LPN-G who was not aware of the facility's transfer agreement policy. On 4/24/24 at 12:50 PM, Surveyor interviewed NHA-A who confirmed the facility did not provide a written transfer notice when R22 was transferred to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not ensure 2 residents (R) (R12 and R22) of 2 residents reviewed for hospitalization received written information of the duration of the facility's bed-hold policy, the reserve bed payment policy, and the right to return to the facility. R12 was transferred to the hospital on 6/3/23 and was not provided a copy of the facility's bed-hold policy. R22 was transferred to the hospital on 11/17/23 and was not provided a copy of the facility's bed-hold policy. Findings include: The facility's Bed-Holds and Returns policy, revised 3/2022, indicates: Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies .1. All residents/representatives are provided written information regarding the facility's bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization s or therapeutic leave). Residents are provided written information about these policies at least twice: well in advance of any transfer (e.g., in the admission packet) and at the time of transfer (or, if the transfer was an emergency, within 24 hours). 1. On 4/22/24, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] with diagnoses including heart failure, pathological fracture, venous insufficiency, and polyneuropathy. R12's Minimum Data Set (MDS) assessment, dated 3/4/24, contained a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R12 had moderately impaired cognition. On 6/3/23, R12 had redness and pain in the right leg from knee to foot and was transferred and admitted to the hospital for evaluation and treatment. R12's medical record did not indicate a copy of the facility's bed-hold policy was provided to R12. From 4/22/24 to 4/24/24, Surveyor requested a copy of R12's bed-hold notification. On 4/23/24 at 12:28 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who was not aware of the facility's bed-hold policy. On 4/24/24 at 11:07 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed R12 was not provided with the facility's bed-hold policy when R12 was transferred to the hospital. 45942 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/22/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty walking, and long-term anticoagulant (blood thinner) use. R22's MDS assessment, dated 8/28/23, contained a BIMS score of 15 out of 15 which indicated R22 had intact cognition. On 11/17/23, R22 sustained a laceration to the head during an unwitnessed fall and was transferred to the hospital for evaluation and treatment. R22's medical record did not indicate a copy of the bed-hold policy was provided to R22. From 4/22/24 to 4/24/24, Surveyor requested a copy of R22's bed-hold notification. On 4/23/24 at 12:28 PM, Surveyor interviewed LPN-G who was not aware of the facility's bed-hold policy. On 4/24/24 at 11:28 AM, Surveyor interviewed NHA-A who confirmed R22 was not provided with the facility's bed-hold policy when R22 was transferred to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not accurately code Minimum Data Set (MDS) 3.0 assessments for 2 residents (R) (R4 and R21) of 13 sampled residents. R4's MDS assessment, dated 2/21/24, did not contain a Brief Interview for Mental Status (BIMS) score or indicate R4's cognition was assessed. R21's MDS assessment, dated 3/28/24, did not contain a BIMS score or indicate R21's cognition was assessed. Findings include: The facility's MDS Completion and Submission Timeframes policy, revised July 2017, indicates: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. 1. The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to the Centers for Medicare & Medicaid Services (CMS') Quality Improvement & Evaluation System (QIES) Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments are based on the current requirements published in the Resident Assessment Instrument Manual. 3. Submission of MDS records to the QIES ASAP is electronic. 1. R4 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, type two diabetes, and heart failure. Between 4/22/24 and 4/24/24, Surveyor reviewed R4's medical record. R4's Quarterly MDS assessment, dated 2/21/24, indicated in Section C (Cognitive Patterns) Question 1 (C0100) that a BIMS interview should be completed, however, a BIMS interview was not completed. In addition, R4's Quarterly MDS assessment, dated 11/21/23, indicated in Section C Question 1 that a BIMS interview should be completed, however, a BIMS interview was not completed. 2. R21 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, cerebral infarction, and type two diabetes. Between 4/22/24 and 4/24/24, Surveyor reviewed R21's medical record. R21's Quarterly MDS assessment, dated 3/28/24, indicated in Section C Question 1 that a BIMS interview should be completed, however, a BIMS interview was not completed. In addition, R21's prior MDS assessment, dated 12/28/23, indicated in Section C Question 1 that a BIMS interview should be completed, however, a BIMS interview was not completed. On 4/23/24 at 11:44 AM, Surveyor interviewed Regional Consultant (RC)-C who indicated MDS' were completed by Minimum Data Set Coordinator (MDSC)-D who worked remotely. RC-C stated RC-C expected MDS and BIMS assessments to be completed. (continued on next page)

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	525494	A. Building B. Wing	04/24/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/24 at 11:52 AM, Surveyor interviewed MDSC-D who indicated MDSC-D coded residents' MDS assessments. MDSC-D indicated R4 and R21's BIMS assessments were not completed because a Social Worker retired and another Social Worker worked part time. MDSC indicated the Social Worker was supposed to complete the in-person resident interview questions, including the BIMS assessment. MDSC-D stated MDSC-D expected BIMS assessment to be completed for MDS assessments. On 4/24/24 at 12:47 PM, Surveyor interviewed RC-C who confirmed the facility follows the MDS policy that was provided to Surveyor.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure a Level I Pre-Admission Screening and Resident Review (PASRR) Screen was completed prior to admission for 1 resident (R) (R22) of 5 residents. The facility did not ensure R22's Level I PASRR Screen was completed prior to admission. Findings include: On 4/22/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), anxiety, and post-traumatic stress disorder (PTSD). R22's Minimum Data Set (MDS) assessment, dated 8/28/23, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R22 had intact cognition. Surveyor noted R22's medical record did not contain a Level I PASRR Screen. On 4/24/24 at 2:31 PM, Surveyor interviewed Regional Consultant (RC)-C who could not locate R22's Level I PASRR Screen but agreed a Level I PASRR Screen should be completed for a resident with a diagnosis of anxiety. On 4/24/24 at 2:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified a Level I PASRR Screen should be completed for a resident with a diagnosis of anxiety.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not ensure a baseline care plan was developed or provided within 48 hours of admission for 1 resident (R) (R178) of 13 sampled residents. A baseline care plan was not completed or provided to R178 within 48 hours of admission. Findings include: The facility's Care Planning-Interdisciplinary Team policy, revised March 2022, indicates: Resident Care plans are developed according to the timeframes and criteria established by state statute (S) 483.21. According to S483.21 Comprehensive person-centered care planning: (a) Baseline care plans: (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must: (i) Be developed within 48 hours of a resident's admission; (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: (A) Initial goals based on admission orders (B) Physician orders (C) Dietary orders (D) Therapy services (E) Social services (F) PASRR recommendation, if applicable (2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan: (i) Is developed within 48 hours of the resident's admission; (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). (3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident; (ii) A summary of the resident's medications and dietary instructions; (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; (iv) Any updated information based on the details of the comprehensive care plan, as necessary. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/24, Surveyor reviewed R178's medical record. R178 was admitted to the facility on [DATE] with diagnoses including mild neurocognitive disorder due to known physiological condition with behavioral disturbance, urinary tract infection (UTI), type two diabetes with hyperglycemia, chronic heart failure, and chronic atrial fibrillation. R178's most recent Minimum Data Set (MDS) assessment did not contain a Brief Interview for Mental Status (BIMS) score and indicated R178 was Rarely or never understood. R178 had an activated Power of Attorney for Healthcare (POAHC). R178's medical record contained an unspecified care plan (not designated as baseline or comprehensive) that was created on 4/12/24 which was outside of the 48-hour requirement. There were no other care plans available for R178 at the time of the survey. On 4/24/24 at 11:08 AM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A. DON-B indicated a resident's plan of care (POC) should be developed immediately upon admission. NHA-A indicated the POC should ideally be completed within 48 hours. NHA-A confirmed the POC should be resident-specific and include the resident's name, diagnoses, goals, and pertinent care information. NHA-A confirmed the information should be available in the baseline POC. On 4/24/24 at 12:47 PM, Surveyor interviewed Regional Consultant (RC)-C who confirmed the care plan policy provided to Surveyor is what the facility follows.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not develop or implement an individualized comprehensive care plan for 1 resident (R) (R21) of 13 sampled residents. R21 required assistance with activities of daily living (ADL). The facility did not develop a comprehensive care plan that included ADL interventions related to toileting and incontinence care. Findings include: The facility's Care Planning-Interdisciplinary Team policy, revised March 2022, indicates: Resident care plans are developed according to the timeframes and criteria established by state statute (S) 483.21. S483.21(b) Comprehensive Care Plans indicates a comprehensive care plan must be .Developed seven days after completion of the comprehensive assessment .(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments .Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) . On 4/23/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, cerebral infarction (stroke), type two diabetes, anxiety, urinary tract infection (UTI), and sepsis. R21's Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated a Brief Interview for Mental Status (BIMS) assessment was not completed. The MDS assessment also indicated R21 was occasionally incontinent of bladder and required partial/moderate assist for toileting hygiene. R21's previous MDS assessment, dated 12/28/23, indicated R21 was frequently incontinent of bladder and occasionally incontinent of bowel and required partial/moderate assist for toileting hygiene. R21 had an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed R21's most recent plan of care (POC) which did not contain interventions related to ADL self-care performance deficits including toileting and incontinence care. On 4/22/24 at 11:09 AM, Surveyor observed R21 in a recliner in R21's room. Surveyor noted R21's bed was stripped of bedding and the middle of the mattress contained irregular circle-shaped stains that were darker at the edges and consistent with that seen on a wet or previously wet mattress. R21 stated R21 was unhappy with the staff and woke up daily in a wet bed. On 4/23/24 at 10:55 AM, Surveyor interviewed R21's POAHC who indicated they were unhappy with R21's care and stated staff should check on R21 at least every 2-3 hours and offer toileting assistance. R21's POAHC indicated R21 often woke up in the morning with a wet bed which was then stripped and left unmade all day. R21's POAHC stated the facility did not address different approaches to help support R21. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 11:08 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed a POC should be resident-specific and include the resident's diagnoses, goals, and pertinent care information. On 4/24/24 at 12:47 PM, Surveyor interviewed Regional Consultant (RC)-C who confirmed the care plan policy provided to Surveyor was what the facility followed.

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NAME OF PROVIDER OR SUPPLIER: Serenity Spring Senior Living at Scandia Village		STREET ADDRESS, CITY, STATE, ZIP CODE: 10560 Applewood Rd Sister Bay, WI 54234	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47248 Based on staff interview and record review, the facility did not ensure the comprehensive plan of care was reviewed and revised in a timely manner for 6 residents (R) (R2, R16, R18, R20, R21, and R22) of 13 sampled residents. R2, R16, R18, R20, R21 and R22's care plans were not reviewed prior to or on the due dates listed on the care plans. Findings include: The facility's Care Planning-Interdisciplinary Team policy, revised March 2022, indicates: Resident care plans are developed according to the timeframes and criteria established in S483.21. S483.21(b) Comprehensive Care Plans indicates a comprehensive care plan must be .Developed seven days after completion of the comprehensive assessment .(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments .Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment. The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.18.1, dated October 2023, indicates all Medicare and/or Medicaid-certified nursing homes must complete . Comprehensive Minimum Data Set (MDS) assessments: include both the completion of the MDS as well as completion of the Care Area Assessment (CAA) process and care planning. Comprehensive MDS' include Admission, Annual, Significant Change .The MDS completion date must be no later than 14 days after the ARD (ARD + 14 calendar days) .The CAA(s) completion date must be no later than 14 days after the ARD (ARD + 14 calendar days) .The care plan completion date must be no later than 7 calendar days after the CAA(s) completion date (CAA(s) completion date + 7 calendar days) . On 4/22/24, Surveyor reviewed R2's medical record and noted R2's care plan was due for review on 4/11/24, however, the review was not completed which made the care plan eleven days overdue. On 4/22/24, Surveyor reviewed R16's medical record and noted R16's care plan was due for review on 4/8/24, however, the review was not completed which made the care plan fourteen days overdue. On 4/22/24, Surveyor reviewed R18's medical record and noted R18's care plan was due for review on 4/11/24, however, the review was not completed which made the care plan eleven days overdue. On 4/22/24, Surveyor reviewed R20's medical record and noted R20's care plan was due for review on 4/14/24, however, the review was not completed which made the care plan eight days overdue. On 4/22/24, Surveyor reviewed R21's medical record and noted R21's care plan was due for review on 4/6/24, however, the review was not completed which made the care plan sixteen days overdue. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/24, Surveyor reviewed R22's medical record and noted R22's care plan was due 4/11/24 but not completed which made the care plan eleven days overdue. On 4/23/23 at 2:54 PM, Surveyor interviewed Regional Consultant (RC)-C who indicated the previous Director of Nursing (DON) did not complete assessments and care plans timely. RC-C stated a past non-compliance form was filled out and indicated the plan moving forward was to ensure all past due cares plans were completed. Regarding the above listed care plans that were not completed timely, RC-C indicated the facility was attempting to complete the care plans with some newer staff, part-time staff, and remote staff. RC-C indicated RC-C would provide Surveyor with the plan for completion of the assessments and care plans. On 4/24/24, Surveyor reviewed the facility's past non-compliance form, dated 4/8/24, that indicated the following: After a transition to and from the permanent to interim DON, a full house sweep of care plans were reviewed. It was noted that some care plans were not up to date or had omissions regarding, but not limited to, baseline care plans, advanced directives, preferences, and social services .Root Cause: Turnover in nursing department, remote social services and MDS nurse in place, transition of DON duties, and floor nurses . Action: Full house sweep of care plans began .Meeting with nursing and departmental staff .Will be discussed in Quality Assurance meeting on 4/18/24. Surveyor noted despite the past non-compliance plan identified on 4/8/24 and reviewed on 4/18/24, care plans for R2, R16, R18, R20, R21 and R22 were overdue and not completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff and resident interview, and record review, the facility did not provide assistance with activities of daily living (ADLs) for 1 resident (R) (R21) of 13 sampled residents. R21 required assistance with toileting and incontinence care which was not consistently provided. Findings include: On 4/23/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, cerebral infarction (stroke), type two diabetes, anxiety, urinary tract infection (UTI), and sepsis. R21's Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated a Brief Interview for Mental Status (BIMS) assessment was not completed. The MDS assessment also indicated R21 was occasionally incontinent of bladder and required partial/moderate assist for toileting hygiene. R21's previous MDS assessment, dated 12/28/23, indicated R21 was frequently incontinent of bladder and occasionally incontinent of bowel and required partial/moderate assist for toileting hygiene. R21 had an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed R21's most recent plan of care (POC) which did not contain interventions related to ADL self-care performance deficits including toileting and incontinence care. On 4/22/24 at 11:09 AM, Surveyor observed R21 in a recliner in R21's room. Surveyor noted R21's bed was stripped of bedding and the middle of the mattress contained large irregular circle-shaped stains that were darker at the edges and consistent with that seen a wet or previously wet mattress. Surveyor interviewed R21 who indicated R21 was unhappy with the staff. R21 stated R21 woke up daily in a wet bed. R21 stated R21 asked staff why R21's bed was wet and was told R21 was peeing the bed. On 4/23/24 at 10:55 AM, Surveyor interviewed R21's POAHC who indicated they were unhappy with R21's care and stated staff didn't pay attention to R21. R21's POAHC stated staff should check on R21 at least every 2-3 hours and offer assistance with needs, including toileting. R21's POAHC indicated R21 often woke up in the morning with a wet bed from incontinence which was then stripped and left unmade all day. R21 had to sit in a chair and could not lay down in bed if R21 wanted to. R21's POAHC stated they gave the facility pads to help with R21's nighttime incontinence, but the staff did not encourage or assist R21 to wear them. R21's POAHC indicated they reported their concerns with the lack of toileting, incontinence care, nighttime incontinence issues, and ignoring R21's needs and were told R21 was independent and staff could not go against R21's wishes. R21's POAHC stated the facility did not address different approaches to help support R21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 9:43 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who indicated R21 was independent with toileting. CNA-E indicated R21 wore an incontinence brief and was occasionally incontinent, including that morning when R21 was wet through R21's brief and pants. CNA-E indicated CNA-E told R21 to change R21's wet pants and brief. CNA-E indicated CNA-E told R21 to change R21's self before. CNA-E indicated CNA-E was aware R21's bed was wet at times in the morning and stated housekeeping changed R21's bedding and cleaned the mattress. CNA-E indicated CNA-E usually checked on R21 one to two times per shift and didn't need to do anything for R21 because R21 was independent. On 4/24/24 at 10:06 AM, Surveyor interviewed CNA-F who indicated R21 usually completed R21's own incontinence care. CNA-F indicated R21 wore a pull up brief for urinary incontinence and stated R21 was mostly incontinent at night when sleeping. CNA-F stated if R21's bed was wet in the morning, the CNAs stripped and sanitized the bed and left the bed unmade to give the mattress time to dry. CNA-F indicated CNA-F usually checked on R21 every 2 hours. On 4/24/24 at 10:20 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who indicated R21 was independent with a lot of things but needed help with bed changes as well as reminders and cues. LPN-G stated R21 was not fully independent.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47248 Based on observation, staff interview, and record review, the facility did not ensure the provision of care and treatment in accordance with professional standards of practice for 1 resident (R) (R13) of 1 sampled resident with edema. R13 had a diagnosis of edema. R13's plan of care did not contain interventions to treat, monitor, or provide edema relief. In addition, the facility did not update R13's physician on the effectiveness of a short-term medication order for edema. Findings include: The facility's undated Goals and Objectives, Care Plans policy indicates: Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence .Care plan goals and objectives are defined as the desired outcome for a specific problem .When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly .Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: are resident oriented, are behavioral stated, are measurable, and contain timetables to meet the resident's needs in accordance with the comprehensive assessment .Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. The facility's undated Medication Utilization and Prescribing-Clinical Protocol policy indicates: Cause Identification .2. The physician and staff will evaluate the effectiveness and effects of the medications in a resident's regimen .Treatment/Management: 1. Based on input from the staff and resident, the physician will adjust medication based on their efficacy, indications, and the continued presence of clinically significant risks .Monitoring .3. If the physician has stopped, tapered, or changed an existing medication, the staff will monitor for, document, and report any return of the symptoms. On 4/22/24 at 8:57 AM, Surveyor observed R13 and noted R13 had bilateral lower extremity edema. On 4/23/24, Surveyor reviewed R13's medical record. R13 had an activated Power of Attorney for Healthcare (POAHC) and had diagnoses including dementia-severe with mood disturbance, amnesia, anxiety, and edema. R13's Minimum Data Set (MDS) assessment, dated 3/13/24, contained a Brief Mental Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R13 had severely impaired cognition. R13's medical record did not contain a current order for diuretic medication or interventions for the relief, monitoring, or management of edema. On 4/23/24 at 12:30 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-O who confirmed R13 had lower extremity edema and stated R13 was previously prescribed medication for edema. CNA-O also confirmed R13 did not have an order for compression stockings or other interventions to prevent edema. CNA-O stated nursing staff should start transferring R13 to a chair in the afternoon to elevate R13's legs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/24 at 1:04 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated interventions for R13's edema included the addition of atenolol (a beta blocker medication) ordered on 3/15/24. DON-B stated the medication was for hypertension (high blood pressure) but could assist with edema as well. DON-B confirmed R13 did not have an order for a diuretic medication to treat edema and verified R13's care plan did not contain interventions to evaluate or monitor for edema. DON-B indicated DON-B would review R13's medical record and obtain further information regarding treatment and monitoring for edema. On 4/24/24 at 7:17 AM, DON-B approached Surveyor and indicated R13 had an order for Lasix (a diuretic medication) 20 mg (milligrams) for five days which was discontinued. DON-B confirmed R13 continued to have edema, but R13's plan of care did not contain interventions to address edema, including assessments or communication with Medical Doctor (MD)-J regarding the effectiveness of Lasix. DON-B provided Surveyor with documentation from R13's medical record regarding treatment that was provided for R13's edema. On 4/24/24, Surveyor reviewed the information provided from DON-B and noted MD-J saw R13 on 3/12/24 and ordered Lasix 20 mg daily for five days for edema. Surveyor reviewed R13's medication administration history and noted R13 was administered Lasix 20 on 3/15/24, 3/16/24, 3/17/24, 3/18/24, 3/19/24, and 3/20/24. Surveyor noted a current order, dated 3/15/24, for atenolol. The information did not contain updates to MD-J regarding edema resolution, the effectiveness of Lasix, or interventions including tubigrips, compression stockings, and repositioning to assist with edema relief. MD-J saw R13 again on 4/9/24 and indicated R13 had one plus to two plus swelling to both lower extremities. Surveyor noted no further plan at that time. An addendum to the assessment and plan, dated 4/24/24, indicated nursing staff commented on R13's increased swelling to the lower extremities and Lasix 20 mg was prescribed for five days in hopes to decrease the swelling. The skilled visit note indicated MD-J may opt to continue Lasix depending on how R13 responded to the medication. Surveyor noted there was not a continuation of the Lasix order or an update to R13's care plan to monitor for edema . On 4/24/24 at 1:22 PM, Surveyor spoke with MD-J via telephone regarding the assessment, interventions, and treatment plan for R13's edema. MD-J indicated Lasix 20 mg was ordered on 3/15/24 to see if the medication would help relieve R13's edema. MD-J indicated MD-J was not updated on the effectiveness of the Lasix, did not receive further communication about continuing the Lasix, and did not receive requests for additional interventions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure the environment remained as free of accident hazards as possible for 2 residents (R) (R22 and R16) of 2 residents reviewed for falls. R22 fell on [DATE] and 11/17/23. The falls were not thoroughly investigated to determine the root cause and R22's plan of care was not updated to prevent future falls. R16 fell on [DATE]. Falls interventions contained in R16's plan of care were not implemented at the time of the fall. Findings include: The facility's Falls-Clinical Protocol, revised March 2018, indicates: .While many falls are isolated, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause .2. In addition, the nurse shall assess and document/report the following: .h. precipitating factors, details on how fall occurred . 3. The staff and practitioner will review each resident's risk factors for falls and document in the medical record .5. The staff will evaluate, and document falls that occur while the individual is in the facility, for example, when and where they happen, any observations of the events, etc .For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall .If the cause of a fall is unclear .a physician will review the situation and help further identify causes and contributing factors .3. The staff and physician will continue to collect and evaluate information until either the cause of the fall is identified, or it is determined that the cause cannot be found or is not correctable. Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls .2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions .Monitoring and Follow-up: .2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falls or the consequences of falling .3. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether the measures are still needed .4. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falls .and also reconsider the current interventions . The facility's undated Goals and Objectives, Care Plans policy indicates: .5. Goals and objectives are reviewed/and or revised: When there has been a significant change in the resident's condition, when the desired outcome is not achieved, when the resident has been readmitted to the facility, and at least quarterly . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 4/22/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), anxiety, muscle weakness, difficulty walking, and long-term anticoagulant (blood thinner) use. R22's Minimum Data Set (MDS) assessment, dated 8/28/23, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R22 had intact cognition. R22's MDS assessment, dated 7/5/23, indicated R22 required partial/moderate assist for toileting. R22's MDS assessment, dated on 2/14/24, indicated R22 required partial/moderate assistance for lower body dressing. Surveyor noted R22 had two unwitnessed falls on 9/16/23 and 11/17/23. R22's falls care plan contained the following intervention: Ensure (R22) is wearing appropriate footwear e.g., fully enclosed slip resistant shoes when ambulating or mobilizing in wheelchair. On 4/23/24 at 10:30 AM, Surveyor observed R22 ambulate with a walker and gripper socks. R22 was not wearing enclosed slip resistant shoes per R22's care plan. On 4/23/24 at 10:35 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-H who was not aware of R22's fall interventions or where to find them. On 4/23/24 at 12:14 PM, Surveyor interviewed Director of Nursing (DON)-B who read out loud R22's falls care plan which indicated R22 was at risk for falls related to deconditioning and gait/balance problems and had an actual fall on 9/16/23. The care plan contained the following interventions: (R22) will be free of falls through the review date; Remind (R22) not to bend over to pick up dropped items; Encourage use of grabber or to ask for assistance; Ensure (R22) is wearing appropriate footwear e.g., fully enclosed slip resistant shoes when ambulating or mobilizing in wheelchair; Avoid clothing that is too loose, slippery, too long. DON-B stared DON-B expected staff to implement R22's fall interventions. On 4/23/24 at 12:20 PM, Surveyor interviewed CNA-F who was not aware of R22's fall interventions. On 4/23/24 at 1:35 PM, Surveyor interviewed DON-B regarding R22's unwitnessed falls on 9/16/23 and 11/17/23. DON-B was unsure of the root cause of the falls. DON-B verified the falls were not investigated or discussed in follow-up meetings. DON-B also verified R22's care plan was not updated after the fall on 9/16/23. On 4/24/24 at 8:56 AM, DON-B stated DON-B read R22's progress notes and indicated the root cause of R22's unwitnessed fall on 9/16/23 was that R22 bent over to pick up something in the bathroom. DON-B stated the root cause of R22's unwitnessed fall on 11/17/23 was that R22 lost R22's balance when R22 attempted to sit on the toilet due to a change of condition and change in medication which affected R22's mobility. On 4/24/24 at 12:51 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated falls should be thoroughly investigated and have interdisciplinary team (IDT) follow up in order to determine the root cause and develop/update resident-centered fall interventions. 47248 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/23/24, Surveyor reviewed R16's medical record. R16 had an activated Power of Attorney for Healthcare (POAHC) and diagnoses including dementia with delusional disorder, cognitive communication disorder, dysthymic disorder, acquired absence of other specified parts of digestive system, and anxiety. R16's MDS assessment, dated 3/6/24, contained a BIMS score of 0 out of 15 which indicated R16 had severely impaired cognition. A progress note, dated 4/22/24, indicated: Certified Nursing Assistant (CNA) indicated R16 lost footing when walking and fell to buttocks on the floor. Bruising noted to R16's right mid back and right hip. R16 transferred with assist and reported no pain. The progress note indicated R16 did not have footwear on during the fall. Surveyor reviewed R16's care plan, with a revision date of 10/15/23, and noted R16 had falls due to confusion and advanced dementia, running down hallways, poor safety, and spatial awareness. The care plan contained an intervention to ensure R16 wore appropriate footwear, including slip resistant shoes or gripper socks when ambulating or mobilizing in wheelchair (dated 1/31/24). The care plan was not updated and did not contain an intervention following R16's fall on 4/22/24. On 4/23/24 at 10:01 AM, Surveyor interviewed CNA-O who was not informed of R16's fall on 4/22/24. CNA-O indicated falls are typically discussed in shift report. CNA-O indicated CNA-O was not informed of the fall or any new interventions that were implemented for R16. On 4/23/24 at 1:17 PM, Surveyor interviewed DON-B who indicated the facility's policy is to complete a falls investigation if they are unsure how the fall occurred. DON-B stated the root cause of R16's fall was that R16 was not wearing appropriate footwear at the time of the fall. DON-B indicated there were no care plan interventions implemented following the fall, however, interventions would typically be discussed in the next day's morning meeting. DON-B confirmed a fall investigation, root cause analysis, and care plan update for R16 did not occur because nursing staff did not follow the fall intervention that was already in place.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47248 Based on observation, staff interview, record review, the facility did not ensure weights were obtained per physician orders for 4 residents (R) (R13, R20, R16 and R128) of 4 sampled residents. Staff did not obtain and document weekly weights for R13, R20, and R16 per physician orders. R128 was admitted to the facility on [DATE]. R128's medical record did not contain weight information. Findings include: On 4/23/24, Surveyor reviewed R13's medical record. R13 had an activated Power of Attorney for Healthcare (POAHC) and diagnoses including dementia-severe with mood disturbance, edema, hypothyroidism, and anxiety. R13's Minimum Data Set (MDS) assessment, dated 3/13/24, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R13 had severely impaired cognition. R13's medical record contained a signed order from Medical Director (MD)-J, dated 2/1/24, for weekly weights on Tuesdays. R13's medical record did not contain weekly weights. Surveyor noted since October 2023, R13's weights were documented monthly. On 4/23/24, Surveyor reviewed R16's medical record. R16 had an activated POAHC and diagnoses including dementia with delusional disorder, cognitive communication disorder, dysthymic disorder, vitamin D deficiency, and acquired absence of other specified parts of digestive system. R16's MDS assessment, dated 3/6/24, contained a BIMS score of 0 out of 15 which indicated R16 had severely impaired cognition. R16's medical record contained a signed order from MD-J, dated 2/1/24, for weekly weights to be obtained on Mondays. R16's medical record did not contain weekly weights. Surveyor noted since October 2023, R16's weights were documented monthly with the last weight obtained on 3/15/24. On 4/23/24, Surveyor reviewed R20's medical record. R20 had an activated POAHC and diagnoses including Alzheimer's disease, dementia, delusional disorder, vitamin D and B deficiency, disease of digestive systems, and malignant neoplasm of the brain. R20's MDS assessment, dated 4/19/24, contained a BIMS score of 0 out of 15 which indicated R20 had severely impaired cognition. R20's medical record contained a signed order from MD-J, dated 2/1/24, for weekly weights to be obtained on Wednesdays. R20's medical record did not contain weekly weights. Surveyor noted since October 2023, R20's weights were documented monthly. On 4/23/24, Surveyor reviewed R128's medical record. R128 was admitted to the facility on [DATE] with diagnoses including dementia and anxiety and had an activated POAHC. R128's MDS assessment, dated 4/17/24, contained a BIMS score of 6 out of 15 which indicated R128 had severely impaired cognition. R128's medical record contained an admission order from MD-J, dated 4/17/24, for weekly weights to be obtained on Mondays. R128's medical record did not include an admission weight or any weight information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER: Serenity Spring Senior Living at Scandia Village		STREET ADDRESS, CITY, STATE, ZIP CODE: 10560 Applewood Rd Sister Bay, WI 54234	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/24 at 10:01 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-O who indicated obtaining weights was a problem on the unit because lightening hit the building and broke the scale in October 2023. CNA-O indicated CNA-O obtained weights when able and stated maintenance staff and administration were aware the scale was broken. CNA-O stated staff had to take residents to another unit to be weighed which was problematic because the unit was a dementia care unit. On 4/24/24 at 8:30 AM Surveyor interviewed Regional Consultant (RC)-C who indicated the facility monitored weights and stated residents who triggered for weight loss were monitored by Registered Dietician (RD)-L. RC-C indicated there were identified problems with weights being obtained and stated the facility had documentation of attempts to obtain a new scale for the unit. RC-C indicated RC-C would provide Surveyor with the information. On 4/24/24 at 8:46 AM, Surveyor interviewed RD-L who indicated residents should be weighed weekly or more often if indicated. RD-L verified RD-L monitored residents who triggered for weight loss or gain. RD-L was not aware staff were not obtaining weekly weights as ordered. On 4/24/24 at 11:32 AM, RC-C provided Surveyor information on the facility's attempts to obtain a new scale. RC-C indicated the scale was ordered and stated facility continued to work with the previous owner for payment of the scale. RC-C stated the facility had a plan for monitoring weights despite the broken scale and stated staff on the dementia unit should call another staff and take residents to another unit to be weighed. RC-C stated all residents should be weighed weekly or as ordered. On 4/24/24, Surveyor reviewed emails provided by RC-C and noted the following: ~2/29/24: An email from Nursing Home Administrator (NHA)-A to the Chief Operating Officer of the organization indicated the previous owners of the facility were responsible for payment of the new scale because the incident occurred prior to the sale of the facility in January 2024. Further communication with the Chief Operating Officer on 2/29/24 indicated NHA-A should obtain a list of the scales, including the make and models, and determine how residents were being weighed since October 2023 despite two broken scales. ~3/7/24: A print out from (supply company) indicated two electronic wheelchair scales were ordered and needed to be paid for. ~4/12/24: An email from the previous owners to RC-C indicated the previous owners would pay for one scale (for the dementia unit) and were looking at how to get the order confirmed and paid for. ~4/24/24 at 9:58 AM: An email from RC-C to the previous owners regarding follow-up on the scales. The previous owners indicated the scale and payment were figured out and they were working with (supply company) on how to order the scale. ~On 4/24/24 at 12:46 PM, RC-C provided Surveyor with a Performance Improvement Plan (PIP), dated 3/7/24, that indicated weight meetings were implemented for individuals who triggered for weight loss. RC-C indicated the PIP was added to the Quality Assurance meeting on 4/10/24 but the plan wasn't completed. RC-C stated staff on the memory care unit should call another staff to the unit to residents off of the unit to be weighed at the nearest nurses's station. RC-C stated the plan for obtaining weights was initiated on 3/7/24 and confirmed the facility was not in compliance with obtaining weights per physician orders. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24, Surveyor reviewed the PIP which indicated the following: ~Education was provided to all staff regarding obtaining daily, 3 day admission, weekly, and monthly weights as ordered. ~All weights will be written orders to ensure each weight is obtained in a timely fashion and documented. ~ All 3 day admission, weekly, and monthly weights should be listed, recorded, and signed off on the Treatment Administration Record (TAR) by nursing staff. Surveyor noted the PIP contained scale instructions, including how to use the scale for a wheelchair, standing, or with a lift. The PIP indicated staff should call additional staff to take residents to another unit with a working scale to obtain residents' weights. On 4/24/24 at 12:46 PM, Surveyor requested the facility's weight policy from RC-C which was not provided.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure monitoring of a high-risk medication was provided for 1 resident (R) (R22) of 5 residents reviewed for unnecessary medications. The facility did not monitor R22 for potential side effects or adverse reactions of anticoagulant (blood thinner) medication. Findings include: On 4/22/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), anxiety, muscle weakness, difficulty walking, and long-term anticoagulant use. R22's Minimum Data Set (MDS) assessment, dated 8/28/23, contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R22 had intact cognition. R22 had a physician order for Eliquis (an anticoagulant mediation) 2.5 mg (milligrams), give 1 tablet by mouth two times daily for atrial fibrillation (abnormal heart rhythm). Surveyor noted R22's plan of care did not contain interventions that alerted staff to monitor R22 for signs and symptoms of bleeding and bruising. On 4/24/24 at 8:41 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R22's plan of care did not contain anticoagulant monitoring. DON-B verified staff should monitor for signs and symptoms of bleeding and bruising for residents on anticoagulant medication.

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47248

Based on staff interview and record review, the facility did not ensure monitoring for adverse effects of psychotropic medication was provided for 3 residents (R) (R16, R128, and R178) of 5 residents reviewed for unnecessary medications.

R16 was prescribed antipsychotic, antidepressant, and anti-anxiety medication. R16's medical record did not indicate a gradual dose reduction was attempted within the last year or that a GDR was contraindicated.

R128 was prescribed antipsychotic, antidepressant, and anti-anxiety medication. R128's plan of care did not contain monitoring for signs and symptoms of adverse effects or the effectiveness of the medication. In addition, R128's medical record did not contain an Abnormal Involuntary Movement Scale (AIMS) assessment.

R178 was prescribed antipsychotic and anti-anxiety medication. R178's plan of care did not contain monitoring for adverse effects or the effectiveness of the medication. In addition, R178's medical record did not contain an AIMS assessment.

Findings include:

The facility's Psychotropic Medication Use policy indicates: A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior .Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: Antipsychotics, antidepressants, anti-anxiety medication and hypnotics . Residents on psychotropic medications receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the medications .Residents who receive psychotropic medications are monitored for adverse consequences, including: anticholinergics effects .cardiovascular effects .neurologic effects including agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events .psychosocial effects .Situations which may prompt an evaluation or re-evaluation of the resident include: admission or re-admission, clinically significant change in condition/status, a new, persistent, or recurrent clinically significant symptom or problem, a worsening of an existing problem or condition, an unexplained decline in function or cognition, a new medication order or renewal of orders, or an irregularity identified in the pharmacist's medication regimen review .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Tapering Medications and Gradual Drug Dose Reduction policy indicates: After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions (GDR) .Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR at least annually, unless clinically contradicted .For any individual who is receiving a psychotropic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: the resident's target symptoms return or worsen after the most recent attempt at a GDR within the facility and the physician has documented that the clinical rational for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. 1. On 4/23/24, Surveyor reviewed R16's medical record. R16 had an activated Power of Attorney for Healthcare (POAHC) and diagnoses including dementia with delusional disorder, cognitive communication disorder, dysthymic disorder, anxiety, and major depressive disorder. R16's Minimum Data Set (MDS) assessment, dated 3/6/24, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R16 had severely impaired cognition. R16's medical record indicated a GDR was attempted on 12/2/20. R16 was prescribed the following medication: Seroquel (an antipsychotic medication), Lexapro (an antidepressant medication), Depakote (an anticonvulsant/mood stabilizing medication), Paxil (an antidepressant medication), Buspar (an antianxiety medication), and Namenda (a cognition-enhancing medication). On 4/23/24 at 11:48 AM, Surveyor requested R16's most recent GDR or physician documentation regarding contraindication for a GDR from Director of Nursing (DON)-B. When Surveyor stated R16's medical record indicated a GDR was last attempted on 12/2/20 and all further monthly medication reviews did not contain a GDR per recommendations or a contradiction from the physician to indicate the reason a GDR was not attempted, DON-B indicated DON-B would obtain and provide the information to Surveyor. On 4/23/23 at 2:54 PM, Surveyor interviewed Regional Consultant (RC)-C who indicated a GDR would be in R16's medical record. RC-C indicated RC-C would obtain the GDR or contradiction information and provide the information to Surveyor. The information was not provided. 2. On 4/23/24, Surveyor reviewed R128's medical record. R128 was admitted to the facility on [DATE] and had diagnoses including dementia and anxiety. R128's MDS assessment, dated 4/17/24, contained a BIMS score of 6 out of 15 which indicated R128 had severely impaired cognition. R128 had an activated POAHC and was prescribed the following medication: lorazepam (an antianxiety medication), duloxetine (an antipsychotic medication), and Seroquel (an antidepressant medication). R128's medical record did not contain an AIMS assessment or monitoring for adverse effects of the psychotropic medications. On 4/24/24 at 8:01 AM, Surveyor requested R128's AIMS assessment and adverse effect monitoring information from RC-C who indicated RC-C would obtain and provide the information to Surveyor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 8:10 AM, DON-B approached Surveyor and indicated monitoring for adverse effects of antipsychotic, antidepressant, and anti-anxiety medication were located in the Treatment Administration Record (TAR) or resident's care plan. DON-B indicated AIMS assessments were located in the assessment section of the resident's medical record. DON-B reviewed R128's medical record, TAR, and care plan and confirmed an AIMS assessment was not completed upon admission. DON-B also confirmed R128 was not being monitored for adverse effects of the psychotropic medications. DON-B indicated an AIMS assessment should have been completed upon admission and monitoring for adverse effects should be contained in R128's care plan or TAR. 49010 3. On 4/22/24, Surveyor reviewed R178's medical record. R178 was admitted to the facility on [DATE] with diagnoses including mild neurocognitive disorder due to known physiological condition with behavioral disturbance. R178 was prescribed lorazepam as needed for agitation and quetiapine (an antipsychotic medication). R178's most recent MDS assessment did not contain a BIMS score and indicated R178 was Rarely or never understood. R178 had an activated POAHC. On 4/23/24 at 12:30 PM, Surveyor requested an AIMS assessment and monitoring for adverse effects of lorazepam and quetiapine for R178 from DON-B. On 4/24/24, Surveyor reviewed an AIMS assessment and printed orders sheet for R178. The AIMS assessment was dated 4/24/24 at 10:45 AM and signed by Licensed Practical Nurse (LPN)-G. The order sheet contained two new orders, dated 4/24/24, to monitor for adverse side effects of lorazepam and to monitor for adverse side effects of quetiapine. On 4/24/24 at approximately 1:30 PM, Surveyor interviewed DON-B who verified R178 did not have monitoring orders or an AIMS assessment completed prior to 4/24/24.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect 27 of 27 residents residing in the facility. Staff did not ensure time/temperature control foods were labeled with open or use-by dates. Staff did not wear hair or beard restraints consistently throughout the kitchen. Kitchen equipment and food services areas were not in a clean and sanitary condition. Findings include: On [DATE] at 9:23 AM, Dietary Director (DD)-K indicated the facility follows the Food and Drug Administration (FDA) Food Code. Open/Unlabeled/Undated/Expired Food: The FDA Food Code 2022 documents at ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (Celsius) (41 F) (Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. The FDA Food Code 2022 documents at ,d+[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition: (A) A food specified in ,d+[DATE].17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in ,d+[DATE].17 (A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in ,d+[DATE].17 (A). The facility's Date Marking-Food and Nutrition Policy, dated [DATE], indicates: Time/Temperature Control for Safety Food (TCS) items are date marked when received, when manufacturer package is opened, and when removed from the freezer into refrigeration .1. When TCS food is received, employees: a. Observe for vendors date of delivery and if not available, date-mark the item with the delivery date .d. If the items are removed from the original container/package, individual items are labeled and dated with date of receiving. 2. a. Ensure that ready-to-eat TCS foods opened at the location are clearly date-marked for: 1) The date/time the original container is opened. 2) The date or day by which the food shall be consumed on the premises, sold, or discarded. During an initial tour of the kitchen with DD-K on [DATE] at 9:23 AM, Surveyor observed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dry Storage: -A unlabeled bag of shredded coconut (identified by DD-K) dated ,d+[DATE] (an open date per DD-K) with no use-by date -An unlabeled half full box of bananas with no delivery or use-by dates -An open box of yellow cake mix dated [DATE] (a delivery date per DD-K) with no open or use-by dates -A plastic container labeled R Bran(per DD-K the container held Corn Flakes) dated ,d+[DATE]. DD-K was unsure if ,d+[DATE] was an open or use-by date. DD-K changed the label to the appropriate product name. -A two-gallon Ziploc bag labeled Raisin Bran dated ,d+[DATE]. DD-K was unsure if ,d+[DATE] was an open or delivery date and there was no use-by date. -An open 35 ounce bag of Corn Flakes with no open or use-by dates -A plastic container labeled Cheerios dated ,d+[DATE]. DD-K was unsure if ,d+[DATE] was an open or delivery date and there was no use-by date. - Three large racks of canned foods more than half of which did not contain delivery dates. Walk-In Cooler: -An unlabeled and undated tray of individual pineapple servings covered with saran wrap -An unlabeled and undated plastic container with six cabbage heads -An open, unlabeled bag of shredded carrots (identified by DD-K) dated ,d+[DATE]. DD-K was unsure if , d+[DATE] was an open or delivery date and there was no use-by date. -An open, undated, and unlabeled bag of salad mix (identified by DD-K) -An open, undated, and unlabeled bag of broccoli (identified by DD-K) -An open, unlabeled bag of carrots (identified by DD-K) dated ,d+[DATE]. DD-K was unsure if ,d+[DATE] was an open or delivery date and there was no use-by date. -An open, undated, and unlabeled container of onions (identified by DD-K) -An open, two-thirds full five-pound bag of shredded mozzarella dated ,d+[DATE] (a delivery date per DD-K) with no open or use-by dates -An open, unlabeled, undated, one-eighth full bag of shredded parmesan cheese (identified by DD-K) Reach-In Cooler: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An undated, unlabeled container with twenty five shelled eggs -An unlabeled plastic quart-sized bag of sliced American cheese (identified by DD-K) dated ,d+[DATE] (an open date per DD-K) with no use-by date -An unlabeled container of tomato salad dated ,d+[DATE] with no use-by date Freezer: -An open bag of stir fry vegetables dated [DATE] (an open date per DD-K) with no use-by date -Three undated, unlabeled plastic bags of frozen peeled bananas (identified by DD-K) -An undated, unlabeled, open to air bag of California vegetable mix (identified by DD-K) -An undated, unlabeled plastic bag of tilapia filets (identified by DD-K) -An undated, unlabeled two gallon plastic resealable bag of cheese curds (identified by DD-K) -An undated, unlabeled plastic bag of chicken breasts (identified by DD-K) -An undated, unlabeled plastic bag of chicken drummies (identified by DD-K) -An undated, unlabeled plastic bag of fajita chicken (identified by DD-K) -Three undated, unlabeled plastic bags of potato chips (identified by DD-K) -An unlabeled five pound package of ground beef (identified by DD-K) dated ,d+[DATE] (a delivery date per DD-K) with no use-by date During the initial kitchen tour on [DATE], Surveyor interviewed DD-K who verified the facility used the FIFO (first in/first out) food storage process. DD-K indicated staff are supposed to date items with an open or made date as well as a use-by date. DD-K stated if staff don't date food when it is delivered, opened, made, or when it needs to be discarded, it makes it difficult to appropriately use food in a FIFO rotation and ensure food safety. DD-K indicated the undated items identified during the initial tour were an oversight with one staff and DD-K would schedule an in-service to ensure all staff followed the policy. DD-K stated DD-K would dispose of the unlabeled and undated items. Hair Net Use: The FDA Food Code 2022 documents at ,d+[DATE].11 Hair Restraints: Effectiveness (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens and unwrapped single service and single use articles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Employee Hygiene and Dress Code-Food and Nutrition Services policy, dated [DATE], indicates: 1. Hair nets or hair restraints and beard nets or beard restraints are used: a. when cooking, preparing, assembling food or ingredients. This includes dish rooms and storage areas. See specific state guidelines. Hair is to be covered completely. On [DATE] at 9:23 AM, Surveyor noted DD-K's hair net did not cover DD-K's hair and left the back lower lower third of DD-K's hair exposed. On [DATE] at 7:52 AM, Surveyor observed Cook (CK)-N prep and serve food without a hair or beard net in the food preparation/serving area of the kitchen. CK-N wore a disposable face mask that did not cover CK-N's nose or the sides of CK-N's facial hair. On [DATE] at 8:04 AM, Surveyor observed an unidentified man enter the kitchen. The man went to the handwashing sink, performed maintenance, and then exited the kitchen. The man wore a hat, but did not wear a hair or beard net. On [DATE] at 8:22 AM, Surveyor again observed DD-K with a hair net that did not cover DD-K's hair and left the back lower third of DD-K's hair exposed. On [DATE] at 12:18 PM, Surveyor interviewed DD-K who stated the man who entered the kitchen was a maintenance man who checked the sink. DD-K indicated DD-K thought CK-N had a bald head and did not realize CK-N grew out CK-N's hair. DD-K verified all staff should wear hair nets and beard nets (if needed) in the kitchen that fully cover any and all hair. 3. Cleanliness: The FDA Food Code 2022 documents at ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. The FDA Food Code 2022 documents at ,d+[DATE].12 Cooking and Baking Equipment: (A) Food-contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. The FDA Food Code 2022 documents at ,d+[DATE].13 Nonfood-Contact Surfaces: Non-food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. The facility's Cleaning Schedule-Food and Nutrition Services policy, dated [DATE], indicates: Cleaning Schedule: 1. The Director of Food and Nutrition Services .or designee is to post daily, weekly and monthly cleaning assignments in the kitchen area .2. Employees are responsible for knowing their assigned duty and carrying it out during the designated work shift. 3. Employees will initial the schedule after completing their cleaning duties each day. During the initial kitchen tour on [DATE], Surveyor noted the following: -The inside of the ice machine contained dark colored debris on the panel above the ice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Scandia Village	10560 Applewood Rd Sister Bay, WI 54234

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The area around the fryer (located between the flat top grill/griddle and steamer) contained grease and debris on the wall behind the fryer that was caked on and ran down the sides of the steamer and flat top griddle. -A large cooking pot contained water and was not covered. -The shelves above the floor in the kitchen (food prep area) and dishwashing area were not clean. The dishwashing area contained dirt and debris on the floor. -The walk-in cooler contained spills on the floor. During a subsequent kitchen tour on [DATE], Surveyor noted the following: -A large cooking pot contained water and was not covered. During the initial kitchen tour on [DATE], Surveyor interviewed DD-K who indicated DD-K does not cover the cooking pot and cleans it out before use. DD-K indicated DD-K expects the floors to be cleaned nightly and the kitchen to be cleaned daily and as needed. DD-K verified the fryer area was dirty and the floors were not clean. DD-K indicated the areas were unacceptable and would be addressed right away. DD-K indicated DD-K did not assign cleaning duties, but DD-K was aware of the cleaning issues. DD-K reported DD-K brought concerns to the Quality Assurance and Performance Improvement (QAPI) meeting on [DATE] and made a new cleaning list; however, DD-K did not start the new cleaning protocol or complete kitchen staff education yet.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45942 Based on staff interview and record review, the facility did not ensure the minimum required members of the Quality Assurance Performance Improvement (QAPI) committee met at least quarterly which had the potential to impact all 27 residents residing in the facility. Three of four required quarterly QAPI meetings held over the past year did not have the Medical Director (MD), Nursing Home Administrator (NHA), Director of Nursing (DON) and/or Infection Preventionist (IP) in attendance as required. Findings include: On 4/24/24 at 8:27 AM, Surveyor reviewed the facility's QAPI sign-in sheets for meetings held during the previous year. The sign-in sheets indicated a QAPI meeting was held on 6/14/23 with the NHA, DON, IP and seven other staff in attendance. A meeting was held on 9/13/23 with the MD, NHA, DON, IP and five other staff in attendance. A meeting was held on 12/13/23 with the NHA and five other staff in attendance. A meeting was held on 3/13/24 with the DON/IP and five other staff in attendance. On 4/24/24 at 9:47 AM, Surveyor interviewed NHA-A who indicated the DON was the delegated IP at QAPI meetings and stated the MD was emailed regarding QAPI meeting content when the MD was not in attendance. On 4/34/24 at 12:48 PM, Surveyor interviewed NHA-A who confirmed the MD attended one meeting in person during the last year. NHA-A indicated NHA-A expected the MD to attend the QAPI meetings in person and participate at least quarterly as required.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47248 Based on observation, staff interview, and record review, the facility did not establish and maintain infection control and water management programs designed to help prevent the development and transmission of disease and infection. In addition, the facility did not ensure enhanced barrier precautions were implemented for 4 residents (R) (R2, R18, R4, and R79) of 4 residents to reduce the transmission of multidrug-resistant organisms (MDROs) and did not ensure staff performed appropriate hand hygiene for 5 (R1, R9, R16, R129 and R19) of 5 residents observed during medication administration. These practices had the potential to affect all 27 residents residing in the facility. The facility did not maintain surveillance logs to assist with the recognition of trends and patterns of infection to help prevent the spread of communicable disease. In addition, the facility did not monitor residents for signs and symptoms of infection. The facility did not have a water management program that identified areas in the water system where Legionella could grow and spread and to reduce the risk of Legionnaires' disease. The facility did not ensure enhanced barrier precautions (EBP) were implemented for R2 who had an indwelling catheter. The facility did not ensure EBP were implemented for R18 and R4 who received wound care. The facility did not ensure EBP were implemented for R79 who received intravenous (IV) antibiotics for an active infection. Licensed Practical Nurse (LPN)-G did not perform proper hand hygiene during medication administration for R1, R9, R16, R129, and R19. Findings include: On 4/23/24 at 2:30 PM, Surveyor confirmed with Regional Consultant (RC)-C that the facility followed the infection prevention and control program policies and procedures listed under the previous owner's name and provided to Surveyor. 1. The facility's Infection Prevention and Control Program indicates: Purpose: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Surveillance policy indicates: Surveillance is an activity that a healthcare institution employs to find, analyze, control, and prevent nosocomial infections. Its definition can further include the following: collection, collation, analysis of data, and passing of the information to those who need to know and act. Once a baseline is established, it can then be determined where control is needed. Components of surveillance are the following: Definitions of infections, data collection procedures, forms and reports, analysis by using cultures, changes in prevalent organisms and increase in rates, and results which are given to appropriate persons .Procedure: Define events to be surveyed for nosocomial infections, define what data will be collected .determine the purpose of the data collection such as obtain baseline, determine endemic level of specific organisms, perform routine surveillance activities, identify outbreaks, prevent spread .report results .an outbreak investigation may be used to find ways to interrupt further transmission of the disease-causing agent .outbreak investigation steps: verify diagnosis and identify the agent, confirm that an outbreak exists, look for additional cases, characterize the cases by person, place and time, explain the observations, consider control measures, initiate the most appropriate .Documentation: For residents, complete the infection and antimicrobial tracking tool. On 4/22/24 at 10:09 AM, Surveyor requested the facility's infection, communicable disease, and outbreak surveillance data from Nursing Home Administrator (NHA)-A for the previous three months. On 4/23/24, Regional Consultant (RC)-C provided Surveyor with COVID-19 surveillance outbreak documentation. Surveyor did not receive any other surveillance data for the previous three months and again requested the information. When Surveyor asked the name of the facility's Infection Preventionist (IP), RC-C indicated RC-C would obtain the information for Surveyor. On 4/23/24 at 3:30 PM, Surveyor again requested infection surveillance data from RC-C who indicated the facility had a change of ownership and turnover in the IP and Director of Nursing (DON) positions. RC-C stated surveillance documentation was being located and would be provided when obtained. On 4/24/24 at 8:38 AM, Surveyor interviewed RC-C and NHA-A regarding surveillance data for upper respiratory infections (URIs) other than COVID-19, gastrointestinal infections, urinary tract infections (UTIs), skin infections, and any other infections tracked by the facility. RC-C stated the facility had no outbreaks besides the COVID-19 outbreak data provided to Surveyor. When Surveyor asked RC-C about R13 who was prescribed an antibiotic in March 2024 for a URI and was not included in the COVID-19 outbreak surveillance data, RC-C stated RC-C would continue to look for other infection surveillance data. NHA-A stated any resident diagnosed with a URI and prescribed an antibiotic should be on infection surveillance as well as antibiotic stewardship surveillance. On 4/24/24 at 8:47 AM, Surveyor interviewed IP-I via telephone. IP-I indicated IP-I worked for the facility remotely since January 2024 when the facility changed ownership. IP-I indicated the facility had surveillance lists for all infection types and had approximately eleven months of data that the previous IP printed for IP-I when the facility changed ownership. IP-I indicated the facility did not have many infections aside from a COVID-19 outbreak and one resident with a non-COVID URI in March 2024. IP-I indicated there was one resident on the February 2024 line list and no residents on the November 2023, December 2023 or January 2024 line lists per IP-I's knowledge. IP-I was uncertain of the accuracy of the line lists and stated IP-I needed to see the documentation because IP-I did not know of any other community-acquired or facility-acquired infections. IP-I stated IP-I would work with RC-C to find the documentation because IP-I did not have access to the line lists during the call. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/24/24 at 10:00 AM, Surveyor interviewed RC-C who stated RC-C spoke with IP-I who attempted via phone to locate the facility's infection surveillance data. RC-C stated the previous IP may have taken the data. When Surveyor indicated IP-I stated during a phone interview that the facility had surveillance data for the previous eleven months and IP-I would provide the data to RC-C to provide to Surveyor, RC-C stated RC-C would provide the data when it was obtained. On 4/24/24 at 12:15 PM, RC-C provided Surveyor with the infection surveillance data. Surveyor reviewed the data noting the following: ~Surveillance data for April 2024 indicated R79 was admitted to the facility in April 2024 with osteomyelitis (a bone infection) and was prescribed antibiotic medication. The April 2024 surveillance data did not contain any other information. Record review and investigation indicated R178 was monitored and tested for a UTI in April with the results pending during the recertification survey. Surveyor noted R178 was not on the facility's infection surveillance data. Record review and investigation also indicated R22 was treated with antibiotics for a toe infection in April. Surveyor noted R22 was not on the facility's infection surveillance data. ~Surveillance data for March 2024 contained COVID-19 outbreak data. Surveyor noted R13 was diagnosed with a URI on 3/17/24 and prescribed an antibiotic but was not on the facility's infection surveillance data. ~Surveillance data for February 2024 contained one resident (who no longer resided in the facility). The data contained the start date and end date of symptoms, the type of infection, and indicated the resident was prescribed Macrobid (an antibiotic) for a facility-acquired infection. The data did not contain information about the start and stop dates for Macrobid, any tests completed, the resident's symptoms, and when and what precautions were initiated/ discontinued to prevent the spread of the MDRO named on the surveillance list. ~Surveillance data for January 2024 indicated there were no infections. ~Surveillance data for December 2023 indicated there were no infections. Record review indicated R21 was admitted to the facility with a diagnosis of sepsis. ~Surveillance data for November 2023 indicated there were no infections. ~Surveillance data for June 2023 through October 2023 indicated the following information: resident name, start date, date symptoms resolved, type of infection (listed either as UTI other genitourinary, other skin and soft tissue, fungal skin, pneumonia, lower respiratory), status as closed or open, infection source as either community or facility- acquired, and surveillance criteria met. There was no information provided regarding signs and symptoms, antibiotics prescribed, tests completed, criteria met or unmet, and start and stop dates of precautions on any of the documentation provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The facility's Legionella Water Management Program, revised 2023, indicates: As part of the infection prevention and control program, our facility has a water management program that is overseen by the water management team. The water management team consists of at least the following personnel: the Infection Preventionist, the Administrator, the Director of Maintenance and the Director of Environmental Services. The purpose of the water management program is to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaires' disease. The water management program used by our facility is based on the Centers for Disease Control and Prevention (CDC) and the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) recommendations for developing a Legionella water management program. The water management program includes, but is not limited to the following elements: An interdisciplinary water management team, a detailed description and diagram of the water system in the facility, including the following: receiving, cold water distribution, heating, and hot water distribution. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following (if applicable): storage tanks, water heaters, filters, aerators, showerheads, hoses, misters, atomizers, air washers, humidifiers, hot tubs, fountains, and medical devices. The identification of situations that can lead to Legionella growth, such as construction, water main breaks, changes in municipal water quality, the presence of biofilm, scale or sediment, water temperature fluctuations, water pressure changes, water stagnation and inadequate disinfection. Specific measures used to control the introduction and/or spread of Legionella, the control limits or parameters that are acceptable and that are monitored, a diagram of where control measures are applied, a system to monitor control limits and the effectiveness of control measures, a plan for when control limits are not met or control measures are not effective, and documentation of the program. During the entrance conference on 4/22/24 at 10:09 AM, Surveyor requested the facility's Legionella prevention policy and water management program from NHA-A. On 4/23/24 at 3:30 PM, Surveyor again requested the information and RC-C stated RC-C would provide the information to Surveyor. On 4/24/24 at 1:15 PM, Surveyor interviewed NHA-A and again requested the information which was not provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The facility's Enhanced Barrier Precautions policy, dated April 2024, indicates: Enhanced barrier precautions (EBP) are recommended by the CDC to prevent the spread of multi-drug resistant organisms (MDROs) to residents .EBP are used as an infection prevention and control intervention to reduce the spread of MDROs and employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply: gloves and gown are applied prior to performing the high-contact resident care activity as opposed to before entering the room, personal protective equipment (PPE) is changed before caring for another resident, face protection may be used if there is also a risk of splash or spray .EBP are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .examples of high contact resident care activities requiring the use of gown and gloves for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting .device care or use of the following are some examples: .urinary catheters, feeding tubes .and wound care (any skin opening requiring a dressing related to drainage) for the following examples: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous/arterial ulcers, and chronic wounds which is a wound that is greater than 30 days .Staff are trained on EBP .signs are posted on the door or wall outside the resident's room indicating the type of precautions and PPE required. On 4/22/24 at 9:30 AM, Surveyor noted EBP precaution signs on R2, R18, R79 and R4's doors. On 4/22/24 at 1:00 PM, Surveyor reviewed R2, R18, R79, and R4's medical records and noted the following: ~R2 had a urinary catheter, received catheter care by staff, and was placed on EBP. ~R18 had a left ankle wound, received wound care by staff, and was placed on EBP. ~R79 received IV antibiotics by staff for a diagnosis of osteomyelitis and was placed on EBP. ~R4 had a heel wound, received wound care by staff, and was placed on EBP. On 4/23/24 at 7:42 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-H who worked the units on which R2, R18, R79 and R4 resided. CNA-H stated CNA-H was not sure about EBP and thought EBP was barrier cream applied to a resident. CNA-H indicated CNA-H provided dressing, showering, toileting, and catheter care to residents on EBP but was unsure what personal protective equipment (PPE) should be used during care. CNA-H stated CNA-H had to ask a nurse or look in the task list to see if residents on EBP required PPE and indicated no residents currently required PPE because the units were free of COVID-19. On 4/23/24 at 1:13 PM, Surveyor observed LPN-G don gloves and perform right ankle wound care for R18. LPN-G did not wear any other PPE during wound care. Surveyor interviewed LPN-G and asked if staff were required to wear PPE for EBP during high contact care. LPN-G indicated LPN-G was not aware of EBP or additional PPE needed for high contact care provided to R18. LPN-G indicated if catheter care is performed, a gown must be worn in addition to gloves. LPN-G was unsure if R18, R79, and R2 were on EBP and was unsure what PPE should be worn for residents on EBP with wounds and IV medication or during high contact care such as toileting and showering, and for residents with MDRO diagnoses. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

On 4/23/24 at 1:30 PM, Surveyor interviewed DON-B regarding the facility's EBP policy and expectation when a resident has an EBP sign on their door. DON-B indicated DON-B was unsure what PPE was needed for EBP. When Surveyor relayed the observation of wound care by LPN-G, DON-B indicated DON-B was not sure which residents were on EBP and stated DON-B would look for a policy and find out what PPE was needed.

On 4/23/24 at 1:45 PM, Surveyor interviewed CNA-F who worked the units on which R2, R18, R79 and R4 resided. CNA-F indicated CNA-F was not sure about EBP and didn't know what PPE was required and when it should be worn. CNA-F indicated CNA-F received training for EBP and stated it depended on the resident.

On 4/23/24 at 3:11 PM, Surveyor interviewed R4's Power of Attorney (POA) who indicated they observed staff perform wound care multiple times because R4's POA was a retired nurse and wanted to ensure R4's wound was healing. R4's POA indicated staff wore gloves during wound care but did not wear gowns or eye protection.

On 4/24/24 at 7:19 AM, Surveyor attempted to observe catheter care for R2, however, R2 informed Surveyor that staff already completed catheter and morning cares. R2 stated the CNA who assisted R2 that morning wore gloves during cares. When Surveyor asked if staff wore a gown or eye protection, R2 stated no and indicated R2 had never seen staff wear anything other than gloves during care.

On 4/24/24 at 8:36 AM, Surveyor interviewed RC-C who indicated EBP training was provided prior to 4/1/24 for all nursing staff as well as on 4/16/24 by RC-C with the direction of IP-I. RC-C indicated staff signed off when they were trained and were given the facility's policy and a hand out that included when to use EBP, information on why EBP is implemented, and instructions to use EBP if there is a sign on a resident's door. Surveyor requested the training information which RC-C provided.

On 4/24/24 at 10:00 AM, Surveyor confirmed with RC-C the following staff were listed on the EBP training log: CNA-F (3/31/24 and 4/16/24), CNA-H (4/16/24), and LPN-G (4/16/24). RC-C confirmed CNA-F, CNA-H, and LPN-G were the only staff signatures on the EBP training sheet.

45942

4. The facility's Handwashing/Hand Hygiene policy, revised October 2023, indicates: This facility considers hand hygiene the primary means to prevent the spread of infections .1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections; 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors .1. Hand hygiene is indicated: a. immediately before touching a resident; b. after touching a resident; e. after touching the resident's environment; g. immediately after glove removal; .2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations .

The facility's Administering Medications policy, revised April 2019, indicates: 25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.

(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/23/24, Surveyor reviewed R1's medical record. R1 had an activated Power of Attorney for Healthcare (POAHC) and diagnoses including dementia with behavioral disturbance. R1's Minimum Data Set (MDS) assessment, dated 3/6/24, indicated R1 had severely impaired cognition. On 4/23/24, Surveyor reviewed R9's medical record. R9 had an activated POAHC and diagnoses including dementia. R9's MDS assessment, dated 4/3/24, indicated R9 had severely impaired cognition. On 4/23/24, Surveyor reviewed R16's medical record. R16 had an activated POAHC and diagnoses including dementia with delusional disorder and acquired absence of other specified parts of digestive system. R16's MDS assessment, dated 3/6/24, indicated R16 had severely impaired cognition. On 4/23/24, Surveyor reviewed R129's medical record. R129 had an activated POAHC and diagnoses including dementia and anoxic (absence of oxygen) brain damage. R129's MDS assessment, dated 2/7/24, indicated R129 had severely impaired cognition. On 4/23/24, Surveyor reviewed R19's medical record. R19 had an activated POAHC and diagnoses including Alzheimer's disease and dementia. R19's MDS assessment, dated 1/24/24, indicated R19 had severely impaired cognition. On 4/23/24 from 7:01 AM to 7:27 AM, Surveyor observed LPN-G prepare and administer medication to R1, R9, R16, R129, and R19. Surveyor did not observe LPN-G performed hand hygiene between medication administration for each resident. On 4/23/24 at 7:31 AM, Surveyor interviewed LPN-G who confirmed LPN-G only performed hand hygiene after LPN-G finished administering medication to R19. LPN-G indicated LPN-G should have performed hand hygiene between residents per the facility's policy. On 4/23/24 at 12:05 PM, Surveyor interviewed DON-B who indicated LPN-G should have performed hand hygiene between residents during medication administration.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47248 Based on staff interview and record review, the facility did not ensure the designated Infection Preventionist (IP) completed infection prevention and control training and was employed at least part-time in the facility. This practice had the potential to affect all 27 residents residing in the facility. The facility's designated IP worked remotely and did not work in the facility at least part-time. In addition, the IP's certificate of completion for infection prevention and control training was not provided to Surveyor. Findings include: The Centers for Medicare & Medicaid Services (CMS) memo QSO-22-19-NH, last revised 6/29/22, indicates: In 2016, CMS overhauled the Requirements for Participation for Long-Term Care (LTC) facilities (i.e., nursing homes) which was implemented in three phases: .Phase 3 (11/28/19) regulations require nursing homes to have an Infection Preventionist who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program. During the entrance conference on 4/22/24 at 10:09 AM, Nursing Home Administrator (NHA)-A informed Surveyor that Director of Nursing (DON)-B was the facility's IP. On 4/22/24 at 3:30 PM, Surveyor requested DON-B's certificate of completion for infection prevention and control training. On 4/23/24 at 7:30 AM, Surveyor interviewed DON-B who indicated DON-B was the interim DON and was not the facility's IP. DON-B stated DON-B replaced the facility's last DON who was also the IP. On 4/23/24 at 9:00 AM, Surveyor interviewed NHA-A who again indicated DON-B was the facility's IP. When Surveyor indicated that DON-B stated DON-B was not the facility's IP, NHA-A stated Regional Consultant (RC)-C might be the facility's IP. NHA-A stated NHA-A would find out and provide their certification to Surveyor. On 4/23/24 at 3:30 PM, Surveyor interviewed RC-C who indicated the previous DON was the IP but their employment ended on 4/8/24. When Surveyor asked the name of the current IP, RC-C stated RC-C would obtain the current IP's certification and provide it to Surveyor. On 4/24/24 at 8:38 AM, Surveyor interviewed RC-C who indicated the facility had an IP interim plan in place since the previous IP/DON left employment. RC-C stated IP-I oversaw the facility's infection prevention and control program and coordinated with other IPs and Registered Nurses (RNs) from the organization. RC-C stated IP-I worked remotely. When Surveyor requested IP-I's certificate of completion for infection prevention and control training, RC-C stated RC-C would obtain the certificate and provide it to Surveyor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Scandia Village	10560 Applewood Rd Sister Bay, WI 54234

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/24/24 at 8:48 AM, Surveyor interviewed IP-I via telephone. IP-I indicated IP-I oversaw the facility's IP program since January 2024 when the facility's ownership changed. IP-I stated IP-I worked remotely and oversaw the program in conjunction with the facility's IP who was also the DON. IP-I stated when the previous IP/DON left employment on 4/8/24, IP-I became the designated IP and worked remotely with another remote IP. IP-I indicated IP-I and the other IP did not work in the building. IP-I stated the goal was for IP-I to continue remote work as the IP and to hire a second RN or Assistant Director of Nursing (ADON) and for the DON to assume the IP role moving forward. On 4/24/24, Surveyor reviewed IP-I's certificate of completion for the Centers for Disease Control and Prevention (CDC) Infection Prevention Program training. Completion for modules 1-15 was provided. The trainings were completed from 1/1/20 through 3/31/23. Surveyor noted the training information did not contain a certificate of completion for all 23 modules or a certificate of completion that indicated the hours of training completed and successful completion of the program. When Surveyor indicated that a training certificate was required, RC-C indicated the certificate would be obtained and provided to Surveyor. The certification of completion was not provided.