STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525504	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review, the Facility did not ensure the medical record reflected the advanced directive wishes for 1 (R47) of 18 residents reviewed. R47's Cardiopulmonary Resuscitation (CPR) Preference form indicated that R47 did not want CPR attempts, however R47's electronic medical record (EMR) indicated R47 was to have CPR performed. Findings include: The Facility Policy titled Advance Directives last revised [DATE] documents: Policy Statement: Advance directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation 1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives . 3. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive will be displayed in the medical record . 8. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. 9. The Nurse will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made . (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R47 was admitted to the facility on [DATE], with a diagnoses that includes cerebral infarction, dementia, type 2 diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction and aphasia. R47's Admission Minimum Data Set (MDS) with an assessment reference date of [DATE] documents that R47 had a Brief Interview for Mental Status score of 11 (moderate cognitive impairment). On [DATE], at 7:52 AM, Surveyor reviewed R47's electronic medical record (EMR) and could not locate a signed advanced directive form indicating whether CPR should be performed or not on R47. Surveyor noted that there was a physician order entered on [DATE] for R47 by Director of Nursing (DON)-B for that documented R47's code status as Full Code. On [DATE], at 08:54 AM, the facility provided a CPR Preference form to the Surveyor signed by R47 on [DATE] indicating No, I do not want Cardiopulmonary Resuscitation (CPR) attempts . Surveyor noted that signed form did not match the code status documented in the EMR. On [DATE], at 10:15 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-K about what LPN-K would do to determine the code status of a resident. LPN-K stated that if they found a resident in duress, they would take vitals and assess the situation. To determine CPR preference, they would look in the EMR to determine code status. Surveyor notes this would not give accurate information on what R47's wishes on CPR administration were. On [DATE], at 10:33 AM, Surveyor interviewed Social Services (SS)-D and asked about R47's CPR preference form that indicates to not resuscitate R47. SS-D informed Surveyor that admissions does the initial form and that the form is in the admission packet. On [DATE], at 10:40 AM, Surveyor interviewed Admissions (A)-C and confirmed the CPR consent form is in the admission packet. Per A-C, A-C uploads the CPR Preference form into the EMR, so everyone in the facility knows the residents CPR choice and so that nursing gets the CPR order from the physician. On [DATE], at 01:12 PM, Surveyor interviewed DON-B regarding the discrepancy between the order in the EMR for CPR and the CPR Preference form which indicates R47 does not want CPR. DON-B responded that yes it says full code here in the EMR and the facility will need to fix the code status in the EMR for R47. Surveyor informed DON-B that this is a concern. On [DATE], at 01:32 PM, Surveyor informed Nursing Home Administrator (NHA)-A regarding the concern that the form signed by R47 and the order in the EMR do not match. Before exiting the survey, Surveyor was informed the discrepancy was fixed. No additional information was provided.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38253 Based on interview and record review, the facility did not ensure their abuse policy and procedure was implemented for 3 of 8 employees reviewed for 4-year background checks. Certified Nursing Assistant (CNA)-U, Medication Technician (MT)-V, and Cook-W did not have up to date background checks completed within the four year time frame. CNA-U and MT-V worked on specific units of the facility while Cook-W did not have direct contact with residents. This deficient practice has the potential to affect 1 unit of residents where CNA-U and MT-V could potentially be providing care. Findings include: The facility policy and procedure titled Abuse, Neglect and Exploitation dated 6/1/2024 documents: 1. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contacted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred. On 12/9/2024, Surveyor requested from Nursing Home Administrator (NHA)-A the personnel files for eight employees to review for the required background checks. 1.) CNA-U was hired on 5/23/2018. The Background Information Disclosure (BID) form was completed 2/4/2020, and the Department of Justice (DOJ) letter and the Interagency Border Inspection System (IBIS) form were completed 4/21/2020. Four years had lapsed since the background check information had been submitted. CNA-U had a BID form, a DOJ letter, and an IBIS form completed 12/9/2024 after being requested by Surveyor. 2.) MT-V was hired 9/23/2019. The BID form was completed 9/19/2019, and the DOJ letter and IBIS form were completed 9/20/2019. Four years had lapsed since the background check information had been submitted. MT-V had a BID form, a DOJ letter, and an IBIS form completed 12/9/2024 after being requested by Surveyor. 3.) Cook-W was hired 8/13/2019. The BID form was completed 7/31/2019, and the DOJ letter and IBIS form were completed 8/9/2019. Four years had lapsed since the background check information had been submitted. In an interview on 12/10/2024 at 1:25 PM, NHA-A stated a new Human Resource (HR) employee, HR-AA, started the previous day and the facility had been without a permanent HR employee since September 2024. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor shared with NHA-A the concern CNA-U, MT-V, and Cook-W did not have the required background check information completed within four years. Surveyor shared with NHA-A that CNA-U and MT-V had a BID form, a DOJ letter, and an IBIS form completed 12/9/2024 after being requested by Surveyor and that Cook-W did not have any current background check information. NHA-A stated yes, the three employee background checks were late, and that NHA-A had completed the background checks yesterday, 12/9/2024. NHA-A stated NHA-A also completed Cook-W's background information and must not have printed it for the employee file. NHA-A provided the completed background check for Cook-W. NHA-A stated that NHA-A told HR-AA this morning that an audit was needed to be done of all employees to make sure the background checks were up to date. HR-AA stated HR-AA was auditing all the files of employees that are currently working to make sure all the background checks are completed. No additional information was provided.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not complete a Quarterly Minimum Data Set (MDS) assessment timely for 2 (R71 and R45) of 2 residents reviewed for timely assessments. *R71 had a Quarterly MDS assessment dated [DATE] with sections signed as completed on 11/20/2024, 11/21/2024, and 11/24/2024. The assessment was signed in Section Z: Assessment Administration as being completed on 11/12/2024. *R45 had a Quarterly MDS assessment dated [DATE] with sections signed as completed on 12/2/2024, and 12/3/2024. The assessment was signed in Section Z: Assessment Administration as being completed on 11/13/2024. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 dated 10/2024 documents: 2.6 Required OBRA Assessments for the MDS . Non-Comprehensive Assessments and Entry and Discharge Reporting . 05. Quarterly Assessment . The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (Assessment Reference Date) (ARD + 14 calendar days). Coding Instructions: For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date must be equal to the latest date at Z0400 or later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members. 1.) R71 was admitted to the facility on [DATE]. R71 had an Admission MDS assessment dated [DATE] and three quarterly assessments dated 3/28/2024, 6/28/2024, and 9/28/2024. The Quarterly ARDs were scheduled appropriately being less than 92 calendar days apart. R71's Quarterly MDS assessment dated [DATE]: -Section A, B, GG, H, I, J, L, M, N, O, and P were signed by MDS Licensed Practical Nurse (LPN)-X on 11/21/2024. -Section C, D, E, and Q were signed by Social Services (SS)-D on 11/24/2024. -Section K was signed by dietary services on 11/20/2024. -Section Z was signed by MDS Registered Nurse (RN)-Y as being completed on 11/12/2024. Surveyor noted Section Z was signed prior to any of the sections being completed. 2.) R45 was admitted to the facility on [DATE]. R45's MDS assessments were scheduled appropriately with the correct dates for assessments. R45's Quarterly assessment dated [DATE]: (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Section A, B, GG, H, I, J, K, L, M, N, O, and P were signed by MDS LPN-X on 12/2/2024. -Section B, C, D, E, and Q were signed by SS-D on 12/2/2024. -Section K was signed by dietary services on 12/3/2024. -Section Z was signed by MDS RN-Y as being completed on 11/13/2024. Surveyor noted Section Z was signed prior to any of the sections being completed. In an interview on 12/10/2024 at 9:00 AM, Surveyor asked MDS LPN-X what the process was for the facility to schedule and complete assessments. MDS LPN-X stated MDS RN-Y is out of state and does everything remotely. MDS LPN-X stated MDS LPN-X just started doing MDS assessments not very long ago. Surveyor shared with MDS LPN-X that Surveyor was reviewing the Quarterly MDS assessments for R71 and R45. MDS LPN-X texted via telephone MDS RN-Y during the interview with the information Surveyor was asking. MDS LPN-X stated MDS RN-Y's phone number would be provided so questions could be asked directly to MDS RN-Y. In a phone interview on 12/10/2024 at 9:14 AM, MDS RN-Y stated R71's and R45's Quarterly MDS assessments were late assessments. MDS RN-Y stated R71's Quarterly MDS was completed on 11/12/2024 so the assessment was late, but R45's assessment was completed on 11/13/2024 so the assessment was not late. Surveyor noted R45's Section Z was signed by MDS RN-Y on 11/13/2024 but the other sections were signed after on 12/2/2024 and 12/3/2024, almost three weeks later. In an interview on 12/10/2024 at 10:42 AM, Surveyor asked MDS LPN-X how MDS assessments are scheduled. MDS LPN-X stated at the end of this month, MDS LPN-X will look to see what is due in January and will open the January assessments. MDS LPN-X stated the assessments do not get touched until their actual dates. Surveyor asked MDS LPN-X when R71 and R45 Quarterly MDS's had been put in to be completed. MDS LPN-X was not able to see when the assessments had been initiated since they had been completed and accepted into the system. MDS LPN-X texted MDS RN-Y to find out why R71 and R45 assessments were not completed until past the due date. MDS RN-Y texted to MDS LPN-Y they were missed assessments and opened late. MDS LPN-X stated MDS RN-Y audits the schedule and pulls the CMS missing assessment report. On 12/10/2024 at 3:07 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R71 and R45 had late Quarterly MDS assessments. No additional information was provided as to why the facility did not ensure that the Quarterly Minimum Data Set (MDS) assessment timely for R71 and R45 were completed in the required timeframe.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not transmit a Quarterly Minimum Data Set (MDS) assessment within 7 days after the assessments was completed for 2 (R71 and R45) of 2 residents reviewed for timely assessments. *R71 had a Quarterly MDS assessment dated [DATE]. The assessment was signed in Section Z: Assessment Administration as being completed on 11/12/2024. The assessment was not submitted to the Centers for Medicare and Medicaid Services (CMS) until 12/10/2024. *R45 had a Quarterly MDS assessment dated [DATE]. The assessment was signed in Section Z: Assessment Administration as being completed on 11/13/2024. The assessment was not submitted to CMS until 12/10/2024. Findings include: The facility policy and procedure titled MDS 3.0 Completion dated 10/1/2024 documents: 7. Transmission Requirements: a. All assessments shall be transmitted to the designated CMS system (iQIES) within 14 days of completion. 1.) R71 was admitted to the facility on [DATE]. R71 had a Quarterly MDS assessment dated [DATE]. Section Z was signed by MDS Registered Nurse (RN)-Y as being completed on 11/12/2024. Surveyor noted on 12/10/2024 the assessment had not been submitted to CMS. 2.) R45 was admitted to the facility on [DATE]. R45 had a Quarterly MDS assessment dated [DATE]. Section Z was signed by MDS RN-Y as being completed on 11/13/2024. Surveyor noted on 12/10/2024 the assessment had not been submitted to CMS. In an interview on 12/10/2024 at 9:00 AM, Surveyor asked MDS LPN-X what the process was for the facility to complete and transmit assessments. MDS LPN-X stated MDS RN-Y is out of state and does everything remotely. MDS LPN-X stated MDS LPN-X just started doing MDS assessments not very long ago. Surveyor shared with MDS LPN-X that Surveyor was reviewing the Quarterly MDS assessments for R71 and R45. MDS LPN-X texted MDS RN-Y during the interview with the information Surveyor was asking. MDS LPN-X stated MDS RN-Y's phone number would be provided so questions could be asked directly to MDS RN-Y. In a phone interview on 12/10/2024 at 9:14 AM, MDS RN-Y stated R71's and R45's Quarterly MDS assessments were late assessments and MDS RN-Y had forgotten to transmit them. MDS RN-Y stated R71's Quarterly MDS assessment dated [DATE] and R45's Quarterly MDS assessment dated [DATE] was submitted that morning. On 12/10/2024 at 3:07 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R71 and R45 had late submissions of Quarterly MDS assessments. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why the facility did not ensure that R71 and R45's Quarterly Minimum Data Set (MDS) assessment were transmitted to CMS within 7 days after the assessments were completed.

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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** 48391 Based on record review and interview, the facility did not accurately screen residents for a mental disorder for 1 (R8) of 1 residents reviewed for PASSAR (Preadmission Screen and Resident Review) Level I and requiring a Level II screening. R8 was admitted to the facility with diagnoses of mental disorders and was not evaluated on the PASSAR Level I screen as having any mental disorders. The Level 2 PASSAR screen was never completed due to the inaccurate PASSAR Level I screen. Findings include: The facility's policy and procedure titled, Pre-Admission Screening for Mental Illness (MI) and Mental Retardation (MR) and dated 4/1/24, documents: The facility will complete a pre-admission screening on all new residents. A Level I, and a Level II if indicated. The screening will note: (a) the resident requires the level of services provided by a nursing facility; and (b) if the resident requires such a level of services, whether the resident requires specialized services for mental illness or mental retardation. 1.) R8 was admitted to the facility on [DATE] with diagnoses of opioid dependence, delirium, schizoaffective disorder, heart failure, type 2 diabetes, and major depressive disorder. R8's PASSAR Level I screen page was completed on 12/6/23. The PASSAR Level 1 screen documents that R8 was not suspected of having a serious mental illness or a developmental disability. This document was signed by the Business Office Manager (BOM). Surveyor was unable to locate a PASSAR Level II screen for R8 in R8's medical record. On 12/11/24, at 12:57 PM, Surveyor interviewed Admission Director-C regarding the screening process for PASSAR Level I and Level II. Admission Director-C stated she is responsible for completing PASSAR's for the facility. Admission Director- C stated that when a new resident is going to be admitted , she will review their medical record including their diagnoses and medications. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked Admission Director-C if schizophrenia would be considered a mental illness that would be listed on a PASSAR Level I. Admission Director-C stated yes, schizophrenia should be listed as a mental illness, and this would trigger a Level II PASSAR. Surveyor reviewed R8's PASSAR Level- I with Admission Director-C and informed hr that R8's PASSAR Level I screen did not include schizophrenia listed as a mental illness or diagnosis for R8. Admission Director-C stated that she did not complete R8's PASSAR Level I and was not responsible at that time of the PASSAR Level I being completed on R8. Admission Director-C stated she should have looked into R8's PASSAR Level I screen when she became responsible for completing the facility's PASSARs. Admission Director-C stated she would expect schizophrenia to be listed on R8's PASSAR Level I screen and that it was an error not having it listed for R8. On 12/11/24, at 3:14 PM, Surveyor shared the above findings with Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B. Surveyor requested additional information if available. None was provided.

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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** 49011 Based on interview and record review, the facility did not develop and implement a comprehensive person-centered care plan for 2 (R8 and R36) of 18 residents reviewed to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment. * R8 has Chronic Obstructive Pulmonary Disorder (COPD) and receives oxygen therapy. R8 receives Torsemide for diuresis. R8 does not have a comprehensive care plan that addresses oxygen or diuretic therapy. * R36 did not have a catheter care plan implemented when returning from the hospital with a foley catheter in place. Findings include: The Facility Policy titled Care Plans-Comprehensive last revised 1/2023 documents (in part): Policy Statement An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (guardian), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS . 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change . 1.) R36 was readmitted to the facility on [DATE] following a hospital stay with a diagnoses that includes acute embolism and thrombosis of left popliteal [NAME], intervertebral disc disorders and muscle weakness. R36's Medicare 5-day Minimum Data Set (MDS) with an assessment reference date of 11/20/2024 indicated R36 had a Brief Interview for Mental Status score of 15 (cognitively intact). R36 makes decisions for themselves. R36's MDS was marked as R36 having an indwelling catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R36's electronic medical record (EMR) which had a care plan for R36 has an ADL self-care performance deficit r/t Activity Intolerance, Limited Mobility, Date Initiated: 09/30/2024. The intervention pertaining to bladder is: -TOILET USE: HAS FOLEY. FOLEY CARES Q (per) SHIFT/ AS NEEDED Date Initiated: 09/30/2024 Revision on: 12/01/2024 Surveyor noted that R36 did not have a catheter on 9/30/2024, after it was placed while in the hospital in November. R36 did not have an intervention added to the care plan until December. Surveyor noted that no comprehensive care plan was in place for care of R36's foley catheter. Surveyor reviewed a physician order in the EMR dated 11/15/24 for Foley Catheter .for a diagnosis of: RETENTION. On 12/11/24, at 01:12 PM, Surveyor interviewed Director of Nursing (DON)-B and asked if there should be individual care plans for residents with a catheter and was told yes. Surveyor asked if a care plan was initiated for R36's catheter after returning on 11/14/24 from the hospital with it, DON-B stated that they don't see anything. On 12/11/24, at 01:32 PM, Surveyor updated Nursing Home Administrator (NHA)-A regarding the concern that R36 did not have a care plan related to foley catheter implemented upon return from the hospital on 11/14/2024. Before exiting the survey, Surveyor was informed the discrepancy was fixed. 48391 2.) R8 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, heart failure, and Type 2 Diabetes. R8's physician order dated 5/14/24, indicates R8 was prescribed oxygen at 2 liters per minute via nasal cannula continuously. R8's physician order dated 4/10/24, indicates R8 was prescribed Torsemide 100 mg, give 0.5 tablet by mouth in the morning for diuresis. R8's Minimum Data Set (MDS) dated [DATE], documents R8 receiving oxygen therapy and a diuretic. Surveyor reviewed R8's comprehensive care plan and could not locate a care plan that addresses R8's oxygen therapy or diuretic therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24, at 12:53 PM, Surveyor interviewed Director of Nursing (DON)- B who indicated the DON and nursing staff, complete resident care plans. DON- B stated the Interdisciplinary Team (IDT) will often review and make changes to resident's care plans. DON- B stated she would expect a resident with oxygen therapy to have an oxygen therapy care plan. DON- B stated she doesn't typically start a diuretic care plan for residents but then states she would expect to see a diuretic care plan on a resident's care plan at some point. Surveyor notified DON- B of concerns with R8 not having a care plan for her diuretic and oxygen therapy. Surveyor requested additional information. No additional information was provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51016 Based on interview, record review and observation, the facility did not ensure 1(R27) of 1 resident reviewed with limited range of motion, received appropriate treatment to prevent further contractures and decreased range of motion in R27's upper and lower extremities. * The facility failed to implement R27's range of motion restorative program ordered and initiated on 9/30/24 by the physical therapy department. Finding include: The facility's policy dated 4/1/24 and titled, Prevention of Decline in Range of Motion documents: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrate that a reduction in range of motion is unavoidable. Policy Explanation and Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/Explain the procedure occupational therapists shall establish an approach for prevention of decline in range of motion, including assessment, appropriate care planning, and preventative care. 2. Assessment for Range of Motion a. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion. b. Nursing assistants will report any significant changes range of motion, as noted during daily care activities, to the residents' nurse when any changes are noted. c. The assessment should include identified risks which could impact resident's range of motion including, but not limited to: i. Immobilization. ii. Neurological conditions causing functional limitations; iii. Any condition where movement may result in pain, spasms or loss of movement; iv. Clinical conditions such as immobilized limbs or digits because of injury, fractures or surgical procedures including amputations. 3. General Guidelines for Range of Motion (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Explain procedure to the resident then ask permission to proceed. b. Move each joint through its range of motion three times unless otherwise instructed. c. Move each joint gently, smoothly, and slowly through its range of motion. d. Stop exercise before the point of pain. e. Report pain to the nurse. 1.) R27's was admitted to the facility on [DATE] with a diagnosis that includes Multiple Sclerosis, Hemiparesis, Hemiplegia, Paraplegia, Quadriplegia (a medical condition that causes partial or total loss of movement and sensation in all four limbs and the torso) and Contracture of the left hand R27's Quarterly Minimum Data Set (MDS) dated [DATE] documents that R27 has bilateral upper and lower extremity functional limitation of range of motion. R27 is documented as total staff assist with all activities of daily living. R27 is documented as not able to ambulate and requires a mechanical lift for transfers. R27 has a Brief Interview for Mental Status (BIMS) score of 13, indicating that R27 is cognitively intact. On 12/09/24, at 9:30AM, Surveyor interviewed R27 about any current concerns at the facility. During the interview R27 informed Surveyor, that R27 has declined because R27 do not get worked with enough. R27 informed Surveyor that they never stretch R27 out and that R27 just get worse. On 12/09/24, at 9:30AM, Surveyor interviewed Family-T regarding R27's range of motion concerns. Family-T informed Surveyor that Family-T works with R27 more than the staff. Family-T informed Surveyor that facility staff does not do anything with R27 and that Family-T works with R27 instead. Family-T informed Surveyor that the facility never has enough people to do range of motion exercises with R27. Family-T told Surveyor that Family-T supplied the passive range of motion machines and light therapy equipment for R27. On 12/10/24, at 12:02PM, Surveyor interviewed DOT (Director of Therapy)-R about R27's therapy program. Surveyor inquired if R27 was still receiving therapy services. DOT-R stated that R27 is no longer receiving therapy services. R27 was discharged from therapy services on October 3rd. DOT-R informed Surveyor, that R27 was set up with passive range of motion program with the facility staff. DOT-R informed Surveyor, passive range of motion is not a skilled need, so therapy set it up to have facility staff complete the program on the unit. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DOT-R informed Surveyor thatR27's Multiple Sclerosis has progressed too far for an active therapy program. DOT-R informed Surveyor thatR27 had several evaluations in the past and R27's decline has made improvements for increased independence in activities of daily living (ADL) unlikely. DOT-R informed Surveyor that a passive range of motion program was set up for R27 to be done by the staff to prevent declines in range of motion and prevent increases in R27's contractures which were now in R27's upper and lower extremities. DOT-R informed Surveyor thatR27 needed a passive range of motion program to help prevent contractures and range of motion decline. DOT-R informed Surveyor that facility staff will do that program, not therapy staff. DOT-R informed Surveyor, therapy trained facility staff on R27's restorative program and gave the staff sheets with the exercises R27 needed to complete. On 12/10/24, at 01:02PM, Surveyor received range of motion plan from Director of Therapy-R with attached exercises and pictures. The range of motion plan for R27 was dated 9-30-24and documented: Goals, Increase bilateral lower extremity (BLE) range of motion and reduce formation of contractures; Approaches: Bilateral lower extremity- hips, knees and ankles gentle stretches (see attached); Lower Body: Range of Motion Exercises for the Legs were included with the program provided to Surveyor. R27's Nurses Note dated, 9/20/2024, at 10:17 AM by RN (Registered Nurse)-O documents: Resident returned from appointment @ 0945 (AM) with orders for PT ROM (Range of Motion) and passive ROM 2 x daily. Will notify Therapy and update orders. R27's physician order created, 9/27/24, at 12:48 PM by NP (Nurse Practitioner)-Q documents: Physical Therapy 3-5 times a week for 90 days for PT (Physical Therapy) for PT evaluation (97162). Therapeutic Activities (97530). Manual Therapy (97140) every day shift for 90 days. R27's physician order created, 12/10/24, at 12:07 PM by NP (Nurse Practitioner)-Q documents: Discontinue on, 11/09/24, at 12:06 PM, Physical Therapy 3-5 times a week for 90 days for PT (Physical Therapy) for PT evaluation (97162). Therapeutic Activities (97530). Manual Therapy (97140) every day shift for 90 days. Reason: Completed PROM program training. (late entry DC for 10/3/24) Confirmed by DOT-R. R27's care plan initiated on 8/24/2020: R27 has an ADL (activities of daily living) self-care performance/mobility deficit r/t Impaired balance, muscle weakness secondary to MS (Multiple Sclerosis) and left sided hemiplegia with upper and lower weakness. * Goal initiated on 8/24/2020, Revision on 11/03/2024: R27 will improve maintain current level of function in (ADLs/mobility) through the review date (Target date: 2/03/2025). Intervention initiated 9/27/2024: provide PROM (passive range of motion) to bilateral upper and lower extremities bid (two times a day). R27's care plan initiated on 9/03/2020: R27 has Multiple Sclerosis and left sided hemiplegia with upper and lower weakness. *Goal initiated on 9/3/2024, Revision on 11/03/2024: R27 will remain free of complications or discomfort related to Multiple Sclerosis through review date. (Target date: 2/03/2025). Intervention initiated 9/03/2024: PT, OT evaluate and treat as ordered. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention initiated 9/20/2024: Range of motion passive with am/pm care daily. On 12/10/24, at 01:44 PM, Surveyor reviewed the care card on R27's door. The care card on R27's door read: Range of motion passive with am/pm care daily and passive PROM (passive range of motion) to bilateral upper and lower extremities bid (two times a day). On 12/10/24, at 01:44 PM, Surveyor observed, R27 had a light therapy blanket on R27's head, and a passive range of motion machine on R27's feet and right arm. Family-T was in the room with R27. On 12/10/14, at 01:44 PM, Surveyor interviewed R27 and Family-T in regards the R27's therapy program. Surveyor asked R27, how R27's passive range of motion program was going. R27 told Surveyor, staff doesn't do range of motion with me. Family-T informed Surveyor, no, absolutely not. Family-T informed Surveyor, that Family-T has never seen range of motion performed for R27 by the staff. Family-T told Surveyor, they do not have time, they are too short staffed and have too many agency people who do not know what to do. Surveyor asked Family-T how agency staff knows what to do for R27. R27 and Family-T, pointed to the door which had a Kardex with R27's cares on it. R27 and Family-T told Surveyor, they were not aware of any staff doing the passive range of motion on R27. Family-T said to the Surveyor, if they have a plan where is it, tell them to show us. On 12/10/24, at 03:20 PM, Surveyor interviewed CNA (Certified Nursing Assistant)-P regarding staff's knowledge on finding and providing care for each resident on this unit. Surveyor asked CNA-P, where would staff find daily range of motion or therapy restorative range of motion plans for the residents on this wing. CNA-P informed the Surveyor, in the book or their care plan behind the door in their room. Surveyor asked if CNA-P could show this book to the Surveyor and where these programs are charted. CNA-P informed the Surveyor, we would chart cares in power clip in the computer. We do not chart in a book. CNA-P explained, if it is not on the care plan or on the back of the door, I wouldn't know where to find it, as that is where they told me to look for a resident's care directions. Surveyor asked CNA-P if CNA-P was aware of anyone on this unit who has a restorative program or range of motion plan of care. CNA-P informed Surveyor, I am not sure because I am agency. Surveyor inquired if it was CNA-P's first day working this unit. CNA-P informed Surveyor, no. Surveyor asked CNA-P to clarify, where would the Surveyor look to find out about a range of motion plan of care. CNA-P replied, on the back of the door card or the care plan. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24, at 07:03 AM, Surveyor interviewed MT (Medication Technician)-M and RN-S about who receives range of motion on the unit and where to find the program information and documentation. MT-M informed Surveyor, I would know, I am regular staff, RN-S is agency. Surveyor inquired of MT-M, where is your restorative or range of motion programs listed including the programs that therapy gives staff to follow and do. MT-M informed Surveyor, the therapy department lets us know when. Surveyor inquired, what did MT-M mean let us know when. MT-M informed Surveyor, therapy will want to have them up at a certain time, so we get them up for the therapy department. Surveyor asked MT-M, where would any range of motion program therapy wants done by staff on the unit be found. MT-M informed Surveyor, I am not sure where they put that. MT-M explained, most of the time that takes place in therapy. Surveyor asked MT-M, where would any range of motion plan for a resident be kept. MT-M replied, maybe in the care plan. Surveyor asked MT-M, how would you know what to do exactly for the resident for a restorative range of motion program. MT-M replied, they usually post them somewhere and have a staff meeting. Surveyor asked MT-M, where would staff get education on what exactly to do for the resident from the therapy department. MT-M informed Surveyor, at the staff meeting or posted like I said. Surveyor inquired where those postings are located. MT-M replied, I am not sure where its posted. Surveyor asked MT-M if any residents on the unit currently receive range of motion. RN-S interrupted and answered the question. RN-S replied, we find that kind of program in the care plan on the back of the door. Surveyor asked RN-S, where did you get education on finding the range of motion care plans or restorative programs: RN-S informed Surveyor, I do not know I am agency, we got an orientation on where to look for that information. RN-S explained, the care plan on the door is where we were told to look for range of motion programs. On 12/11/24, at 07:10 AM, Surveyor interviewed CNA-I about how staff can find range of motion programs staff need to do on the residents on this unit. CNA-I informed Surveyor, I am not sure. CNA-I told Surveyor, I have been working at the facility since March. CNA-I informed Surveyor, they have not mentioned that any resident has a program like that or that we should go in with a resident and do range of motion as physical therapy does that. Surveyor asked CNA-I, where the information for a resident range of motion or therapy program might be if staff needed to look it up. CNA-I replied, I don't know maybe in their chart or word of mouth or if the nurse asks us to do it. Surveyor asked CNA-I if any residents were receiving any range of motion programs. CNA-I informed Surveyor that CNA-I did not know of any right now. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24, at 07:28 AM, Surveyor interviewed CNA-H. CNA-H had approached the Surveyor and asked if the Surveyor was looking at resident cares this morning. Surveyor told CNA-H yes, specifically any range of motion and therapy restorative programs on the unit. CNA-H informed the Surveyor, I am the restorative aid and know that information. Surveyor asked CNA-H, where do you find the range of motion programs. CNA-H informed Surveyor, on the back of the resident's door. Surveyor asked CNA-H, who has a program on this unit currently. CNA-H told Surveyor that R27 has one. CNA-H told Surveyor, I stretch R27's legs out and stretch R27's arms. Surveyor asked CNA-H, how often this program was done. CNA-H informed the Surveyor, this is done every day. CNA-H said, I put a pillow out to stretch R27's legs and stretch R27's arms. Surveyor asked, how does staff know what to do for R27's exercises. CNA-H informed the Surveyor, therapy showed CNA-H how to perform the exercises on R27. Surveyor asked, how would a new person or other staff know which exercises to do for R27, and how to do them. CNA-H informed Surveyor, I never got the sheets or the binder, they showed me (CNA-H) how to do them in October or November. Surveyor asked if any other staff were trained on R27's range of motion. CNA-H informed the Surveyor, I asked for them, they never gave me the information sheets or the binder so I could do the training. Surveyor asked who does the range of motion for R27 when CNA-H is not at the facility. CNA-H stated that CAN-G is not sure who does the restorative program when CNA-H is not at the facility. Surveyor asked how often CNA-H works. CNA-H informed the Surveyor that CNA-H works 9 days during a two-week period. Surveyor asked which residents have a restorative program on this unit. CNA-H replied, R27 is the only one that I know of. Surveyor asked when the range of motion is done for R27. CNA-H informed Surveyor that R27 has a card on the back of the door, but that CNA-H does it when R27 wants it as R27 is done when staff lay R27 back down after R27 has been up for several hours. Surveyor asked if range of motion is done only once daily for R27. CNA-H replied, yes. On 12/11/24, at 08:22 AM, Surveyor interviewed CNA-H. Surveyor asked CNA-H, where CNA-H documents that R27's restorative program is being done. CNA-H informed Surveyor, I don't, there is nowhere to document it. On 12/11/24, at 09:47 AM, Surveyor interviewed NHA (Nursing Home Administrator)-A about how the facility implements and documents their restorative programs. NHA-A informed the Surveyor that facility staff do not document that and that only therapy documents those type of programs. Surveyor asked NHA-A, about programs therapy sets up for staff to perform after therapy is done. NHA-A informed Surveyor, we don't document those either, you would have to speak to CNA-H. CNA-H could tell you when those programs are done. On 12/11/24, at 03:18 PM, Surveyor expressed concerns over the restorative range of motion plan not being implemented for R27 to DON (Director of Nursing)-B and NHA-A. NHA-A told Surveyor, that CNA-H was trained. Surveyor told NHA-A, that CNA-H informed Surveyor, she was shown R27's program but had not been given the program binder and the range of motion direction sheets to follow. Surveyor informed NHA-A, there is no evidence of other staff completing the training except CNA-H. Surveyor informed NHA-A and DON-B, that no evidence was found that range of motion was being done for R27 when CNA-H was not working, and that R27 was receiving passive range of motion only once a day when CNA-H was working. The care plan interventions document that R27 is to have passive range of motion done two times a day. NHA-A informed Surveyor, to be fair it is because we just got this restorative person recently and we do not have a lot of our own staff at this time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of exit no further information was provided by the facility on the range of motion program for R27.

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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** 49011 Based on interview and record review, the facility did not ensure that 1 (R335) of 3 residents reviewed for falls had adequate supervision and assistance devices to prevent accidents. R335 did not have a care plan for falls, even after a post fall on 9/28/2024, developed that contained interventions in place to prevent falls and accidents. Findings include: The Facility Policy titled Care Plans-Comprehensive last revised 1/2023 documents (in part): Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (guardian), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect the resident's expressed wishes regarding care and treatment goals; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and i. Reflect currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Incorporate the resident's personal and cultural preferences. k. Reflect the resident's preference for future discharge. 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. At least quarterly . 1.) R335 was readmitted to the facility on [DATE] with diagnoses which include cellulitis of left lower limb, type 2 diabetes, and metabolic encephalopathy. R335 was admitted on [DATE] and readmitted on [DATE] and again 11/29/2024. R335's Discharge Minimum Data Set (MDS) with an assessment reference date of 10/12/24 indicated R335 has a Brief Interview for Mental Status score of 13 (cognitively intact). The assessment is coded that R335 has not had any falls. R335 has a care plan stating R335 is at risk for falls r/t (related to) (not completed by the Facility). This was both initiated and revised on 12/03/2024. Surveyor notes R335 had a fall on 9/28/2024 and the care plan was not initiated on 9/28/2024 or updated with the intervention determined by the interdisciplinary team to encourage R335 to call for assistance when transferring. Keep walker within close reach. On 9/27/24 a Fall risk Evaluation was completed by the Facility which assessed R335 as a moderate risk of falls with a score of 08. Surveyor notes no care plan was initiated for the risk of falls. On 9/28/24 a Fall risk Evaluation was completed after R335's fall which assessed R335 as a high risk of falls with a score of 17. Surveyor notes no care plan was initiated with the high risk identified. On 12/11/24, at 01:12 PM, Surveyor interviewed Director of Nursing (DON)-B and asked if a resident whom has had a fall should have a care plan developed related to falls. DON-B answered yes. Surveyor then asked if fall interventions determined by the interdisciplinary team from a fall on 9/28/24 for R335 should be added to R335's plan of care. DON-B stated having no answer except that R335 was a readmit to the facility. On 12/11/24, at 01:32 PM, Surveyor informed Nursing Home Administrator (NHA)-A regarding the concern that R335 did not have a care plan related to falls after the fall in September. (continued on next page)

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Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before exiting the survey, Surveyor was informed the care plan was fixed and that fall interventions were added for R335. No additional information was provided.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on the comprehensive assessment of a resident, the facility did not ensure that residents received the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management for 1 of 4 (R38) residents reviewed for pain. R38 is a hospice patient and was not administered his scheduled pain medication as ordered. Findings include: The facility policy titled Pain Management dated 4/1/24 documents (in part): .The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 7. Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain. The following are general principles the facility will utilize for prescribing analgesics: a. Evaluate the resident's medical condition, current medication regimen, causes and severity of the pain and course of illness to determine the most appropriate analgesic therapy for pain. c. Consider administering medication around the clock instead of PRN (pro re nata/on demand) or combining longer acting medications with PRN medications for breakthrough pain. h. Opoids will be prescribed and dosed in accordance with current professional standards of practice and manufacturer's guidelines to optimize their effectiveness and minimize their adverse consequences. R38 admitted to the facility on [DATE] on hospice care with a diagnosis that includes Diastolic Congestive Heart Failure, Hypertension, Type 2 Diabetes Mellitus, Chronic Kidney Disease and Myocardial Infarction. R38's Admit/Readmit Screener dated 9/24/24 documented: Have you had any pain or hurting at any time in the last 5 days? Yes. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	How much of the time have you experienced pain or hurting over the last 5 days? Frequently. Pain effect on sleep: Frequently. Pain interference with day to day activities: Frequently. Numeric Rating Scale (00-10): 8. Verbal Descriptor Scale: Severe. R38's progress note entered by RN (Registered Nurse)-J dated 12/8/24 at 10:36 PM documents: This nurse received a call from POA (Power of Attorney) of resident stating that resident isn't getting his pain medication as prescribed and that she witnessed this herself. Resident went 5 hours without medication even when voiced to staff. It's also charted that resident was asleep at times medication was supposed to be given. Spoke with PM nurse and noc (night) nurse to give medication as prescribed and all voiced understanding. On 12/10/24 at 2:50 PM, Surveyor spoke with RN-J (shift supervisor) who reported she received a call from R38's POA reporting concern that the resident wasn't getting pain medication. RN-J reported the family spent the night and he went 5 hours without without receiving pain medication. RN-J stated I believe the MAR charted it wasn't given because he was sleeping. I spoke to the PM nurse and told her that it's ordered every 2 hours scheduled and it should be given, even if the resident is sleeping, and I told her to add that to the 24 hour board. Surveyor asked what is the expectation regarding scheduled pain medication and hospice patients. RN-J stated If it was me, I would give it every 2 hours, but maybe some nurses think if they're sleeping, and not appearing in pain that it could be held. R38's MAR (Medication Administration Record) documented an order for Morphine Sulfate Oral solution 100 MG (milligrams)/5 ML (milliliters) Give 0.25 ml by mouth four times a day for pain Times to be administered: Midnight, 6:00 AM, 12:00 PM and 6:00 PM. Order date 9/26/24, discontinued 12/6/24. R38's MAR documented and order for Morphine Sulfate Oral Solution 100 MG/5 ML Give 0.5 ml by mouth every 2 hours for pain, dyspnea. Order Date 12/6/24. The MAR included chart codes which documented: 5 = Hold/see nurse notes 7 = Sleeping 9 = Other/see nurse notes Surveyor review of R38's MAR documented: 12/6/24 at 12:00 PM 9 was entered, at 6:00 PM 5 was entered and at 10:00 PM 5 was entered. 12/7/24 at 2:00 AM 7 was entered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/8/24 at 6:00 PM 7 was entered. Surveyor reviewed R38's progress notes. There was no documentation regarding the codes entered or why the medication was held or not administered. Additionally, Surveyor noted the Physicians order for scheduled Morphine for this Hospice patient did not include instructions to hold the medication if the resident is sleeping. R38's progress note dated 12/6/24 at 3:00 PM documents: Restlessness and pain throughout shift, PRN comfort meds (medications) effective for short periods of time. Tip of penis has scant amt of blood d/t (due to) trauma when pulling out Foley. Morphine and Ativan is now scheduled. Family at bedside. On 12/10/24 at 9:50 AM, Surveyor spoke with Hospice RN-G who reported R38 is the first patient the Hospice agency has had at the facility. Hospice RN-G stated There has been some on and off issues about him (R38) not receiving pain meds, that's why I scheduled it. He's very close to the end and he should be getting his pain meds to keep him comfortable at the end of life. I got a call Sunday from the POA, who said his wife was at (R38)'s bedside for 5 hours and no-one came in and gave him pain medications. I was off, so my supervisor called the facility, it was hard to get hold of someone, but finally did and I guess they straightened it out. I was still concerned, because he is close to the end, so I spoke with the DON (Director of Nursing) yesterday about it. Last night was a good night for him, he got his meds as ordered. On 12/11/24 at 9:56 AM, Surveyor informed NHA (Nursing Home Administrator)-A of the above concern regarding pain management. R38 is a Hospice patient with orders for scheduled morphine, which was not administered as ordered and there is no documentation as to why the pain medication was not given. NHA-A reported this would be a nursing question for DON-B to answer. On 12/11/24 at 10:39 AM, Surveyor spoke with DON-B. DON-B stated I did find out that the nurses weren't giving the morphine at times because they thought he was sleeping, his family reported it. Surveyor advised DON-B the Physicians order does not indicate the medication is to be held for any reason, including sleeping. DON-B stated I know, so I went and talked to the PM nurse and let her know that just because a resident is sleeping, we can't assume they aren't having pain and the medication should be given. Surveyor asked DON-B if this was communicated and education was provided to all staff. DON-B stated Well, not really, the supervisor was going to go around and tell the nurses, but no, we haven't done education with everyone, because well, you guys came in on Monday and it's been a little busy. No additional information was provided as to why the facility did not ensure that R38 received the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review, the facility did not ensure the accurate and safe administration of medication for 1 (R47) of 5 residents reviewed. R47 had a Consultant Pharmacist Recommendation to Physician form that was signed by the Nurse Practitioner ordering a medication change be initiated that was not acted upon by the facility. Findings include: The Facility Policy titled Pharmacy Services implemented 6/1/2024 documents (in part): Policy: It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice . 1. The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice . R47 was admitted to the facility on [DATE], with a diagnoses that includes cerebral infarction, dementia, type 2 diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction and aphasia. R47's Admission Minimum Data Set (MDS) with an assessment reference date of 11/12/24 indicated R47 had a Brief Interview for Mental Status score of 11 (moderate cognitive impairment). R47 does not have an activated guardian or power of attorney. R47's progress note written 11/30/2024, at 6:39 PM documents:Monthly Medication Regimen Review completed, see pharmacist report for further details. Surveyor requested the report from the facility. R47's Consultant Pharmacist Recommendation to Physician form that was provided had the recommendation to reduce the dose of pantoprazole to 20 mg (milligrams) per day. This order was then signed by the Nurse Practitioner on 12/3/2024. As of 12/11/24, at 09:09 AM, the EMR reflected an order entered on 11/8/2024 for Pantoprazole Sodium Oral Tablet Delayed Release 40 MG. Surveyor noted no change in the dose after the order was signed 8 days and became effective. On 12/11/24, at 01:12 PM, Surveyor interviewed Director of Nursing (DON)-B and asked who was responsible for updating physician and medication orders and was told that in December the interim Assistant DON was responsible. DON-B was not sure why the update was not made to R47's medication order. On 12/11/24, at 01:32 PM, Surveyor updated Nursing Home Administrator (NHA)-A regarding the concern that the pharmacy recommendation which was signed by the Nurse Practitioner was not acted upon. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before exiting the survey, Surveyor was informed the discrepancy was fixed. No additional information was provided.

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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** 20025 Based on interview and record review, the facility did not ensure 1 (R37) of 5 residents that are on antipsychotic medications received a gradual dose reduction. R37 has a diagnosis of dementia with psychotic disturbance and major depressive disorder. R37 receives olanzapine 2.5 mg (milligram) daily, an antipsychotic medication. R37 receives olanzapine for sundowning with dementia. The 10/16/24 pharmacy recommendation documents that there should be a gradual dose reduction (GDR) attempt for R37 olanzapine. The NP (nurse practitioner) (unknown) noted a GDR was not needed due to psychiatric disorder. There is no evidence R37 has a psychiatric diagnosis and a GDR was not attempted. Findings include: 1.) R37 was admitted to the facility on [DATE] with diagnosis of dementia with psychotic disturbance and major depressive disorder. The annual MDS (minimum data set) dated 11/1/24 indicates that R37 has severe cognitive impairment. It also documents that R37 does not exhibit any physical and verbal aggression and does not exhibit any rejection of care behaviors. The physician order dated 3/26/24 documents that R37 was prescribed olanzapine 2.5 mg daily for sundowning with dementia. The pharmacy recommendation to physician form documents that R37 olanzapine was due for a GDR attempt. The NP (unknown NP) signed and dated 10/16/24 indicating no GDR is to be attempted due to psychiatric disorder (i.e. schizophrenia, delusional behavior, bipolar, atypical psychosis in absence of dementia, huntingtons, mania). R37 medical record does not indicate R37 has a psychiatric disorder diagnosis. R37's medical record documents that R37's behaviors are being monitored, such as delusion beliefs about the facility, verbal aggression, resistive to cares and tearful without knowing why. No behaviors were noted for November 2024. The psychiatric NP note dated 11/28/24 indicates that R37's mood was normal, no delusions, paranoia or hallucinations and affect is normal. The psychiatric NP note also indicates olanzapine is used for dementia with moderate agitation. On 12/11/24 at 1:06 p.m. Surveyor interviewed NHA (Nursing Home Administrator)-A. NHA-A stated the former DON no longer works at the facility. NHA-A indicated the former DON followed through with pharmacy recommendations. Surveyor asked NHA-A who was the NP that signed the pharmacy recommendation form and dated it 10/16/24. NHA-A stated she was not sure who it was. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor explained R37 should have a GDR but pharmacy recommendation form signed by an unknown NP indicates a GDR was not attempted because R37 has a psychiatric diagnosis. Surveyor explained R37 was prescribed olanzapine for dementia with agitation and does not have a psychiatric diagnosis. NHA-A stated she understood and would look into R37 getting a GDR. As of 12/12/24, NHA-A had no additional information. No additional information was provided as to why R37 did not receive a gradual dose reduction for R37's antipsychotic medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38146 Based on observations and interview, the facility did not store food in accordance with professional standards for food service safety. This deficient practice had the potential to affect 80 of 80 residents residing in the facility. Findings include: The facility's policy titled Storage of Foods dated 4/1/24 documents: Food supplies received will be stored in a manner that will ensure preservation of nutritive value and quality. Refrigerated foods: Foods in the refrigerator will be covered, labeled and dated. Spot checks will be done periodically to ensure foods are held in refrigeration at 41 degrees or below. Raw foods will be stored below cooked foods, and ready to eat foods. All foods should be stored at least 6 inches from the floor. Dry storage: Will be in a room designated for the storage of dry goods. Will be stored and handled to maintain the integrity of the packaging until they are ready to use. 1.) On 12/9/24 at 9:05 AM, during the initial tour of the kitchen, Surveyor observed the following: In a freezer, on the floor under the metal rack, Surveyor observed an unopened package of imitation crab meat, an opened bag of whipped topping (which was not dated) and 3 small containers of ice cream. On the metal shelf of the freezer, surveyor observed 2 opened boxes with plastic bags inside containing hamburger patties. The boxes and bags containing the hamburger patties were open to air and not sealed. Surveyor noted the boxes were not dated when they were opened. In the refrigerator, on the top shelf, Surveyor observed a box with a plastic bag inside containing hot dogs. The box and the bag containing the hot dogs was open to air and not sealed and the box was not dated of when the box was opened. The dry storage area had 2 plastic containers on the shelf, one containing what appeared to be red beans, the other containing white seed like items. Neither container was labeled or dated with an open or use by date. Surveyor located an opened bag with the same white seed like items labeled pearled barley. The bag was closed with a twist tie and was not dated with a used by or opened date. Surveyor observed the ice machine outside the freezer door. The entire right side of the ice machine was covered with a dry, crusty white substance. Surveyor noted the filter on the right side of the ice machine was covered with dust. Surveyor removed the filter, revealing the inside filter completely covered with dust. The sign under the filter read clean twice a month. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/10/24 at 7:57 AM, during subsequent kitchen observation, Surveyor noted the box of hot dogs had been removed from the refrigerator. The crab meat, whipped topping and ice cream remained on the floor of the freezer and the opened boxes of hamburgers remained on the shelf in the freezer. The ice machine remained unchanged. The open and unlabeled containers remained on the shelf of the dry storage area. Dietary Manager-N entered the dry storage area and Surveyor asked what the items were and when the were opened. Dietary Manager-N reported items are usually labeled, but they are from the summer menu and will be discarded because we are on the fall/winter menu now. On 12/10/24 at 9:56 AM, Surveyor spoke with Dietary Manager-N and informed him of the above observations. Dietary Manager-N stated I saw that, I got rid of them. I got rid of the hot dogs in the refrigerator too. All the bags were opened, but not dated and the bags weren't tied, so I just got rid of it all. Surveyor confirmed all previous observed items had been discarded. Surveyor asked about the ice machine and what the white substance on the machine was. Dietary Manager-N stated I really don't know. Nothing's leaking, but I've scrubbed and it don't come off, it's like calcium deposit or something. Surveyor asked how often the filter is cleaned and who is responsible for cleaning it. Dietary Manager-N stated, I guess that would be me, to be honest I'm not sure how often it's supposed to be cleaned, it's probably been awhile, but I'll take care of it now. On 12/10/24 at 10:02 AM, Dietary Manager-N advised Surveyor she spoke with maintenance staff who looked at the side of the ice machine. It was covered with original plastic which contained the substance. The plastic was peeled off and removed and she reported the filter was cleaned. Surveyor confirmed the findings with observation. On 12/11/24 at 2:10 PM, Surveyor spoke with Maintenance-F who reported he removed the plastic covering from the ice machine which contained the white substance. Surveyor asked if he knew what the substance was. Maintenance-F stated I'm not sure, I think maybe it was a leak or overflow of something if the filter isn't changed or cleaned. We don't mess with that ice machine, it's contracted out. Surveyor confirmed, the facility does not change or clean the filter. Maintenance-F stated I don't think so. Surveyor advised Dietary Manager-N reported she is responsible for cleaning the filter and is not sure how often it's supposed to be cleaned. The side of the ice machine indicates it should be cleaned twice a month. Maintenance-F reported he was not sure and would look to see if he had any paperwork on the ice machine. On 12/11/24 at 2:24 PM NHA (Nursing Home Administrator)-A was advised of the above observations and concerns regarding the kitchen. No additional information was provided as to why the facility did not store food in accordance with professional standards for food service safety.