STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525507	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Age Manor	220 Scholl CT Amery, WI 54001

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on observation, interview and policy review, the facility did not maintain confidentiality of resident medical record information for 3 of 5 sampled and supplemental residents (R45, R19, R16) reviewed. This is evidenced by: Facility policy titled, Confidentiality, Security, and Access to Protected Health Information, with an effective date of 08/19/03, states in part: Protected health information .written, verbal, or stored in paper, photographic, video, or electronic format .will remain confidential. 2. Protected Health Information (PHI) - Health information (medical record) that is identifiable to a specific individual and that is maintained or transmitted by a covered entity in any form, whether in oral, paper, or electronic form. Confidentiality and Security of PHI: 2. Care needs to be taken .in an area and manner that ensures client privacy. Surveyor reviewed facility's training for new hire employees included in the employee handbook titled, Privacy/HIPAA, with no date, states in part: .employees are exposed to confidential information about residents .it is important that all such information be kept strictly confidential. On 04/09/25 at 7:32 AM, Surveyor observed medication administration performed by Licensed Practical Nurse (LPN) H. LPN H prepared R19's medications and entered R19's room leaving medication cart locked in hallway with the computer screen open with R19's medical record displayed unattended. On 04/09/25 at 7:35 AM, Surveyor observed LPN H exit R19's room and return to medication cart. LPN H retrieved a stethoscope from the medication cart and returned to R19's room. LPN H left R19's medical health record displayed on the computer screen unattended. Surveyor observed a staff member walk down the hallway past the open computer screen. On 04/09/25 at 7:40 AM, Surveyor observed LPN H prepare R45's medications and enter R45's room leaving medication cart locked in hallway with the computer screen open with R45's medical record displayed unattended. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/25 at 8:10 AM, Surveyor observed LPN H enter R16's room with medications leaving the medication cart outside of room in hallway with R16's medical record displayed unattended. Surveyor observed two certified nursing assistants walk past open computer screen looking for LPN H. On 04/09/25 at 8:32 AM, Surveyor was standing in the 100 unit and observed LPN H outside of rooms [ROOM NUMBERS] at the medication cart. Surveyor observed LPN H leave medication cart and enter a resident's room with the computer screen open and resident information displayed on the screen. Surveyor was unable to see which resident was displayed on the screen. Surveyor stopped Nursing Home Administrator (NHA) A in the hallway and asked if she could see the medication cart with the open computer screen unattended down the hallway. NHA A pointed to cart and stated, Ok. I see what you are seeing, and walked down to the medication cart as LPN H exited the resident's room. Surveyor heard NHA A ask LPN H why the computer screen was left open unattended. Surveyor heard LPN H respond that she forgot to close the screen. On 04/10/25 at 10:24 AM, Surveyor interviewed NHA A regarding observation. NHA A stated that employees are expected to safeguard PHI and close/lock the computer screen when left unattended to protect resident's privacy.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview, observation and record review, the facility did not take action through documenting grievances, conducting a thorough investigation of the issues identified or provide resolution of the concerns brought to the attention of facility staff regarding missing laundry items. This affected R27, R42, R47, R44, and R4. This is evidenced by: Procedure for completing complaint reports: 1. All sections in complaint/grievance box must be completed entirely. 2. 2. After the complaint is recorded determine if a complaint is related to misappropriation. If the answer is Yes, the Administrator must be notified immediately. 3. In documentation of investigation box, the person in charge in the building will need to start the initial investigation. This may include interviews with staff or other residents, observations, memos posted to particular staff, etc. Use the back of form to contribute other details of investigation. 4. If a plan can be implemented right away, please implement and resolve the complaint. 5. If further investigation needs to occur, etc. The IDT will assist and resolve the complaint . Surveyor reviewed resident council meeting minutes for months December 2024-March 2025: -December 2024 resident council meeting minutes stated in part, [R27] said that his laundry has not been getting back to him as quickly as he would like, He is unsure if the clothing is getting lost before finding its way to him, but he would like to see them get back sooner. Surveyor reviewed Grievance logs: -On 01/07/25, grievance report filed by R42 who reported blue printed bathrobe was stolen. Documentation noted bathrobe was found in laundry on 01/08/25 and returned. Bathrobe was then marked with resident name in case it accidentally goes to laundry in the future. -On 01/08/25, grievance report filed by R47 who reported that he is missing a multicolored quilt that he received as a gift. Quilt was located in lower drawer of cabinet in room and now is gone. Documentation noted after staff searched, quilt was found in laundry services and returned to R47. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/25 10:30 AM, Surveyor met with resident council president R27, R44 and R4. R27 indicated that R27 had several missing clothing items over the last year. R27 reported the missing clothing items to staff members. R27 indicated the facility never could find R27's pants and shirts. R27 indicated that facility did not replace the missing items. R27 just let the missing items go and did not bring it up again until during resident council meetings. R27 indicated that activities aide usually helps find missing items. R44 spoke and indicated that R44 was missing several clothing items as well. R44 could not describe items. R4 indicated that R4 was admitted back August 2024 and had a beautiful grey, black, white fur coat that went missing. R4 indicated that R4 let a staff member know about the missing fur coat and R4 has never seen R4's fur coat again. R4 stated, I must keep a journal every day, and whenever an item goes to laundry, I write down the description of item and the date. When the item is returned to my room, then I cross it off so that I know I am getting my items of clothing back. On 04/09/25 at 11:01 AM, Surveyor toured laundry services with Laundry Director (LD) L. Surveyor asked LD L what the process for inventory is on residents' new clothes on admission and how unlabeled clothes are processed in the laundry department. LD L indicated that LD L's expectation would be that when residents are admitted , or any new clothing items come into the building that the Certified Nursing Assistants (CNA)s check inventory and bag the clothing items and mark on bag that clothes need labeling and send down to laundry to be labeled. LD L indicated what is happening is that CNAs are either labeling resident clothes with permanent marker and then it is not legible, or they are not labeling the clothing items at all. LD L then stated, Look at this clothing cart and how many items are unlabeled. Surveyor noted approximately 80 different pieces of clothing on unlabeled clothing cart. Surveyor asked LD how long the unlabeled clothing cart has been this way. LD L indicated that LD L has only been managing this site for a couple months and the facility has had the unlabeled clothing cart issue since LD L started. On 04/09/25 at 11:26 PM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked NHA A what the process is for labeling resident clothes. NHA A indicated there is not a clear process for labeling clothes. NHA A indicated that NHA A's expectation is that the CNAs will process new admission or new articles of clothing for a resident by placing clothes in a bag then labeling on front needs labeling and send the bag down to laundry so that LD L can process and label the clothing. NHA A indicated that if there is a missing item, staff will reach out to LD L. NHA A indicated that usually the item is found, and things are resolved. NHA A indicated that if residents complain of missing items or clothes, social services or the activities department will try to find the missing items and resolve the concern. NHA A stated, I hear about missing clothing items being resolved all the time and don't think about it much. Surveyor indicated to NHA A that there are about 80 articles of clothing not labeled on the unlabeled clothing cart in laundry in the basement. NHA A did not indicate any prompt efforts to resolve the missing clothing issue or have evidence of actively working toward a resolution for this resident concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NHA A indicated the process for staff labeling unmarked clothes has been a part of the annual training for the last [AGE] years but could not provide documentation of training for staff to Surveyor. NHA A then stated, I did not realize there was such a problem with missing items grievances or complaints are to be filled out when items are missing that are of value, personal or financial. We replace things lost, especially when personal or financial value after talking to family. Surveyor asked NHA A if NHA A knew of any recent missing items. NHA A indicated that NHA A is not aware of anything recently but that NHA A's expectation is that staff members report the concern or grievance from residents who may not know how to formally file a grievance and then facility will look into missing items. On 4/9/25 at 2:55 PM, Surveyor was at nursing station in 100 wing when resident approached desk. R44 was attempting to communicate a need but was unable to verbalize. R44 was motioning to his clothing and attempting to verbalize needing something. RN I asked if R44 was referring to pads and R44 responded, Yes! Pants! On 4/9/25 at 3:05 PM, Surveyor observed R44 attempting to go through the locked doors that go to basement. Surveyor observed a staff member ask R44 what R44 needed. R44 indicated needed downstairs while R44 was pulling at R44's pants. Staff member indicated to R44 that staff member would let activities department know to search down in laundry room for R44's pants. On 4/10/25 at 12:00 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B what the process is for resolving grievances related to missing laundry. DON B indicated that DON B recognizes the potential for lost/missing items due to the incorrect labeling process for residents' clothing. DON B acknowledged that this concern of missing laundry items has not been resolved by the facility.

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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** 49353 Based on observation, interview and record review, the facility did not develop and implement a comprehensive person-centered care plan addressing medical and nursing needs. This occurred for 2 of 15 residents (R), (R1, R3) reviewed. R1 did not have a care plan developed to monitor for adverse reactions when R1 was prescribed a diuretic medication. R3's care plans were not developed for hospice and end of life care. This is evidenced by: Facility policy titled, Care Plans, Comprehensive Person-Centered, with a revised date of 03/2022, states in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .reflects currently recognized standards of practice for problem areas and conditions .interventions are chosen only after data gathering, proper consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. R1 was admitted to the facility on [DATE] with pertinent diagnoses of type 2 diabetes mellitus, chronic kidney disease stage 3b and edema. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment, makes self understood and able to understand others. Medications being administered include diuretics. Surveyor reviewed R1's care plan after observation and record review and did not observe a plan of care in place for monitoring and assessing R1 while being administered diuretic medications. Review of R1's medication noted: Furosemide 20 mg once daily with a start date of 12/29/23; Furosemide 40 mg twice a day with a start date of 04/05/25. On 04/08/25 at 9:04 AM, Surveyor observed R1 wheeling self in wheelchair from dining. R1's left arm and both lower legs were significantly edematous. Surveyor observed a urinary catheter hanging below the wheelchair in a dignity bag. Surveyor observed R1 having difficulty wheeling self and having to stop numerous times. On 04/10/25 at 10:45 AM, Surveyor interviewed Director of Nursing (DON) B regarding R1's care plan. DON B stated recognition that R1 should have had a care plan in place to monitor for adverse events and efficacy with the use of diuretics. DON B stated that she is currently working with the pharmacist to identify high-risk medications requiring close monitoring, such as diuretics, to ensure resident safety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	31086 Example 2 R3 was admitted to the facility on [DATE]. R3's current diagnoses include Alzheimer's disease, dementia, constipation, hypertension, neuralgia, osteoarthritis of knee, muscle weakness, spinal stenosis, pain, transient ischemic attack, anxiety, dysphagia, hemiplegia and hemiparesis, dysphagia, atrial fibrillation, cognitive communication deficit. On 03/12/25, R3 was started with hospice services. R3's Minimum Data Set (MDS), dated [DATE], documented R3's Brief Interview for Mental Status (BIMS) score as having severely impaired cognition. R3 is dependent on staff for all activities of daily living (ADL) and receives hospice services. R3's care plans did not have a hospice or end of life plan of care developed. On 04/08/25 at 3:30 PM, Surveyor asked Nursing Home Administrator (NHA) A if a hospice care plan was developed for R3. NHA A indicated there is no hospice care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on interview and record review, the facility did not ensure care plans were revised to reflect residents' current needs and to provide the needed direction to staff in providing necessary care and services. The facility practice affected 1 of 15 residents' care plans reviewed (R55). R55 had recent increase in behaviors resulting in resident-to-resident altercations on 3/03/2025 and again on 4/1/2025. R55's care plan was not updated to reflect changes identified and the care the resident received. Findings include: Surveyor reviewed the facility's policy titled Care Planning -Interdisciplinary Team revised March 2022. The policy reads in part: Policy Statement The interdisciplinary team is responsible for the development of the resident care plans. Policy Interpretation an Implementation . 11. Assessments of the residents are ongoing, and care plans revised as information about the residents and residents' conditions change. According to the Resident Assessment Instrument, The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving. R55 was admitted to the facility on [DATE] with a diagnosis that includes Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, and anxiety disorder. R55's most recent quarterly Minimum Data Set (MDS) dated [DATE] stated a Brief Interview of Mental Status (BIMS) score of 3/15 indicating R55 is cognitively impaired. Surveyor requested and reviewed R55's care plan initiated on 12/30/2024 which states in part: Problem: Mood State Increased mood and behavior problems related to diagnosis of Alzheimer's disease with late onset and Anxiety Disorder. R55 is very angry, verbally, and physically abusive, resistive to cares and has delusional thoughts. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Long Term goal Target Date: 04/02/2025 [R55] will not harm herself or others when she becomes anxious or confused. Approach- Approach start date 12/30/24 Give Trazadone as ordered. Monitor for effectiveness and report potential side effects. Monitor and record behaviors each shift: Physical aggression to others, Verbal aggression towards others, Delusional thoughts, threats of harm. Three Times a Day Surveyor reviewed R55's behaviors documentation: Documentation states in part, 03/30/2025 13:11[1:11 p.m.] -Res was reported to be walking out of her room when another res approached her and contact with her breast. Res screamed out, she hit me in the boob. No further contact, Res removed from one another's area. No injury noted to either breast. Call placed to POA and Administrator to update. Surveyor reviewed R55's charting notes: On 3/30/2025 at 1:18 p.m., Licensed Practical Nurse (LPN), E documented in part, It was reported by staff that resident approached another resident and made contact with her Breast area and the other res yelled out. Staff immediately intervened, removed res for one another's areas. No further incident noted. Message left for POA to call back for update regarding event, and call made to Administration for updated. Further documentation was noted on 3/31/25 and 4/1/25 of R55 behaviors including, Spitting, swearing, yelling, throwing things, mocking anyone that is speaking, following staff into resident rooms, slamming doors. CNA tried to give her something to drink and she knocked the glass over. She is getting upset when someone looks at her and upset if talked to or looked at and upset if not looked at or talked to. PRNs were given. Surveyor review Progress Note documented by LPN E on 4/01/2025 at 9:30 which states in part, Resident walked past another resident that was sitting in the common area watching television and punched at the back of her head. Resident [resident name] jumped up and started yelling at her. Writer immediately intervened and removed resident from situation. She was placed with a CNA while writer spoke and checked on [resident name]. [Resident name] stated she was alright. As long as no one cuts my hair I'll be alright. [Resident name] appears irritated but denies fear. Writer then brought resident into charting room and had her speak with her son/daughter-in-law. This calmed her down. Further documentation from LPN E on 4/1/25 at 14:26 is as follows Resident is screaming at people and throwing chairs and other objects she comes in contact with. Staff are following her at a safe distance to keep her from other residents. LPN E documented that NHA A was updated and NHA A is scheduling another 1:1 for her. R55's medications were adjusted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25, Surveyor requested from NHA A all documentation of interventions and updates that were done since R55's behaviors escalated. A recently constructed timeline was provided by NHA A indicating the facility is providing 1 on 1 care to R55, starting on 4/1/25 and when family was not available. Direction for 1 on 1 supervision of R55 was reportedly given but not documented until 4/8/25, after survey was initiated. On 4/09/25 at 8:55 AM, Surveyor interviewed NHA A. NHA acknowledges there should have been documentation of R55's interventions and R55's care plan should have been updated to indicate changes made.

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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** 31086 Based on observation, interview and record review, the facility did not ensure a resident with limited mobility receives appropriate restorative services, and assistance to maintain or improve mobility with the maximum practicable independence for 2 out of 6 sampled residents (R3 and R9). R3 and R9's passive range of motion (PROM) exercise programs were not completed as ordered. The programs were not reviewed and assessed for appropriateness. This is evidenced by: Example 1 R3 was admitted to the facility on [DATE]. R3's current diagnoses include Alzheimer's disease, dementia, constipation, hypertension, neuralgia, osteoarthritis of knee, muscle weakness, spinal stenosis, pain, transient ischemic attack, anxiety, dysphagia, hemiplegia and hemiparesis, dysphagia, atrial fibrillation, cognitive communication deficit. R3's Minimum Data Set (MDS), dated [DATE], documented R3's Brief Interview for Mental Status (BIMS) score as having severely impaired cognition. R3 is dependent on staff for all activities of daily living (ADL). R3's care plan with the approach start date of 05/22/2020 read in part, Restorative: LLE (left lower extremity) gentle PROM (passive range of motion) in bed bending hip knee and ankle sliding leg out to the side. 2. Gentle BLE (bilateral lower extremities) ankle stretching in bed to prevent contractures. 3. Gentle UE (upper extremities) PROM all joints 5 reps each. Once a day on Mon, Tue, Wed, Thu, Fri, 06:45 - 14:45. Review of restorative nursing logs documenting the number of minutes PROM was completed. The month of January staff provided PROM for 1 minute one day, 2 minutes on three days, 5 minutes on nine days, 6 minutes on two days, 10 minutes on one day and 15 minutes on one day and did not complete PROM on 01/17/25. The month of February staff provided PROM for 2 minutes on one day, 3 minutes on three days, 4 minutes on two days, 5 minutes on five days, 6 minutes on three days, 7 minutes on two days, 10 minutes on two days, 15 minutes on one day, and did not complete PROM on 02/18/25. The month of March staff provided PROM for 2 minutes on two days, 3 minutes on two days, 5 minutes on eleven days, 6 minutes on two days, 15 minutes on one day and did not complete PROM on 03/14/25. On 04/08/25 at 1:15 PM, Surveyor interviewed Certified Nursing Assistant (CNA) J and asked when R3's PROM is completed. CNA J indicated ROM is completed with morning cares. Example 2 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9 was admitted on [DATE]. R9's current diagnoses include multiple sclerosis, dysphagia, acute right heart failure, pulmonary hypertension, neuralgia and neuritis, vitamin D deficiency, myalgia, pain, hypertension, paraplegia, pressure ulcer of sacral region stage 4, colostomy, muscle weakness, and peripheral venous insufficiency. MDS, dated [DATE], a quarterly assessment documented BIMS score of 11/15, meaning R9 has moderately impaired cognition. R9 has impairment to 1 side upper extremity and both sides of lower extremity. R9 requires maximum staff assistance for upper body dressing and personal hygiene. R9 is dependent on staff assistance for showering, lower body dressing, bed mobility and transfers. R9 has no behaviors of rejecting cares from staff. R9's care plan dated 04/11/24, Category: Restorative: R9 is at risk for contractions r/t (related to) MS. Long term goal target date: 06/26/25: R9 will be able to bend bilateral knees and elbows with assistance. Approach start date: 04/11/24: Restorative Program: Stretching program 10x each day QHS (every bedtime). See bulletin board for program specifics. At bedtime: HS 7:00 PM - 11:30 PM). Review of restorative nursing logs documenting the number of minutes PROM was completed. The logs started documentation on 03/25/25 with no previous data available. Staff provided PROM on 03/25/25 and 03/26/25 for 6 minutes, 03/27/25 and 03/28/25 for 12 minutes, 03/29/25 PROM was not completed, 03/30/25 for 10 minutes, 03/31/25 PROM not completed, 04/01/25 for 10 minutes during the AM shift and 5 minutes during the PM shift, 04/02/25 for 6 minutes, 04/03/25, 04/04/25, 04/05/25 and 04/06/25 PROM was not completed, 04/07/25 for 10 minutes, and 04/08/25 PROM was not completed. On 04/07/25 at 11:39 AM, Surveyor interviewed R9 asking if ROM is completed as ordered. R9 stated having contractures to her legs and the exercises are listed on the bulletin board. R9 likes to have ROM completed at bedtime and R9 needs to ask staff to complete ROM otherwise it does not get done. On 04/09/25 at 2:31 PM, Surveyor interviewed Registered Nurse (RN) C about ROM program assessments and monitoring. RN C indicated there is no review of the program and therapy would be consulted to evaluate if a decline was noted. Staff should be documenting when the resident refuses. Surveyor reviewed R3's number of minutes to complete PROM and R9's logs not being completed. RN C stated R9's ROM tracking was entered incorrectly prior and was not tracked. Surveyor asked if assessments of the program were completed would this issue have been identified. RN C indicated if the assessments of the program were completed it would have been caught.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record reviews, the facility staff failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, to develop comprehensive person-centered care plans to meet residents' goals for pain for or adequately assess and treat pain for 5 of 5 residents (R) reviewed (R49, R1, R24, R30 and R35). -Facility did not provide adequate pain relief, properly assess for pain, or develop a pain care plan for R49, R35 and R1. -R24 had no non-pharmacological interventions for pain. Care plan did not include resident's desired/tolerable pain level or follow-up pain assessment. -R30 received tramadol (an opioid medication) for pain. The facility did not implement pain assessments or interventions to determine the effectiveness of the medication. This is evidenced by the following: Facility policy titled, Pain Assessment and Management, dated last reviewed on October 2022, states in part, .General Guidelines: 1. The pain management program is based on a facility -wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management . 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristic of pain; d. Addressing the underlying causes of pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Acute pain (or significant worsening of chronic pain) should be assessed every 30-60 minutes after the onset and reassessed as indicated until relief is obtained. Assessing Pain: 3. Assess the resident whenever there is a suspicion of new pain or worsening of existing pain. 4. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. 5. During the pain assessment gather the following information as indicated from the resident: c. Characteristics of pain: 1. Location of pain, 2. Intensity of pain (as measured on a standardized pain scale), 3. Characteristics of pain (e.g., aching, burning, crushing, numbness, burning, etc); 4. Pattern of pain (e.g., constant pain or intermittent); and 5. Frequency, timing, and duration of pain. Defining Goals and Appropriate Interventions: 1. The pain management interventions are consistent with the residents' goals for treatment which are defined and documented in the care plan. Pain management interventions reflect the sources, types, and severity of pain. 2. Pain management interventions shall address the underlying causes of resident's pain. Monitoring and Modifying Approaches: 1. Monitor the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. 2. Monitor the resident by performing a basic assessment with enough detail and, as needed, with standardized assessments tools (e.g., approved pain scales, etc) and relevant criteria for measuring pain management (e.g., target signs and symptoms). 5. Contact the prescriber immediately if the resident's pain or medication side effects are not adequately controlled. #6. If pain has not been adequately controlled, the multidisciplinary teal, including the physician, shall reconsider approaches and make adjustments as indicated . Example 1 R49 was admitted to the facility on [DATE] with diagnoses including encounter for palliative care, anxiety disorder, bipolar disorder, restlessness and agitation, alcoholic cirrhosis of liver without ascites, alcohol dependence, sleep disorder, personal history of suicidal behaviors, post-traumatic stress disorder, depression, and chronic pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49's Minimum Data Set (MDS) assessment, completed on 12/30/24, confirmed R49 scored 9/15 during Brief Interview for Mental Status (BIMS), indicating moderate cognition impairment. MDS indicated that R49 had chronic pain and was on an opioid for pain management. Surveyor reviewed pain assessments: -On 10/29/25, staff assessed R49's pain to be 9/10 pain. -On 11/04/25, staff assessed R49's pain of 9/10 pain. -On 12/29/24, staff assessed R49's pain of 10/10 frequent pain occurring more often. -On 02/05/25, staff assessed R49's pain of 10/10 frequent pain occurring more often. -On 03/31/25, staff assessed R49's pain to be 9/10 pain. Surveyor reviewed R49's care plan and did not find a pain care plan implemented to address R49's chronic and acute pain needs upon admission and during R49's care in the facility to present 04/10/25. R49's physician orders indicate: -General opioid monitoring for the following side effects will be monitored for while resident is on an opioid: -tolerance (more medication may be needed to achieve the same level of pain relief). -Medication is stopped, or a dose is held or missed. -Increased sensitivity to pain, constipation, nausea, vomiting, and dry mouth. Sleepiness, dizziness, and/or confusion. Depression, itching and sweating. Respiratory depression. Report to provider any noted side effects ordered on 10/29/2024. -Fentanyl 75mcg, give schedule II patch every 72 hours; 1 patch transdermal, check placement of patch every shift ordered on 11/21/24. -Lorazepam 1mg tab, give 2 tabs as needed every 4 hours for anxiety, nausea, and agitation ordered on 11/25/24. -Belbuca (buprenorphine hcl) - Schedule III film; 450 mcg; amt: 450 mcg; buccal every 12 Hours at 8:00 AM and 8:00 PM, ordered on 03/26/2025. -Oxycodone - Schedule II tablet; 5 mg; amt: 5 mg; oral special instructions: give for severe pain every 4 Hours as needed start date of 10/29/24. ordered on 03/28/2025. Surveyor reviewed R49's progress notes and assessments: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/03/2024 at 6:32 AM (late entry), At 1:30 AM, Resident reports having terrible pain 10/10 in back. Requested and was given prn oxycodone which was effective, but didn't last long enough and pain came back rated 10/10 at 2:30 AM. Again, resident requested prn pain Rx, and it wasn't time yet. Repositioning and warm cloth offered but declined. Resident did not want to move at that time. This writer brought pain Rx at 4:20 AM. Resident was crying at that time. She says she is having terrible pain and needs her pain Rx ordered more often. Currently prn oxycodone 10 mg is q 3 hours. Resident reports her pain this AM was not controlled, and she is requesting to have it every 2 hours prn. Complaint of pain in right ribs and hip that travels down her leg. Message of the above left for Nurse Practitioner (NP). -On 12/04/2024 at 11:14, Serum labs obtained and taken to [town name] lab. In addition, NP written note to continue using as needed Lorazepam as an adjunct for pain. -On 12/08/2024 at 5:18 AM, Resident did awake approximately 2:15 AM and requested prn pain Rx for right hip, leg, and foot pain rated 10/10 which was given. Resident was weepy at that time. 1:1 given and effective. Offer given to reposition, and Res declined. Also offered warm pack but declined. Currently is resting quietly with HOB elevated 30 degrees, eyes closed, respiration 16, even, and non-labored. No facial grimace or other outward sx's of pain noted. -On 12/08/2024 at 7:15 AM, This writer noted Resident fentanyl patch had not been changed for > 3 days. (Order reads to change q 3 days). This writer and RN applied a new fentanyl patch. Also gave Resident prn pain Rx at 6:15 AM due to complain of pain in right hip, leg, and foot. Charge nurse updated of the above and will notify on-call MD, contact person, and hospice of med error. Resident cognition remains per baseline, and she is currently resting quietly in bed with eyes closed. Also, the above information printed and put in N.P. folder to update her. Surveyor found no other documentation addressing R49's pain during 11/30/24-12/10/24. The fentanyl patch was not placed on 12/3 or 12/6 as ordered. R49 did continue to utilize the prn oxycodone 3-5 times per day. Pain levels were not consistently documented on the MAR to determine R49's pain levels during this time. No new orders or interventions were put into place for R49's pain increase during the medication error of no Fentanyl patch being administered to R49 as physician orders stated. Surveyor did not find any assessments of pain for R49 after the increase in pain on 12/03/24, or after increase in pain on 12/04/24, and after increase in pain on 12/08/24. Medication error report review: -On 12/08/24, medication error was found that R49's Fentanyl patch 75 mcg was last applied on 11/30/24 and was noted it had not been changed since that date. Physician was notified with no new orders but to contact hospice. Clarified order in the Electronic Medication Administration Record (E-MAR). -On 12/08/2024 at 9:30, Doctor was updated about med error. No new orders. Hospice called and will update RN. Message left for POA to call facility for an update. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/09/2024 at 6:50 AM, Resident complain of pain x1 during the night. This writer offered re-positioning, but Res declined. She was weepy at that time and was given prn oxy at 0110 for right hip and leg pain rated 10/10 which was effective. -On 12/09/2024 at 9:34 AM, NP noted fentanyl patch change incident. No new orders. Surveyor notes that pain medication is given with a pain level prior, but the post pain level is not entered in Medication Administration Record on a routine basis. Surveyor reviewed R49's Hospice progress notes: -On 12/04/24, Resident requesting her as needed pain medication more often. NP ordered to consult Hospice and use R49's as needed Lorazepam as an adjunct as well, which was not used. -On 12/09/2024 at 2:22 PM, Meeting held with Hospice, SS, NP, and nursing to discuss an update on the resident's plan of care. Hospice's official end date of service will be 12/24. At that time, care will be transferred to facility. NP is working with Palliative Services to see if they will work with the patient. Currently, there is no other option to take over. POA however wants to continue to move towards progressive care rather than a hospice approach. Currently, she is often sleeping or reporting that she is in pain. -All other Hospice progress notes indicate no pain assessment was completed as nurse states, could not complete pain assessment due to R49 in and out of sleep for all hospice visits. Surveyor reviewed NP visits and emergency room (ER) visits: -On 02/10/25- NP visit indicated, the plan after visit: A thorough discussion was had with the patient and her caregiver today. I explained that I had a thorough discussion with the doctor, who included there is nothing that we can offer to help the patient. We discussed that injections would not be helpful due to the patient already being on palliative care. We discussed that a total hip replacement would not be necessary. I discussed with the patient that we do not manage narcotic pain medications long term. I explained that a pain specialist would be a resource to help manage the patient's pain long term. All of the patient's questions were answered and she will follow up as needed. -On 03/13/2025 at 7:59 AM, Social Services Review: Resident complained of pain in knees and hips. NP will refer to pain clinic and palliative care regarding pain management. -On 03/23/2025 at 5:23 AM, Resident requested PRN pain medication. She stated that her pain is uncontrollable, and she stated that she needs to go to the ED for this as nothing is helping and if it does there is relief for a very short time. She stated that she wants to have her pain meds increased and she is not able to move the right leg much. She will not use the wheelchair to use the bathroom, so two staff have to assist her to the bathroom for safety. She stated that she needs to be sent over now. Call placed to her POA and she was okay with her being sent over. Updated that EMS would be called now. emergency room (ER) visits (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/23/25, ER visit note: Resident reports of bilateral hip pain and bilateral distal femur pain/knee pain. R49 does have a chronic underlying avascular necrosis involving bilateral hips. I suspect this is most likely etiology of her pain and likely progression of this disease. Unfortunately, resident has been evaluated by orthopedic surgery earlier on in her course of her nursing home stay and was determined not to be a candidate for injections or surgical management and was referred for pain management primarily as she was on hospice/palliative. -On 03/26/2025 at 3:39 PM, Resident requested pain medication for her right hip and knee. She stated that she wanted an extra dose of oxycodone. Writer let her know that we are not allowed to give an extra dose unless it is ordered by the doctor. She stated that she will call the doctor and get that changed. She then later stated that she felt like she might need to go to the ER again. Gave her different pain medication at that time and writer and CNA repositioned her in bed. Asked her what she was wanting from the ER. She stated that she wanted more pain meds. Repositioned her and she is now asleep at this time. -On 03/31/25, Addressing pain, Insurance issues for Orthopedic treatments for the pain in hips. Continues to decline. Observations: On 04/08/25 at 9:13 AM, Surveyor observed R49 in dining room to eat breakfast. R49 stated out loud in dining room with multiple staff members present, My back of knee hurts so bad right now. On 04/08/25 at 9:21 AM, Surveyor observed R49 request pain medication from Licensed Practical Nurse (LPN) H. Surveyor observed LPN H cut film and give to R49. At 9:25 AM, Surveyor interviewed LPN H and asked what LPN H's process is in assessing R49's pain and treating R49's pain appropriately. LPN H indicated that usually R49 will come to LPN H for pain medications, so LPN H waits for R49 to approach. Surveyor asked LPN H if LPN H usually asks R49 what pain level is and how does LPN H assess R49's pain as facility protocol entails. LPN H indicated that R49 whispered R49's pain was 8 out of 10, so LPN H gave pain medication as requested. LPN H stated, That is usually all I do. On 04/08/25 at 10:02 AM, Surveyor interviewed R49 and asked how R49 feels about how the facility manages R49's pain. R49 indicated the facility really has not completed much for R49 other than changing some medications around sometimes. Surveyor asked R49 if R49 can remember back in December if R49 had an increase in pain levels. R49 indicated that R49 remembers something went wrong with R49's Fentanyl patch and R49 stated, I remember being in an excruciating pain of 10/10. Facility had to give me more Oxycodone at the time. R49 indicated that R49 is supposed to see a specialist but facility has not set this up yet and R49's pain is still 10/10 at times during some days. On 04/09/25 at 12:52 PM, Surveyor interviewed Director of Nursing (DON) B and noted that in the Electronic Health Record (EHR) that R49 went several days without coverage of pain medication for R49's Fentanyl patch order and suffered increasing pain, which had to be supplemented with as needed medications. DON B indicated that a medication error form was filled out. DON B indicated that DON B did not place any new interventions into place for R49. Surveyor asked DON B if R49 had a pain care plan in place and what are some interventions put into place for R49 to manage R49's acute and chronic pain. DON B indicated that R49 does not have a pain care plan. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor asked DON B what DON B's expectation is for R49's pain management. DON B indicated that all staff should be assessing pain adequately by using a numerical scale or FACES scale as appropriate for residents and ask how often pain is occurring, describe the pain, and rate the pain. Staff should be following back up with R49 after giving the pain medication to help assess if pain is being managed appropriately. DON B indicated that comprehensive pain assessments are to be conducted upon admission, quarterly, as needed, and with any increase in pain. Surveyor indicated to DON B that Surveyor could not find any comprehensive pain assessments during 11/30/24-12/10/24 when R49 had increased pain related to the missed doses of Fentanyl patch application. DON B indicated staff should have been assessing R49 closely for the increase in pain. Surveyor asked DON B if the facility has set up pain specialist services for R49. DON B indicated the facility has not set up services at this time as R49 has had some insurance issues, but they have been working on this. Surveyor asked DON B what steps the facility put into place to manage R49's pain management other than prescribing pain medications. DON B indicated they do offer nonpharmacological interventions, which R49 refuses. R49 does not have a care plan in place listing these interventions. 49353 Example 2 R1 was admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus type 2 and polyneuropathy. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment, makes self understood and able to understand others. R1 is noted to receive scheduled and as needed pain medications, pain presence is constantly, no non-medication interventions used, pain interferes with day-to-day activities occasionally, and numerically rates pain as 10/10. R1's care plan, dated 09/26/23, with a target date of 01/01/25, states: [R1] has chronic back pain that limits activity and sleep. Interventions include verbalize relief with PRN non-pharmacologic interventions, administer PRN medications as ordered, trial heat, ice, muscle rub, etc. as non-pharmacologic options. Of note: care plan did not include update of new pain areas noted on the medication administration record (MAR). Surveyor was unable to locate documentation of non-pharmacological interventions used, pain assessment to include resident's desired/tolerable pain level, or follow-up pain assessment. Review of R1's orders noted: 11/27/23 OPIOID MONITORING: The following side effects will be monitored for while resident is on an opioid: -tolerance (more medication may be needed to achieve the same level of pain relief). -Medication is stopped, or a dose is held or missed. -Increased sensitivity to pain. -Constipation. -Nausea, vomiting, and dry mouth. -Sleepiness, dizziness, and/or confusion. -Depression. -Itching and sweating. -Respiratory depression. Report to provider any noted side effects; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Of note: no documentation was noted monitoring for the adverse reactions of constipation, sleepiness, respiratory depression, or pain tolerance associated with opioid use. 11/27/23 bisacodyl delayed release 5 mg once a day PRN for constipation; 11/27/23 Milk of Magnesia 400 mg/5 ml give 30 ml once a day PRN for constipation; 03/06/24 Miralax powder 17 g once a morning PRN for constipation; 03/25/24 Senna Plus 8.6-50 mg 2 tabs once a day for constipation; 01/27/25 hydrocodone-acetaminophen 5-325 mg (opioid medication) give 2 tabs four times daily for pain; 03/04/25 assess need for PRN oxycodone every 6 hours; 03/24/25 oxycodone 20 mg/dL (opioid medication) give 0.25 ml (5 mg) every 4 hours as needed for severe pain Of note: multiple entries did not include numerical pain scale to assess pain or location; MAR did not include numerical pain scale to evaluate efficacy. Review of R1's progress notes noted: 04/08/2025 17:26 Medication Error: It was reported to me that R1 received noon dose of Norco too early. No adverse effects noted. NP notified via phone and she is in agreement with plan to monitor vital signs Q shift for the remainder of the day (pms, nocts). NP to see R1 tomorrow to f/u on recent concerns and medication changes. R1 and son notified and neither had any concerns. R1 voiced her frustrations regarding the pain in her left foot and is requesting something for pain at this time. She declined offer of ice and elevation stating, nothing else helps. Updated pm nurse of resident's request. resident takes an Antidepressant Medication. Of note: this is the only mention of non-pharmacological interventions for pain noted in R1's medical record. R1 was assessed routinely after this incident for respirations, blood pressure, heart rate, and level of consciousness. No abnormal assessments noted. Review of R1's intake/output noted: On 04/03/25, R1 had 3 bowel movements. Between 04/04/25 - 04/09/25, documentation notes no bowel movement. Of note: No bowel assessment noted. R1 is noted to eat between 25-75% of all meals during this time period. No documentation of nausea or vomiting noted. Review of R1's medication administration record (MAR) noted: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/08/25 at 9:38 AM administered PRN oxycodone 0.25 ml/5 mg; PRN reason: Pain; Comment: L foot -(no time noted) PRN result - Follow-up: Somewhat effective Of note: no pain scale used to assess pain prior to administration or follow-up for efficacy. No documentation of respiratory assessment completed. 04/08/25 at 9:40 AM (scheduled 8:00 AM) administered hydrocone-acetaminophen 5-325 mg 2 tabs; Late Reason: administered late; Comment: Care Prioritized Of note: no pain scale used to assess pain prior to administration or follow-up for efficacy. No documentation of respiratory assessment completed. 04/08/25 at 11:27 AM (scheduled 12:00 PM) administered hydrocone-acetaminophen 5-325 mg 2 tabs Of note: no pain scale used to assess pain prior to administration or follow-up for efficacy. No documentation of respiratory assessment completed. No administration documented for Milk of Magnesia for PRN constipation noted between 04/04/25-04/09/25. No administration documented for bisacodyl for PRN constipation noted between 04/04/25-04/09/25. No administration documented for Miralax for PRN constipation noted between 04/04/25-04/09/25. On 04/08/25 at 9:04 AM, Surveyor observed R1 struggling to wheel self in wheelchair in hallway and began to cry. Surveyor asked R1 why she was upset. R1 stated that she was angry and frustrated because of recent health changes and pain. Surveyor asked where R1 was having pain. R1 stated her foot and pointed to her left foot. On 04/08/25 at 11:45 AM, Surveyor observed R1 sitting in wheelchair in room sleeping. On 04/08/25 at 12:04 PM, Surveyor observed staff member wake R1 and state it was time for lunch. Staff wheeled R1 into dining room. Shortly after being seated at dining table in wheelchair, Surveyor observed R1 close eyes and appear to be sleeping. On 04/08/25 at 12:06 AM, Surveyor observed staff approach R1 and rub her shoulder. Staff asked R1 if she was sleepy today. R1 opened eyes, looked at staff, did not verbalize a response, and closed eyes again. On 04/08/25 at 12:23 PM, Surveyor observed Certified Nursing Assistant (CNA) N wake R1 and ask if she was going to eat today. R1 opened eyes and looked at CNA N, but did not verbalize a response. CNA N then began assisting R1 with meal. Surveyor observed R1 to consume approximately 15% of meal. On 04/08/25 at 12:54 PM, Surveyor observed CNA N assist R1 back to room. CNA N transferred R1 to recliner and positioned for comfort. Surveyor observed R1 close eyes and appear to be sleeping before CNA N left room. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/08/25 at 2:22 PM, Surveyor observed R1 sitting in wheelchair with eyes closed and appeared to be sleeping. On 04/08/25 at 2:23 PM, Surveyor interviewed Director of Nursing (DON) B regarding observation and record review. DON B stated the expectation is for nurses to give the scheduled pain medication first, wait 30-60 minutes, reassess pain, and then determine if additional PRN medication should be administered. DON B stated that it would not be acceptable practice for nurses to give both scheduled and PRN opioid pain medications at the same time and then to administer the next scheduled opioid 30 minutes early. DON B stated that R1 should be assessed after receiving the multiple doses of opioids. On 04/10/25 at 10:45 AM, Surveyor interviewed DON B regarding pain assessments and care plans. DON B stated the expectation is for nurses to complete a pain assessment with all administrations of pain medication. DON B stated the pain assessment should include, at a minimum, a pain score, location, and characteristic for both the initial and follow-up documentation. DON B stated that recent review of resident's MARs have been documented inconsistently in this area and the facility is working on fixing this. Surveyor asked DON B if residents receiving high-risk medications, like opioids, should have a care plan in place to monitor for adverse effects. DON B stated that residents receiving opioids should have a care plan in place to monitor for things like constipation, level of sedation, respirations, etc. DON B stated the charge nurse reviews all residents' bowel movements daily and are expected to administer a PRN medication if it has been at least 3 days since the last bowel movement. DON B was unable to state why R1 had not had an intervention during this timeframe. Example 3 R24 was admitted to the facility on [DATE] with pertinent diagnoses of chronic pain syndrome, malignant neoplasm of breast and lung, constipation, and dorsalgia (back pain). R24's annual MDS assessment dated [DATE] noted a BIMS score of 11 indicating moderately impaired cognition, makes self understood, and understands others. R24 received scheduled pain medications, as needed pain medications was offered, and did not receive non-medication interventions for pain. R24's care plan, dated 10/09/23, with a target date of 06/27/25, states: [R24] requires more assistance from staff .experiencing more anxiety and pain with end of life. Interventions include monitoring for signs and symptoms of tolerance, administering scheduled and as needed medications, and perform non-pharmacologic pain interventions such as heat, cold pack, repositioning, pillow support . Of note: no documentation found for non-pharmacological interventions being used. Care plan did not include resident's desired/tolerable pain level or follow-up pain assessment. Review of R24's orders noted: 03/27/25 morphine extended release 30 mg four times daily Special Instructions: cancer pain give in addition to the 60 mg 03/27/25 morphine extended release 60 mg four times daily Special Instructions: cancer pain give in addition to the 30 mg (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/24/25 morphine concentrate 100 mg/5 ml (20 mg/ml) give 15 mg four times daily 03/24/25 morphine concentrate 100 mg/5 ml give 0.5 ml-1.0 ml (10-20 mg) Special Instructions: pain/restlessness/dyspnea GIVE IRREGARDLESS OF SCHEDULED DOSES! Every one hour as needed Of note: documentation with administration did not include pain scale or location with initial or follow-up administration. 10/19/2023 OPIOID MONITORING: The following side effects will be monitored for while resident is on an opioid: -tolerance (more medication may be needed to achieve the same level of pain relief). -Medication is stopped, or a dose is held or missed. -Increased sensitivity to pain. -Constipation. -Nausea, vomiting, and dry mouth. -Sleepiness, dizziness, and/or confusion. -Depression. -Itching and sweating. -Respiratory depression. Report to provider any noted side effects Of note: no documentation was noted monitoring for the adverse reactions of constipation, sleepiness, respiratory depression, or pain tolerance associated with opioid use. On 04/10/25 at 10:45 AM, Surveyor interviewed DON B regarding pain assessments. DON B stated this should have been initiated on admission and revised at least quarterly to include resident's tolerable pain level, pain level before and after pain medication administration, location, duration, characteristics, and non-pharmacological pain interventions. DON B stated that all of this should have been documented and monitored to assess for efficacy and changes. Example 4 R30 was admitted to the facility on [DATE] with pertinent diagnoses of reduced mobility and diabetes mellitus type 2 with diabetic neuropathy. R30's admission Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 13 indicating cognition is intact. R30 receives scheduled and as needed pain medications. Review of R30's physician orders noted on 03/14/25 tramadol 50 mg three times a day; and tramadol 50 mg Special instructions: as needed for pain every 6 hours. Review of R30's care plan identified no pain care plan was developed to include specific and measurable goals and non-pharmacological interventions. Review of R30's medical record did not identify a pain assessment to include frequency, intensity, duration, outcomes, location, or precipitating factors to determine efficacy and monitor for change in pain characteristics. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/25 at 10:45 AM, Surveyor interviewed DON B regarding R30's use of a pain regimen. DON B stated recognition that R30 should have had a comprehensive pain assessment completed upon admission to identify cause and establish a baseline care plan to address pain concerns. DON B also stated that a detailed pain assessment should have been completed with each administration of a scheduled or as needed pain medication to include a pain score, location, and characteristic prior to administration and a follow-up assessment of, at minimum, a pain score to determine efficacy and have effective pain management. 51804 Example 5 R35 was admitted to the facility on [DATE] with the diagnoses that include bilateral primary osteoarthritis of knee, chronic pain syndrome, unspecified hip pain, anxiety, and vascular dementia with other behavioral disturbances. R35's MDS assessment, dated 1/7/25, indicates that R35 has moderate cognitive impairment, and is rated to be dependent to needing substantial assistance for personal cares and activities of daily living. R35 is dependent for mobility, staff use a mechanical lift to transfer from bed to chair and to shower/bathe chair. R35 has no impairment to the upper body but impairment to the lower body. R35's care plan, dated 1/13/25, does not include pain management. Surveyor found no pain management care plan or approaches for pain management embedded in other care planned areas either, including the general section titled health maintenance. R35 has an order in the eMAR for OPIOID MONITORING: The following side effects will be monitored for while resident is on an opioid: -tolerance (more medication may be needed to achieve the same level of pain relief). -Medication is stopped, or a dose is held or missed. -Increased sensitivity to pain. -Constipation. -Nausea, vomiting, and dry mouth. -Sleepiness, dizziness, and/or confusion. -Depression. -Itching and sweating. -Respiratory depression. Report to provider any noted side effects. 12/31/2024 - Open Ended On 4/8/25 at 8:09 AM, Surveyor interviewed R35 while sitting alone in dining room. R35 denied pain currently. R35 stated that movement hurts the most. R35 stated as long as R35 gets medication on time, R35 usually does not have a lot of pain. R35 stated R35 has other medications they can give R35 when that happens. On 4/8/25 at 1:20 PM, Surveyor interviewed LPN H regarding pain management. LPN H reported there are orders to monitor for opioid side effects but there is no formal tracker, checking off in the E-MAR, or required daily progress notes. Pain assessments are done quarterly for MDS. LPN H stated her process is to administer scheduled medication first; residents will let LPN H know if it doesn't help them. LPN H stated at that t [TRUNCATED]

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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** 49353 Based on observations, interviews and record reviews, the facility failed to provide pharmaceutical services related to the accurate administration of inhaled medication for 1 of 2 residents (R), (R19) reviewed. This is evidenced by: Facility policy titled, Administering Medications, with a revised date of 04/2019, states in part: .22. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: c. the route of administration; d. the injection site (if applicable) R19 was admitted to the facility on [DATE] with a pertinent diagnosis of allergic rhinitis. R19's orders noted calcitonin spr 200/act instill one spray into 1 nostril once daily - alt nostril daily. On 04/09/25 at 7:24 AM, Surveyor observed medication administration performed by Licensed Practical Nurse (LPN) H. Surveyor observed LPN H administer the nasal spray into R19's right nostril. Surveyor observed LPN H document medication as administered. No documentation of which nostril was noted. On 04/09/25 at 7:38 AM, Surveyor interviewed LPN H regarding documentation of medication. LPN H stated that staff used to document which nostril the spray was administered, but it went it away a while ago. LPN H stated that she works everyday with R19 and knows which nostril to administer the medication. On 04/10/25 at 10:24 AM, Surveyor interviewed Director of Nursing (DON) B regarding observation. DON B stated that nursing staff are expected to document the location a medication is administered to ensure accurate medication adminnistration and was unaware this was not being completed.

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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** 51804 Based on observation, interview and record review, the facility did not ensure that a resident's drug regimen was free from unnecessary medications for 3 of 5 residents (R) reviewed for unnecessary medications (R35, R8, R9). R3 is on medications for sleep, without adequate indication for use for the medications melatonin and trazadone. R8 receives an antibiotic daily for urinary tract infection (UTI) prevention. R8 receives a sleep aid of melatonin and hydroxyzine for sleep without adequate indication for use and no sleep care plan with non-pharmacological interventions to promote sleep. R9 receives melatonin for sleep without adequate indication for use and no sleep care plan with non-pharmacological interventions to promote sleep. Example 1 Findings include: The facility policy titled Behavioral Assessment, Intervention, and Monitoring, dated 2001, states: 1. Residents will have minimal complications associated with the management of altered or impaired behavior. 2. Behavioral symptoms are identified using facility-approved behavioral screening tools and the comprehensive assessment. Comprehensive Resident Assessment . 2. As part of the comprehensive assessment, staff evaluate (based on input from the resident, family and caregivers, review of the medical record and general observations): . d. the resident's previous patterns of coping with stress, anxiety, and depression. Cause Identification: 1. The IDT (interdisciplinary team) evaluates new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including: a. physical or medical changes (for example) . b. emotional, psychiatric, and/or psychological stressors (for example) . c. functional, social, environmental factors for example (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(3) sleep disturbances. Interventions and Management: 1. The care plan includes as a minimum: a. description of the behavioral symptoms, including: (1) frequency; (2) intensity; (3) duration; (4) outcome; . (7) precipitating factors or situations. b. targeted and individualized interventions for the behavioral and /or psychosocial symptoms; c. the rationale for the interventions and approaches; d. specific and measurable goals for targeted behaviors; and e. how the staff will monitor the effectiveness of the interventions. 4. Interventions are individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and [NAME] to understand, prevent, or relieve the resident's distress or loss of abilities. R35 was admitted to the facility on [DATE] and was admitted with the diagnoses that include bilateral primary osteoarthritis of knee, chronic pain syndrome, unspecified hip pain, anxiety, and vascular dementia with other behavioral disturbances. Surveyor reviewed R35's orders and noted the following: Melatonin tablet; 3 mg; Amount to Administer: 1 tab; oral At Bedtime trouble sleeping - started 12/31/2024 - Open Ended Trazodone tablet; 150 mg; Amount to Administer: 75 mg; oral At Bedtime Notify NP if behaviors worsen started- started 12/31/2024 - Open Ended R35's Minimal Data Set (MDS) assessment, dated 1/7/2025, indicates that R35 has moderate cognitive impairment, and is rated to be dependent to needing substantial assistance for personal cares, and movement. R35 has no impairment to the upper body but impairment to the lower body. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's care plan, dated 1/13/25, does not include plan for sleep management. Surveyor reviewed in computer and the printed copy; no sleep management embedded in any of the problem areas in the care plan. Surveyor reviewed R35's medical records, no assessment or monitoring of sleep patterns or tracking of sleep quality completed. On 4/9/24, at 8:34 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated there is no sleep assessment or specific care plan for sleep issues to determine the effectiveness or need for the medication. DON B stated we do not monitor sleep. DON B stated there is no expectation of nightly or weekly nursing notes about a resident's sleep pattern. 31086 Example 2 R8 was admitted to the facility on [DATE]. R8's current diagnoses include Alzheimer's disease, muscle weakness, essential tremor, pulmonary hypertension, major depressive disorder, congestive heart failure, pain, dementia, depression, chronic kidney disease stage 3a, generalized anxiety disorder, insomnia, and type 2 diabetes mellitus. MDS dated [DATE] documented R8 having a BIMS score of 9/15 indicating R8 has moderately impaired cognition. The MDS documented R8 as having delirium, inattention and disorganized thinking. R8 has delusions, verbal behavioral directed toward others, and other behaviors not directed toward others. Review of physician order documented, 01/30/25 cephalexin capsule; 250 mg; amt: 1 capsule; oral Special Instructions: For UTI Prevention Once A Day; 08:00 01/13/25 melatonin tablet; 5 mg; amt: 10 mg; oral, Special Instructions: Give with Hydroxyzine 50 mg every HS PRN BETWEEN 2000-0200. At Bedtime - PRN HS dx: insomnia 01/13/25 melatonin tablet; 5 mg; amt: 5 mg; oral Special Instructions: GIVE BETWEEN 2000-0200 if needed At Bedtime - PRN HS. R8 was treated with antibiotic cephalexin for a UTI on 01/22/25 - 01/29/25 for lab results of >100,000 CFU/ML Escherichia coli (e coli). The previous UTI was treated on 09/23/24 - 09/30/24. No further documentation of previous UTIs was noted. Surveyor was not able to identify the physician's rationale for continued antibiotic prophylactic use. Surveyor requested information of the prophylactic antibiotic use, and no further information was provided. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/25 at 11:12 AM, Surveyor interviewed infection preventionist, Registered Nurse (RN) C, about antibiotic tracking and surveillance for R8 since R8 is on a prophylactic antibiotic. RN C asked Surveyor, What do you mean? Surveyor asked RN C what criteria RN C uses to indicate that R8 met the criteria for being on an antibiotic for E. coli and then after going forward as prophylactic. Surveyor asked if it was appropriate for antibiotic used to treat a culture of 100,000 CFU's for E.Coli. RN C indicated that RN C does not know and just does what the doctor ordered. RN C stated, I am not a doctor. I don't know. RN C stated, The NP (nurse practitioner) decides what residents should be on and is hard to change NP's mind. RN C indicated that NP just orders a urinalysis on everyone, especially R8, and if we don't do what that person wants, that person and family come after us. Surveyor asked if there is any rationale to show the antibiotic medication is needed for R8. RN C said, No. Example 3 R9 was admitted on [DATE]. R9's current diagnoses include multiple sclerosis, dysphagia, acute right heart failure, pulmonary hypertension, neuralgia and neuritis, insomnia, vitamin D deficiency, myalgia, pain, hypertension, paraplegia, pressure ulcer of sacral region stage 4, colostomy, muscle weakness, and peripheral venous insufficiency. MDS, dated [DATE], a quarterly assessment documented BIMS score of 11/15, meaning R9 has moderately impaired cognition. R9 has impairment to 1 side upper extremity and both sides of lower extremity. R9 requires maximum staff assistance for upper body dressing and personal hygiene. R9 is dependent on staff assistance for showering, lower body dressing, bed mobility and transfers. R9 has no behaviors of rejecting cares from staff. Review of physician order documented, 02/10/25 melatonin tablet; 5 mg; amt: 5 mg; oral Special Instructions: PRN between 0000-0300 for insomnia Once A Day - PRN R9 does not have a sleep care plan developed with non-pharmacological interventions to promote sleep. R9's medical record did not have sleep assessments and tracking of sleep to determine sleep patterns and effectiveness of the medication. On 04/09/25 at 1:58 PM, Surveyor interviewed Director of Nursing (DON) B about sleep behavior monitoring and physician rationale for continued medication use. DON B indicated sleep assessments are completed quarterly and the person completing the assessment would interview staff and ask what the resident's normal sleep pattern is. Surveyor asked if the staff interviewed are the same staff on day and night shift to identify the sleep patterns. Surveyor asked how are you accurately collecting data to support the need for the sleep medication. Surveyor asked if all staff are reporting and documenting when all residents are asleep or awake. DON B stated she understands the need to collect data to support the medication use. Surveyor asked if there was a sleep care plan with non-pharmacological intervention to promote sleep. DON B indicated there was not a complete assessment and there is not a care plan.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51095 Based on interview and record review, the facility did not designate a person to serve as the director of food and nutrition services who had completed the minimum qualification requirements for the position. This practice could potentially affect all 60 residents residing in the facility. This is evidenced by: On 4/7/25 at 9:10 AM, Surveyor conducted initial tour of the kitchen with Dietary Manager (DM) D. Surveyor interviewed DM D and requested verification of DM D's qualifications. DM D directed Surveyor to the two certifications on her office wall. On 4/8/25, Surveyor was provided copies of the certifications. In review of the DM certification, Surveyor noted it is for a Food Protection Manager which is accredited by the American National Standards Institute (ANSI)-Conference for Food Protection (CFP). Completed 2023-8-10 and valid through 2028-8-10 from the Always Food Safe Company. On 4/9/2025 at 8:50 AM, Surveyor interviewed Nursing Home Administrator (NHA) A, as DM D was unavailable. Surveyor asked if the facility has a full-time dietician in house. NHA A indicated they do not. The dietician is fully remote. Surveyor asked for any evidence the dietician was monitoring compliance in the kitchen. NHA A did not provide any information. NHA A reported the facility's understanding was the DM certification fell under the state qualifications listed in the SOM F801 483.60 (a) (2) (i) .(C) Has similar national certification for food service management and safety from a national certifying body. Surveyor investigated the certification further and informed NHA A the certificate provided does not meet requirements for Certified Dietary Manager.

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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. 51095 Based on observation, interview and record review, the facility did not ensure the safety of food handling in accordance with professional standards for food service safety. The facility practices had the potential to affect all 60 residents. Foods stored in the walk-in-cooler were not labeled and dated and the Head [NAME] did not allow the thermometer probe to air dry after cleaning with isopropyl alcohol prior to inserting into foods items intended to be served to residents for lunch. This is evidenced by: The facility policies titled, Food Receiving and Storage revised December 2008, states in part, 7. All foods stored in the refrigerator or freezer will be covered, labeled and dates (use by date). The Food and Drug Administration (FDA) Food Code states in part, 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with food. On 4/07/25 at 9:10 AM, during initial tour of the kitchen with Dietary Manager (DM) D, Surveyor observed several opened foods in the walk-in-cooler had been opened but were not labeled with an opened date or use by date. These foods included sliced tomatoes, repackaged sour creams, opened bag of shredded cheese, a tray of individually portioned salads (coleslaw, potato salad, Jello salads) and pre-poured juice in cups. These foods were covered and on a tray; however, nothing on the tray was labeled or dated resulting in the potential for foodborne illness to spread. During this initial tour, Surveyor interviewed DM D, who reported the expectation would be that opened and/or prepared foods would be dated with an opened or prepared on date or a use by date. DM D did remove potentially hazardous foods and dispose of them. On 4/08/25 at 11:17 AM, Surveyor observed Head [NAME] G take temperature of foods to be served. During checking temperature of the foods, Head [NAME] G would stick probe into isopropyl alcohol probe wipe packet, rub probe end and immediately stick in next food item without waiting to let air dry as directed. This was done with 5 of the 9 foods that were checked during observation. On 4/08/25 at 11:44 AM, Surveyor interviewed Head [NAME] G, who reported she was trained on checking temperatures of foods a long time ago. Head [NAME] G reported she was unsure of when that would have been. Head [NAME] G reported she was not aware of the amount of time to allow cleaner to dry or that probe needs to dry and acknowledged she does not allow probe cleaning wipe to dry before checking temperature between foods. On 4/09/25, Surveyor informed Nursing Home Administrator A of the deficiencies in food preparation and storage that were observed.

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Golden Age Manor	220 Scholl CT Amery, WI 54001

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not 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 diseases and infections. -The facility did not a have a clear water management process or plan in effect to prevent transmission of Legionella infection. This has potential to effect 60 of 60 residents reviewed. -The facility did not have a tracking program in place for the early detection of infected and exposed residents (R) and staff for COVID-19 and Norovirus during an outbreak. -R9 is on enhanced barrier precautions and staff did not perform proper hand hygiene practices during personal cares. -R1 has an indwelling catheter and was not on EBP -Staff did not perform proper hand hygiene during personal cares for R33. This is evidenced by the following: Example 1 Surveyor reviewed the facility policy titled, Water Management Program to Reduce Legionella Growth and Spread, dated last reviewed in September 2017. The policy did not have control measures for the building water system to prevent the spread of legionella described in the policy or on the flow diagram, addressing unoccupied rooms and the vacant North wing to decrease the spread of opportunistic waterborne pathogens. On 04/10/25 at 10:39 AM, Surveyor interviewed infection preventionist, Registered Nurse (RN) C, and asked who oversees the water management program. RN C indicated that RN C, Nursing Home Administrator A, and Maintenance work together to complete water management. Surveyor asked if RN C had control points and any corrective actions to address stagnation and decrease spread of Legionella for the unoccupied rooms and vacant north wing. RN C indicated that everyone completes flushes on Fridays for the vacant north wing but didn't know any other unoccupied rooms need to be flushed as well. Surveyor asked where that description of flushing on Fridays is occurring. RN C indicated that Flush Friday is just something that we know to do but it is not described in the facility water management policy. RN C indicated that RN C would update the water management policy to show control points and corrective actions needed when flushing vacant north wing and any unoccupied rooms in the facility. Example 2 Surveyor reviewed infection surveillance logs dated from February 2024-present. Surveyor found missing documentation on all line lists for surveillance to include complete: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Symptoms onset date. -Location/last worked. -Culture/test type and result. -Treatment parameters. -Isolation type/date start and end. -Resolution date and times for infections. Surveyor reviewed facility Influenza outbreak dated sometime in February. Surveyor could not find the exact start day of Influenza outbreak and what measures were placed to prevent the spread of infection. Surveyor could not find last worked dates for staff members that became infected and worked in the facility to decrease the spread of infection. Surveyor found missing documentation on all line lists for surveillance to include complete: -Culture/test type and result. -Treatment parameters. -Isolation type/date start and end. In Influenza outbreak summary, Surveyor could not find when isolation and proper PPE usage was underway, any audits of hand hygiene, proper PPE usage, or any education to staff to decrease the spread of Influenza. Surveyor reviewed facility COVID-19 outbreak dated sometime in September. Surveyor could not find the exact start day of COVID-19 outbreak and what measures were placed to prevent the spread of infection. Surveyor could not find last worked dates for staff members that became infected and worked in the facility to decrease the spread of infection. Surveyor found missing documentation on all line lists for surveillance to include complete: -Culture/test type and result. -Treatment parameters. -Isolation type/date start and end. -Return to work dates. In COVID-19 outbreak summary, Surveyor could not find when isolation and proper PPE usage was underway, any audits of hand hygiene, proper PPE usage, or any education to staff to decrease the spread of Influenza. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/10/25 at 10:39 AM, Surveyor interviewed RN C after reviewing facility's IC surveillance lists and asked RN C what is RN C's process for managing and decreasing the spread of infection. RN C indicated that she follows the CDC guidelines and keeps track of infections monthly. Surveyor asked RN C what the process is and expectations for sick employees. RN C indicated that the expectation is for staff to stay home and call staffing recruiter if symptomatic. Staff Specialist K will take sick calls and make referrals to staff on what staff should do as far as testing goes and when to return to work. Surveyor asked RN C if Staff Specialist K has training on consulting with staff about their sickness and actions to take going forward. RN C indicated that everyone is trained at the onboarding orientation on staying home when sick. RN C indicated that Staff Specialist K does not hold a CNA license or Nurse license and is not medically trained. Surveyor asked RN C to provide Surveyor with Staff Specialist K's training pertaining to how to consult with and make corrective actions for staff when sick. RN C indicated that RN C does not have any formal training that has been completed for Staff Specialist K. RN C indicated that before staff can return to work the staff member brings a form physically into the building and has charge nurse review the form to decide if sick employee is ok to return. RN C reviewed online spreadsheet with Surveyor in which Surveyor observed a staff member who had fever, migraine, and vomiting on 03/09/25 at 5:30 AM, and the staff member returned to work on 03/10/25 at 4:30 AM. RN C indicated that the staff member probably shouldn't have come back into work until over 24-hour fever free. Surveyor asked RN C to provide the spreadsheet to Surveyor to document the facility's process. In review of spreadsheet Surveyor asked RN C how RN C keeps track of what tests are performed to minimize the spread of infection. RN C indicated that Staff Specialist K has the COVID-19 test available to staff to test if symptomatic, but RN C does not have any other tests in place such as influenza or RSV. Surveyor asked RN C if RN C suggests staff members go get tested for anything else. RN C indicated that it is up to staff members if they want to see a doctor or not and get tested for other things. Surveyor asked RN C how RN C keeps track of testing on spreadsheet, resolution date, what precautions or isolation needed, and location of where employees had worked if staff were working sick while on shift. RN C indicated that RN C is not tracking location of employees worked unless an outbreak, resolution dates were not updated on spreadsheet accurately, and testing for infections is not being offered or suggested unless COVID-19. Surveyor asked RN C if RN C thought it was appropriate that staff needed to bring in their form and physically walk into building without properly making sure the staff member was still not currently sick. RN C indicated that RN C's line lists are not as thorough as they should be, and knows the process needs to be fixed as it is not decreasing the spread of infection. 31086 Example 3 Facility policy titled, Enhanced Barrier Precautions, dated 05/01/24, states in part: It is the policy of this facility to implement enhanced barrier precautions for the preventions of transmission of multidrug-resistant organisms . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 4 R1 was admitted to the facility on [DATE] with pertinent diagnoses of chronic kidney disease stage, edema, and urinary tract infection. Review of R1's care plan identified no urinary catheter care plan in place to prevent the spread of infection. Review of R1's orders noted: 04/04/25 Foley Catheter for Urinary Retention. Of note: no order for enhanced barrier precautions (EBP) was noted. On 04/08/25 at 11:58 AM, Surveyor observed a transmission sign outside of R1's room stating, Contact Precautions. A personal protective equipment (PPE) cart was observed outside of room. No other precaution sign was noted. R1 was observed sitting in wheelchair in room. R1 had a urinary catheter hanging below wheelchair inside a dignity bag. Surveyor observed urinary catheter tubing exiting the bottom of R1's right pant leg with clear yellow urine. On 04/08/25 at 12:04 PM, Surveyor asked Registered Nurse (RN) I what the contact precaution sign outside of R1's room was for. RN I stated that it was for R1's roommate. On 04/10/25 at 10:24 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding observation. NHA A stated that R1 should have had EBP order initiated when the urinary catheter was placed. NHA A stated recognition that this had the potential to spread infection and put R1 and other residents at risk. 51095 Example 5 On 4/07/25 at 10:46 AM, Surveyor observed CNA F use sit to stand to transfer R33 from a wheelchair to the toilet. R33 remained on the toilet. On 4/07/25 at 10:56 AM, CNA F put on gloves and provided incontinence care for R33. CNA F wiped liquid stool from resident buttocks and perineal area. After getting bowel movement (BM) on gloves, CNA F used a disposable wipe to clean off her gloves. CNA F continued to provide incontinence cares for R33 without changing her gloves. After cleaning the BM, CNA F removed the gloves, did not practice any form of hand hygiene, and without donning new gloves put R33's clean incontinence pad on and pulled up her pants. CNA F then moved sit to stand lift, transferred R33 into her wheelchair, and removed R33's transfer belt for stand lift. CNA F continued without gloves to push R33 in the wheelchair to door before CNA F stopped and used hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/07/25 at 11:01 AM, Surveyor interviewed CNA F who reported she had hand hygiene training last month. When Surveyor asked CNA F what should be done when there are visibly soiled gloves, CNA F reported she was not aware the gloves should be changed and not wiped cleaned. CNA F reported she is aware that she should use hand hygiene when leaving room. Surveyor pointed out that hand hygiene was not practiced immediately after removing soiled gloves. On 4/08/25 at 8:29 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E who reported her expectations would be that if gloves are visibly soiled they be removed, and that hand hygiene should be performed immediately when gloves are removed. On 4/10/25 at 8:45 AM, Surveyor interviewed RN C, who reported the expectation would be soiled gloves be removed, not wiped clean, and hand hygiene be performed immediately after removing gloves, and after resident incontinence cares. RN C acknowledged further infection control/hand hygiene education is required and will be provided.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 48793 Based on interview and record review, the facility did not establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, the following elements: An Antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use. This has the potential to affect all 60 residents in the building who may utilize antibiotics. The facility did not ensure a standard of practice for antibiotic use or surveillance was being utilized in the facility's antibiotic stewardship program. This is evidenced by: The Facility policy titled Antibiotic Stewardship Program, dated 10/23, states in part: The Infection Preventionist is responsible for monitoring; investigating and setting forth a control plan to prevent unnecessary infections. The IP is responsible for monitoring and trending the facility infection incidence rates and this information is reviewed quarterly assurance committee with the interdisciplinary team and medical director each at least quarterly . Surveyor reviewed infection surveillance logs dated from February 2024-March 2025. Surveyor found missing documentation on all line lists for infection surveillance to include complete: -Symptoms onset date. -Culture/test type and result. -Treatment parameters. Such as Antibiotics of choice and when started and stopped. -Resolution date and times for infections. On 04/10/25 at 11:12 AM, Surveyor interviewed Infection Preventionist, Registered Nurse (RN) C, about antibiotic tracking and surveillance. RN C indicated that RN C receives a printout from Health Direct on who was on antibiotics for the month. Surveyor asked RN C when RN C receives this report. RN C indicated the report is sent roughly two weeks after residents are started on antibiotics for that month and that is when RN C is reviewing antibiotic use. Surveyor asked RN C how RN C is tracking infections, what kind of antibiotics residents are put on, and how RN C knows when residents are started on antibiotics and is it the correct antibiotic. RN C asked what Surveyor meant. RN C indicated that RN C leaves that up to the doctor to decide on antibiotic use. RN C stated, I am not a doctor. I don't know. Surveyor asked RN C what criteria is used to determine if an antibiotic is needed or that residents are on the correct antibiotic for their infections. RN C indicated to Surveyor that RN C is unsure what Surveyor is talking about. RN C indicated she does not have a process in place for monitoring correct antibiotic use for residents. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor asked RN C what criteria RN C utilizes such as the McGeer's or Loeb's criteria. RN C indicated RN C was not using either the McGeer's or Loeb's criteria at all. Surveyor referred RN C to the CDC guidelines for monitoring antibiotic use and utilizing McGeer's or Loeb's. RN C indicated that she would start utilizing the McGeer's or Loeb's criteria.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51804 Based on interview and record review, the facility did not maintain documentation of screening, education, and ensure offering of current Coronavirus 19 (COVID) vaccination for 1 of 5 residents (R) reviewed. (R1) This is evidenced by: The facility policy titled Influenza and Pneumococcal Vaccinations, dated March 2022, does not refer to COVID vaccinations. This was the only policy provided when requested. Two requests for a related policy were made. The CDC COVID 19 Staying Up to Date with Covid 19 Vaccines states in part: Everyone ages 6 months and older should get a 2024-2025 COVID 19 vaccine. It is especially important to get your 2024-2025 COVID 19 vaccine if you are ages 65 and older, are at high risk for severe Covid-19, or have never received a COVID 19 vaccine. R1 was admitted to the facility on [DATE] and was admitted with the diagnoses that include: Alzheimer's disease, edema, urinary tract infection, polyneuropathy, chronic kidney disease stage 3b, dementia, depression, anxiety disorder, tremor, bipolar disorder, and insomnia. Surveyor reviewed R1's electronic medical record and noted it did not contain documentation of R1 being screened and offered COVID 19 Immunization for 2024-2025 vaccination year. Surveyor requested documentation of immunization documentation in print. No documentation was available. On 04/10/2025 at 8:05 AM, Surveyor interviewed Infection Preventionist (IP) C regarding immunizations. IP C stated that staff and residents are offered immunizations every year. If there is a Power of Attorney (POA) for the resident, then IP C sends them a letter with the education and consent form and follows up with the POA for questions and consent. IP C stated if the resident is their own person, then IP C educates and gets the consent from them. IP C will get Surveyor copies of all Influenza, Pneumonia, and COVID consents and declinations for 2024/2025 vaccinations and the policy. On 4/10/2025 at 8:56 AM, IP C provided Surveyor with written copies of consent and declination forms. IP C stated this is what IP C could find. There was no COVID consent or declination form for R1. Surveyor asked IP C about COVID paperwork. IP C stated IP C did not think R1 needed to be approached again because she had declined in 2023. On 4/10/2025 at 11:46 AM, IP C stated to Surveyor that she checked with pharmacy for consents and declinations and that was all we have.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51804 Based on observation and interview, the facility did not ensure at least 100 square feet in a single resident room for 1 of 63 residents (R)58. R58 resides in a room that is less than the required 100 square feet in a single resident room. This is evidenced by: The state Operations Manual, titled Appendix PP- Guidance to Surveyors for Long Term Care Facilities, dated 8/8,24, states: Unless a variance has been applied for and approved under CFR (Code of Federal Regulation) 483.90 (e)(1)(ii), . (rooms must) Measure at least . 100 square feet in single resident rooms. R58 was admitted to the facility on [DATE] with diagnoses atrial fibrillation, anxiety, depression, malnutrition, unspecified mental disorder due to unknown physiological concern and attention deficit hyperactivity disorder. R58 scored as severely cognitively impaired, her speech is unclear but R58 is rated to be able to make herself understood usually and understands others. R58 is independently mobile and able to ambulate without assistance. During the entrance conference, it was noted the facility has a room with less than the required square footage and is occupied by R58. room [ROOM NUMBER] measures 96 1/2 square feet. On 04/08/25 at 2:34 PM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding the size of room [ROOM NUMBER]. NHA A stated it's less than 100 square feet. NHA A stated we have not made any changes or done any remodeling. It is really only 4 sq. feet too small and not cost effective to remodel the room to expand. We have limited private rooms. NHA A stated administration reviews the decision to continue to use the room annually. NHA A reported the patients that have been placed in that room like the room. NHA A stated that we explain to the residents and Power of Attorney (POA) the room size difference and they agree to the room before being placed in that room. NHA A stated we always put a smaller ambulatory person in the room. They have their own bathroom and privacy. On 04/08/25 at 2:52 PM, Surveyor called R58's POA and left a message on the phone to return the call to Surveyor. A return call was not received. On 04/09/25, at 07:06 AM, Surveyor interviewed R58. R58 was up in her room watching TV. R58 can't remember how long she has been in this room. Surveyor noted that she was admitted on [DATE]. R58 likes her small room, stating it is comfy. R58 stated the size fits me well. My friends help me set it up. R58 likes the big window with a ledge to put her things on and stated she can see the sun.