STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525513	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kinnic Health and Rehabilitation Center	1663 E Division St River Falls, WI 54022

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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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to allow resident the right to choose physicians/treatment options for 1 of 18 residents (R) reviewed. (R4). -Facility denied R4 the right to follow up with the wound provider of choice. R4 wanted to follow up with the VA wound provider and not the facility in-house provider. -R4 was seen by provider of choice and when returned to the facility with new orders, staff told R4 the facility will not do those treatments and had the attending physician discontinue the orders. Findings include: According to the Board on Aging and Long-term Care, residents have a right to self-determination which includes, in part: - Offered choices and allowed to participate in decisions important to you. - Expect a reasonable accommodation of your needs and preferences. - Participate in the planning of your care and services, and to receive care and services in a way that respects your personal and cultural wishes. - Request, discontinue or decline care and treatment. - Choose your health care provider. R4 was admitted to the facility on [DATE] with diagnoses including left femur fracture, diabetes, heart failure, chronic kidney disease, peripheral vascular disease, and edema to both lower legs with venous ulcers. R4 was dependent on staff to meet the dressing changes and care for daily living. R4 was expected to have a short term stay and return to the community. On 06/09/25 at 7:55 AM, R4 informed Surveyor R4 did not have the right to choose own provider. (continued on next page)

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

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/25 at 10:48 AM, Surveyor interviewed Registered Nurse (RN) G and Licensed Practical Nurse (LPN) J and asked about appointments for R4. RN G and LPN J denied any frequently cancelled appointments. LPN J stated R4's daughter would take her to the VA clinic and nursing had no idea an appointment was even made. Then they would return with all the orders from the VA. There was a lot of collaboration with the VA and DON L. The floor nurses were instructed by DON L to run everything past the medical director. On 06/09/25 at 1:33 PM, Surveyor interviewed R4. R4 said she was told on admission R4 needed to cancel all VA appointments and only use in-house providers except for the orthopedic doctor. R4 said R4 and R4's daughter got in an argument with the previous DON L and felt DON L was not listening, so daughter set up R4's own appointments and transportation. On 06/09/25 at 1:41 PM, Surveyor interviewed Director of Rehab (DOR) M and asked if DOR M was aware of treatment concerns for R4. DOR M stated DON L refused to allow staff to change the order and said what they are doing is fine. DOR M said DON L pulled off all the dressings the VA had on R4, stuffed them in a bag and put them in the closet. DOR M pulled a bag out of the bottom of R4's closet with all the supplies needed for the new orders from the VA provider. DOR M stated DON L just contacted the primary provider who discontinued the orders. Now DON L is no longer employed at the facility, everything is back on track, and R4 can see the provider of her choice. DOR M said due to the nature of the issues, the concern was reported to Nursing Home Administrator (NHA) A. R4's records indicate: R4 was seen on 04/28/25 by the VA wound provider. Specific orders were received for treatments to leg wounds which including silvadene, [NAME] boots, kerlix, tubigrip, and abdominal pads. DON L sent a copy of orders with a note to the primary doctor indicating R4 expressed concerns with the VA orders and asked them to be discontinued and resume the previous orders. The attending physician did discontinue the orders on the same day and the treatments were not transcribed. On 06/09/25 at 1:54 PM, Surveyor interviewed Social Services Director (SSD) H and asked if residents are allowed to choose their own physicians. SSD H stated it is in the admission packet. Surveyor informed SSD H there is a resident who felt they did not have that right until a family member made an appointment themselves for the resident. SSD H stated she was aware of that incident, and DON L investigated the grievance. Surveyor asked SSD H if it would be ethical for staff to change orders with another provider without a resident's consent. SSD H felt this was a violation of R4's rights. On 06/09/25 at 2:56 PM, Surveyor interviewed NHA A. Surveyor asked what the expectation would be regarding residents choosing their own provider. NHA A said residents have the right to pick their own providers. They are aware of the behaviors of DON L and addressed this in QAPI but missed the resident's right to choose aspect.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview and record review, the facility did not provide Advanced Beneficiary Notice (ABN) of non-coverage for residents (R) whose Medicare Part A coverage was discontinued with benefit days remaining for 2 of 3 residents (R) reviewed. (R43, R33) R43 and R33 were discharged from Medicare Part A services with benefit days remaining and remained in the facility. The facility did not provide an ABN informing the residents of their liability once Medicare coverage ended. Findings include: On 06/09/25 at approximately 9:00 a.m., Surveyor reviewed documents provided by the facility for residents who had been discharged from Medicare Part A with benefit days remaining. R43 start of services: 4/14/25, Last Covered Date (LCD): 6/02/25, notice of non-coverage 5/29, with no notice of patient liability provided to R43. R43 remained in the building. R33 start of services: 4/01/25, LCD: 5/30/25, notice of non-coverage 5/27/25 and no notice of liability was provided to R33. R33 remained in the building. On 06/09/25 at 2:13 PM, Surveyor interviewed Business Office Manager (BOM) I who is responsible for providing notice of non-coverage and potential liability when services end. BOM I indicated she has been doing notices for a few years. BOM I stated when the forms changed a few years ago she misinterpreted the forms and was not providing notice of potential liability for residents who remained in the building and Medicare non-coverage was provided.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for 1 of 18 residents (R) reviewed for abuse (R98). The facility did not ensure all staff were trained on the abuse policy, did not complete audits of staff to protect residents from abuse, or ensure staff knowledge of the abuse and reporting policy, and did not have a quality improvement plan to prevent further verbal abuse. This is evidenced by: Facility's policy titled Abuse, Neglect and Exploitation with no date implemented, read in part, II. Employee Training, B. Existing staff will receive annual education through planned in-services and as needed .III. Prevention of Abuse, Neglect and Exploitation, H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors .VIII. Coordination with QAPI, A. The facility has written policies and procedure that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program .iv. Measures to verify the implementation of corrective actions and timeframes, and v. Tracking patterns of similar occurrences. R98 was admitted to the facility on [DATE] with hospice services. R98's diagnoses included nondisplaced fracture of base of neck of right femur, pain right hip, palliative care, dementia without behavioral, major depressive disorder, protein-calorie malnutrition, anxiety disorder, and cervical disc degeneration. On 02/10/25, an admission Minimum Data Set (MDS) assessment documented R98's Brief Interview of Mental Status (BIMS) score of 3/15 meaning R98 has severe cognitive impairment. MDS documented R98 had acute onset of mental status change, inattention and disorganized thinking that is continuously present. R98's care plan documented on 02/20/25, The resident has impaired cognitive function r/t Dementia. Care plan on 03/11/25 documented, The resident has a behavior problem r/t dementia. Resident often tries to get up to walk not remembering she is unable to do so safely independently. Resident becomes agitated at times and often requires 1:1 to keep her safe and content. Resident can become verbally and physically aggressive. Review of the Facility Reported Incident (FRI) investigation documented on 03/10/25 Certified Nursing Assistant (CNA) C reported to Assistant Director of Nursing (ADON) F on the night shift on 03/09/25 into 03/10/25 Registered Nurse (RN) E had raised his voice and swore at R98 while attempting to assist R98, CNA D not attempting to do interventions with R98, and CNA D appeared to be intimidating R98. The facility immediately suspended RN E and CNA D and completed an investigation and educated all staff on dementia behavior. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the staff education sign in sheets for behaviors in dementia dated 03/10/25 which included 27 staff names. Review of the current employee list documented a total of 78 staff were employed on 03/10/25. Surveyor reviewed the list of staff education sign in sheets for abuse dated 03/10/25 after this incident. The list included 17 staff names. Surveyor reviewed the staff sign in sheets for abuse and reporting training from 11/11/24, which documented 23 staff signatures and did not include RN E. On 06/11/25 at 9:26 AM, Surveyor interviewed Nursing Home Administrator (NHA) A about the 03/09/25 incident. Surveyor asked if NHA A completed audits of staff interactions and knowledge of abuse policy to ensure no further verbal abuse occurred. NHA A stated no formal audits were completed. Surveyor reviewed the education that was provided to staff on 03/10/25 of abuse education informing NHA A the staff sign in sheet did not include all staff. Surveyor asked how NHA A ensures all staff are trained. NHA A stated she sends out an email that there is education to be reviewed and signed. NHA A stated the system can be improved to ensure all staff are educated. Surveyor asked if the facility's Quality Assessment & Assurance (QAA) had identified abuse as an issue to be reviewed and to initiate a plan. NHA A stated this was talked about and we could do better. NHA A stated they don't have a written PIP (Performance Improvement Plan).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not implement policies and procedures for ensuring the reporting of verbal abuse in accordance with section 1150B of the Act when an allegation of verbal abuse was not reported immediately but no later than 2 hours to the administrator and local law enforcement in accordance with state law through established procedures for 1 of 2 residents (R) reviewed (R98). This is evidenced by: Facility's policy titled Abuse, Neglect and Exploitation with no date implemented, read in part, VII. Reporting/Response, 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury R98 was admitted to the facility on [DATE] with hospice services. R98's diagnoses included nondisplaced fracture of base of neck of right femur, pain right hip, palliative care, dementia without behavioral, major depressive disorder, protein-calorie malnutrition, anxiety disorder, and cervical disc degeneration. On 02/10/25, an admission Minimum Data Set (MDS) assessment documented R98's Brief Interview of Mental Status (BIMS) score of 3/15, meaning R98 has severe cognitive impairment. MDS documented R98 had acute onset of mental status change, inattention and disorganized thinking that is continuously present. MDS documented R98 had impairment to one side of lower extremity. R98 requires moderate assist of staff for toileting hygiene, bed mobility, sit to stand, toilet transfer, shower transfer, and to walk 10 feet. R98 has a history of falls prior to admission. Review of the Facility Reported Incident (FRI) investigation documented on 03/10/25 Certified Nursing Assistant (CNA) C reported to Assistant Director of Nursing (ADON) F on the night shift on 03/09/25 into 03/10/25 Registered Nurse (RN) E had raised his voice and swore at R98 while attempting to assist R98, CNA D not attempting to do interventions with R98, and CNA D appeared to be intimidating R98. The facility immediately suspended Registered Nurse (RN) E and CNA D and completed an investigation and educated all staff on dementia behavior. On 06/09/25 at 2:25 PM, Surveyor interviewed CNA C about when the incident on 03/09/25 was reported. CNA C reported to ADON F in the morning. This happened Sunday night and no other nurses were on at that time. CNA C could have called the Director of Nursing (DON) but waited until morning until they came in. On 06/10/25 at 12:44 PM, Surveyor interviewed ADON F about the incident on 03/09/25. ADON F stated she came into the facility around 6:00-6:30 AM, and CNA C came to ADON F and reported CNA D and RN E's treatment to R98 was rough. ADON F reported to former Director of Nursing (DON) L about the report. RN E was immediately interviewed, and DON L reported to Nursing Home Administrator (NHA) A. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25 at 9:26 AM, Surveyor interviewed NHA A asking when DON L reported the 03/09/25 incident. NHA A stated ADON F reported to former DON L, and DON L texted NHA A between 7-7:30 AM. DON L told NHA A that R98 was having behaviors and CNA C reported not liking how the guys (RN E and CNA D) handled R98. They were verbally aggressive. Surveyor asked NHA A when CNA C should have reported the verbal abuse. NHA A stated CNA C should have called in the middle of the night within 2 hours. Surveyor asked if the allegation was reported to police. NHA A stated it was not reported to police because when talking with RN E and CNA C it was determined RN E was not swearing directly at R98. RN E was frustrated and swore, and it was not calling R98 names but a reply when R98 called RN E an asshole and RN said, Ya I am an . Of note the facility's investigation was not completed and reported to the state agency until 03/17/25.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure residents (R) received proper treatment and assistive devices to maintain hearing abilities. This affected 1 of 3 residents reviewed who needed hearing aids (R28). R28's hearing aid was broken and not replaced for several months. R28 continues with no left ear hearing aid, which impacts R28's ability to adequately hear. Findings Include: R28 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, primary open-angle glaucoma right eye-moderate state, low vision right eye, blindness left eye, disorientation-unspecified, and cognitive communication deficit. R28's Minimum Data Set (MDS) assessment, dated 3/31/25, indicated R28's Brief Interview for Mental Status (BIMS) score is 9/15, which means mild cognitive impairment. R28 requires supervision or touching assistance with eating, substantial/maximal assistance with toileting hygiene, shower, partial/moderate assistance with dressing, personal hygiene, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer, walking, and set up with rolling left to right, sit to lying, R28's care plan: Focus -The resident is HOH and wears bilateral HA's. I need assistance putting them in my ears and taking them out at bedtime. Is missing left hearing aide, Health Drive is replacing hearing aid. Date initiated 1/17/2023. Revision 3/11/2025. -The resident will be able to make basic needs known daily through the review date. Date initiated 1/17/2023. Revision 4/14/2025. Target Date 7/25/2025. -Anticipate and meet needs. Date Initiated: 01/17/2023. -Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Date Initiated: 01/17/2023. -COMMUNICATION: Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed. Date Initiated: 01/17/2023. -Ensure bilateral hearing aids are in place. Assist as needed. Date Initiated: 01/17/2023 (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. Date Initiated: 01/17/2023 -Monitor for/record confounding problems: decline in cognitive status, mood, decline in ADL, deterioration in respiratory status, oral motor function, hearing impairment (ear discharge and cerumen (wax) accumulation, poor fitting/missing dental appliances etc. Date Initiated: 01/17/2023. -Monitor/document resident's ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. -Refer to Audiology for hearing consult as ordered. Date Initiated: 01/17/2023. -Report to Nurse changes in: Ability to communicate, Possible factors which cause/make worse/make better any communication problems. Date Initiated: 01/17/2023. On 06/08/25 at 12:09 PM, Surveyor observed staff who were taking R28's order for lunch and speaking in louder than normal voice to R28's right ear. On 06/08/25 at 1:01 PM, Surveyor observed staff, who were standing near R28 and talking about cake, were talking close to R28's right ear loudly, but not yelling and R28 was responding. On 06/09/25 at 6:35 AM, Surveyor spoke with R28 in attempt to obtain permission to observe cares. R28 was unable to hear Surveyor talking when Surveyor was standing on R28's left side. When Surveyor was on R28's right side and spoke with a loud tone of voice and asked if care could be observed, R28 said it was ok to observe but repeated incorrect name of Surveyor. R28 had 2 hearing aids, and one broke several months ago and was not replaced. R28 needs people to talk in the right ear with the hearing aid and then she does fine, otherwise she can't hear. Left hearing aid was never replaced. On 06/10/25 at 6:43 AM, R28 was sitting in lounge area with peers, had glasses on and hearing aid in right ear. Surveyor attempted to speak to R28 on R28's left side and R28 did not respond. On 06/09/25 at 11:00 AM, Surveyor interviewed Social Service Director (SSD) H. Surveyor asked about R28's hearing aid. SSD H stated the issue should have been followed up on sooner. SSD H stated R28's husband had the hearing aid and was going to have it replaced. Unfortunately, R28's husband passed away. R28's nephew became R28's Power of Attorney (POA) and nephew was unsure of the status of the hearing aid. SSD H stated SSD H was supposed to schedule an appointment with the Health Drive audiologist. SSD H stated there is not a good system in place, and SSD H dropped the ball. SSD H did contact Health Drive and process is in place at this time. SSD H stated she should have responded sooner because R28 has sensory issues with vision and hearing, so she should have her hearing aid.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that residents with a suprapubic catheter received the appropriate care and services for 1 of 2 residents (R2), observed during catheter cares. -The facility had no policy to direct staff for daily suprapubic catheter site care. -R2 had a urinary tract infection (UTI) with sepsis in September 2024. -Registered Nurse (RN) G did not perform hand hygiene or glove change during suprapubic catheter care. Findings: Facility had no policy for staff to follow and direct the care for a suprapubic catheter site care. According to MediLexicon International. (n.d.). What to know about e.coli uti treatment. Medical News Today. https://www.medicalnewstoday.com/articles/e-coli-uti-treatment, If bacteria get into the bladder and travels to the bladder, they can cause an infection. CAUTIs can become serious, especially in those with weakened immune systems and other health conditions. Risk of infection can be significantly reduced by washing hands before and after changing, emptying, or handling the catheter, or changing a dressing and applying a new one. R2 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis (a disease that causes breakdown of the protective covering of nerves), neuromuscular dysfunction of the bladder, and appendicovesicostomy (surgeons use the appendix to create a channel that connects your bladder to an opening (stoma) in your abdominal wall). R2's Minimum Data Set (MDS) assessment documents a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated R2 was cognitively intact. A discharge summary note dated 10/02/2024 stated R2 had met sepsis criteria for a UTI. On 06/09/25 at 12:56 PM, Surveyor observed suprapubic catheter site care by RN G to R2. RN G gathered dressing supplies, performed proper hand hygiene when entering the room as well as put on proper personal protective equipment (PPE) for enhanced barrier precautions (EBP). RN G removed the old dressing. No hand hygiene or glove change after removing the dressing. RN G washed the site of the catheter insertion. RN G then put a new T-sponge gauze over the insertion site. RN G then threw away the garbage, removed PPE, and performed hand hygiene. *Note: Placing a clean sponge gauze at catheter insertion site with dirty gloves after handling a soiled dressing significantly increases the risk of bacteria entering the catheter and traveling to the bladder and causing an infection. On 06/09/25 at 1:01 PM, Surveyor asked Assistant Director of Nursing (ADON) F for a policy on suprapubic catheter site care. ADON F said she would find it. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/25 at 1:23 PM, ADON F informed Surveyor, I cannot find a policy on suprapubic catheter site care. I am making one now. We have a suprapubic catheterization policy but nothing which talks about site care. Surveyor reviewed the suprapubic catheterization policy and section f of section 7 which states to quickly change to sterile gloves but does not indicate to wash hands between glove changes. On 06/09/25 at 1:30 PM, Surveyor received policy titled Suprapubic Catheter Care created today, 06/09/25. This policy also has no indication for hand hygiene between old dressing and new split gauze dressing which increases the risk for bacteria to enter the catheter and travel to the bladder and cause an infection. On 06/10/25 at 8:35 AM, Surveyor asked ADON F when would you perform hand hygiene and glove changes when doing a suprapubic catheter site care to prevent an infection. ADON F stated, I would perform hand hygiene before I start the procedure, and I would have my items set up. I would remove the old dressing. Take off my gloves perform hand hygiene, then put on new gloves, and put on the new dressing. On 06/10/25 at 9:35 AM, Surveyor explained the process observed yesterday with the site care with RN G. Surveyor asked RN G where in this procedure should you have performed hand hygiene and glove change so as to prevent an infection. RN G replied, Oh I see what you're asking. Yes, I should have removed my gloves and performed hand hygiene before I put the new dressing on the site.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not assess trauma and care plan person centered approaches to prevent re-traumatization for 1 out of 1 resident reviewed for trauma informed care (R30). R30's diagnosis includes post-traumatic stress disorder (PTSD) and past trauma of her sister dying. The facility did not assess R30's trauma and care plan individual person-centered approaches to prevent potential re-traumatization. Findings Include: The facility policy titled Trauma Informed Care not dated, states the following: Policy: It is the policy of this facility to provide care and services, which in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/re re-traumatization. Policy Explanation and Compliance Guidelines: 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others. 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. R30 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, Alzheimer's disease, unspecified psychosis not due to substance or known psychological condition, panic disorder and post-traumatic stress disorder (PTSD). R30's most Recent Minimum data Set (MDS) completed on 5/19/25 notes R30 understands, is understood, is cognitively intact and has no mood or behavioral concerns. Takes antipsychotics (AP), antidepressants (AD), diuretic (D), anticonvulsants, and is hypoglycemic. Surveyor reviewed R30's record and found no assessment of R30's trauma. R30's care plan: The resident has a mental illness: depression. PTSD diagnosed d/t sister's death when she was 9. Reports her parents didn't allow her to grieve the loss or talk about her following her death. Date Initiated: 11/12/2024 Revision on: 11/25/2024 (continued on next page)

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	525513	A. Building B. Wing	06/11/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident will remain free of signs/symptoms (s/sx) of distress, symptoms of depression, anxiety or PTSD by/through review date. Date Initiated: 11/12/2024 Revision on: 05/29/2025 Target Date: 08/31/2025 o My PASRR screening will be completed. Date Initiated: 01/20/2025 Revision on: 05/29/2025 Target Date: 08/31/2025 Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 11/12/2024 o Assist the resident in developing a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise and socialization Date Initiated: 11/12/2024 Revision on: 11/12/2024 o Discuss with the resident any concerns, fears, issues regarding health or other subjects. Date Initiated: 11/12/2024 Revision on: 11/12/2024 o Encourage the resident to express feelings and allow time to talk Date Initiated: 11/12/2024 Revision on: 11/12/2024 o Follow state program requirements Date Initiated: 11/14/2024 o Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, and tearfulness. Date Initiated: 11/12/2024 o Praise accomplishments (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 11/14/2024 o Referral for level II screening Date Initiated: 11/14/2024 The resident has had a decline in psychosocial well-being r/t admission and decline in health status. Would prefer to be home, but her husband is unable to provide the care needed. Date Initiated: 01/20/2025 Revision on: 01/20/2025. The resident will show evidence of adjustment to nursing home by eating all meals in dining room, attending out of room (ORR) activities daily through the review date. Date Initiated: 01/20/2025 Revision on: 05/29/2025 Target Date: 09/05/2025. On 06/08/25 at 3:55 PM, Surveyor attempted to interview R30. R30 did not wish to discuss past trauma. On 6/10/25 at 10:20 AM, Surveyor requested a trauma informed assessment from Social Service Director (SSD) H. SSD H informed Surveyor the facility does not currently complete trauma informed assessments for residents with identified trauma. SSD H learned of R30's trauma during social services initial assessment when R30 was admitted . Facility developed a care plan in attempts to meet R30's emotional needs. SSD H stated she can see why it would be important to assess resident's specific trauma and develop person-centered approaches to address potential triggers and prevent re-traumatization. On 06/10/25 at 1:33 PM, Surveyor interviewed Certified Nursing Assistant (CNA) X who has been on staff almost 3 years and is familiar with R30. CNA X explained she did not know anything about R30's past trauma or PTSD diagnosis. CNA X further explained R30 has been upset and indicated she is having nightmares related to hearing of a father who had killed his three daughters which was recently on the news. CNA X expressed she has been talking with R30 about it but is unaware of specific approaches staff should follow related to R30's past trauma. On 06/10/25 at 1:38 PM, Surveyor interviewed CNA P who has been employed at the facility for 3 years working 4-5 days a week on R30's wing full time on day shift. CNA P is familiar with R30. CNA P is unaware of past trauma. CNA P has noticed R30 has some sensitivity to lights and is startled if you go into her room too fast or loud. CNA P reported R30 apologizes a lot. CNA P is unaware of care planned approaches specific to R30's past trauma.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on record review and staff interviews, the facility did not ensure Certified Nursing Assistant (CNA) received a performance review every 12 months for three of three CNAs reviewed (CNA C, CNA D, CNA P). The facility failed to have a system in place to ensure that performance reviews were being done for any of the facility CNAs. This had the potential to affect all 49 residents residing in the facility. This is evidenced by: On 06/10/25, a sample of CNAs employed by the facility was selected for review for the completion of annual performance reviews. The facility provided the following information: CNA C has been employed at the facility since 12/15/20. An annual performance review could not be located. CNA D has been employed at the facility since 09/2019. An annual performance review could not be located. CNA P has been employed at the facility since 12/06/21. An annual performance review could not be located. On 06/10/25 at 8:15 AM, Surveyor interviewed Nursing Home Administrator (NHA) A about yearly performance evaluations on staff. NHA A was not able to find yearly reviews, only yearly wage adjustment form. The lack of regular performance reviews significantly impacts the quality of care provided by the staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility did not ensure expired medications were removed from currently used supply in the medication storage room refrigerator. This occurred for 1 of 1 medication storage rooms observed. An opened bottle of a resident's (R) multiuse medication kept in the medication storage room refrigerator was labeled with a beyond use date of 6/7/25. This medication was expired and had been given to resident (R34) since it expired, resulting in the potential to affect 1 out of 49 residents that reside in the facility (R34). Findings include: The facility's policy titled, Storage of Medication Requiring Refrigeration not dated with an implemented or reviewed date, but provided by facility upon request of policy, states in part, .5. Staff should observe proper storage and labeling requirements for all medications and vaccines during the performance of their daily tasks and should demonstrate safety in regard to the medication's integrity, such duties should include but not be limited to: . c. Remove any expired medications from active stock and discard medications according to facility policy. On 6/09/25 at 9:20 AM, during review of medication storage room with Licensed Practical Nurse (LPN) J, Surveyor observed refrigerated liquid medication for R34, omeprazole 20 ml po twice daily (BID) was labeled with a beyond use date of 6/7/25. No other expiration dates were noted on this bottle. On 6/9/25 at 12:39 PM, Surveyor reviewed medication record, and the expired medication was destroyed. On 6/10/25 at 8:44 AM, Surveyor interviewed Assistant Director of Nursing (ADON) F who reported the expectation is that all medications have the expiration date checked by nursing staff prior to being given to a resident and if a medication is expired, it will be disposed of in accordance with facility policy. ADON F reported ADON F does inspect all refrigerated medications every Wednesday when doing new medication orders.

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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. Based on observation, interview and policy review, the facility did not prepare, distribute, and serve food in accordance with professional standards for food service safety. Staff were observed not allowing thermometer to dry prior to checking temperatures of food items and not inverting mixer and bowls in storage. This had the potential to affect all 49 residents in the facility. Findings: Example 1 On 06/08/25 at 10:45 AM, Surveyor conducted the initial tour of kitchen with [NAME] T who has been on staff 12 years. Surveyor observed the Kitchen Aide mixer on the counter with bowl under it that was not inverted. Surveyor also observed large industrial size mixer in kitchen with bowl stored under it which was not inverted. Neither of the mixers were covered. Surveyor interviewed [NAME] T and asked what the normal way is to store when not in use. [NAME] T stated both mixers are used 2-3 times a week and stored uncovered and not inverted when not in use. Surveyor observed a rack of large bowls and pans that were not inverted. [NAME] T stated that is normal to store the rack of dishes in this manner. Surveyor discussed potential for contamination with storing items uncovered and not inverted. [NAME] T indicated understanding there is a risk of bacteria with the manner the mixing bowls, bowls and pans are stored. [NAME] T acknowledged the mixing bowls, bowls and pans should be inverted or covered when not in use. Example 2 On 06/09/25 at 7:30 AM, Surveyor observed [NAME] R perform food temps and food service. [NAME] R used an alcohol pad for thermometer probe used to temp oatmeal. [NAME] R wiped probe and inserted the undried probe into the cream of wheat. [NAME] R then wiped and inserted the undried probe into the scrambled eggs with no wait time for probe to air dry. [NAME] R proceeded to wipe the probe with alcohol pad and insert in pureed eggs with no wait time for probe to air dry. [NAME] R continued to wipe the probe with the alcohol pad and insert into sausage. [NAME] R exited kitchenette to obtain additional alcohol pads. [NAME] R returned, wiped the probe and inserted into pureed toast. Surveyor interviewed [NAME] R asking what education he has had for sanitizing the thermometer probe prior to inserting into food items. [NAME] R stated he was not exactly told nor really ever trained on waiting to allow probe to air dry. Surveyor asked if the undried thermometer has the potential to contaminate food items with the sanitizer. [NAME] R verbalized understanding as to why he should wait for the sanitizer to dry prior to inserting into food items. On 06/11/25 at 9:41 AM, Surveyor interviewed Dietary Manager (DM) U. DM stated the bowls should be covered. DM U acknowledged after dishwashing moisture remains in the dishes and is an opportunity for bacteria to grow. The dishes are stored in areas where anything could fall in the dishes and contaminate them. The dishes should be inverted or covered.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility did not ensure accurate reporting of the mandatory submission of staffing information based on payroll data to the Centers for Medicare and Medicaid Services (CMS). The facility failed to enter accurate data in their Payroll Based Journal (PBJ) system from 7/1/24 - 3/31/25 which triggered excessively low weekend staffing. This has the potential to affect all 49 residents residing in the facility. This is evidenced by: Centers for Medicare & Medicaid Services (CMS) Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, states in part: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate . Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: 1 October 1 - December 31, (quarter 1) 2 January 1 - March 31, (quarter 2) 3 April 1 - June 30, (quarter 3) 4 July 1 - September 30 (quarter 4) . PBJ Staffing Data Report, CASPER Report (Certification and Survey Provider Enhanced Reports) 1705D for Fiscal Year Quarter 4 2024 (July 1-September 30), Quarter 1 2025 (October 1-December 31), and Quarter 2 2025 (January 1- March 31) all indicate the following: Excessively low weekend staffing. On 6/10/25, Surveyor reviewed a sample of the nursing working weekend schedule in each quarter. Surveyor was not able to identify any systematic concerns with staffing during this review. On 6/10/25 at 11:54 AM, Surveyor interviewed Scheduler K, who stated the facility assesses census and acuity of the residents to determine if they should schedule extra staff by obtaining staff input. Scheduler K stated, If the census is below 47, we would typically have the same number of nursing staff on the weekends, as we do on the weekdays, except for the Director of Nursing (DON) or ADON F. Scheduler K stated if the census is greater than 47 or there are higher acuity resident(s) there will typically be more Certified Nursing Assistants (CNA) scheduled. The CNAs are scheduled for 8-hour days, so if they are short, they can ask them to work longer hours and on other shifts. On 6/11/25 at 9:00 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. Surveyor asked why the facility triggers for low weekend staffing. NHA A stated she is not sure why they trigger for the low weekend staffing, as they schedule the same amount of nursing staff on the weekends as they do during the week. NHA A stated they will request staff to work longer shifts to cover if staff calls in sick. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NHA A confirmed the number of direct care staff scheduled does not change on the weekends versus during the week. NHA A reported the nursing hours worked are submitted to the owner through their payroll system and are entered into the PBJ system by the owner. NHA A reported attempts were made to contact the owner to verify how hours are being submitted into the PBJ system, but no further information was provided to Surveyor. Surveyor did not identify evidence of excessively low weekend staffing. NHA A reported she believes staff hours worked went unreported into the PBJ system entered by the owner, as some staff may enter information incorrectly on their timecard which may have triggered low weekend staffing. NHA A reported she will review with the owner when she is able to contact.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for 1 of 2 residents (R2), observed during catheter cares. Registered Nurse (RN) G did not perform hand hygiene or glove change during suprapubic catheter care. Findings: Facility had no policy for staff to follow and direct the care for a suprapubic catheter site care. Facility policy titled Hand Hygiene with no date implemented or date revised stated in part: .2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table .after handling contaminated objects .before performing invasive procedures .before and after handling clean or soiled dressings .after handling items potentially contaminated with blood, body fluids, secretions, or excretions . R2 was admitted to the facility on [DATE], with diagnoses of multiple sclerosis (a disease that causes breakdown of the protective covering of nerves), neuromuscular dysfunction of the bladder, and appendicovesicostomy (surgeons use your appendix to create a channel that connects your bladder to an opening (stoma) in your abdominal wall). R2's Minimum Data Set (MDS) assessment, dated 03/26/25, documented a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated R2 was cognitively intact. On 06/09/25 at 12:56 PM, Surveyor observed suprapubic catheter site care by RN G. RN G gathered dressing supplies, performed proper hand hygiene when entering the room as well as put on the proper personal protective equipment (PPE) for enhanced barrier precautions (EBP). RN G removed the old dressing. No hand hygiene or glove change. RN G washed the site of the catheter insertion without hand hygiene or glove change. RN G then put a new T-sponge gauze over the insertion site. RN G then threw away the garbage, removed PPE and performed hand hygiene. On 06/10/25 at 8:35 AM, Surveyor asked Assistant Director of Nursing (ADON) F, When would you perform hand hygiene and glove changes when doing a suprapubic catheter site care? I would perform hand hygiene before I start the procedure, and I would have my items set up. I would remove the old dressing. Take off my gloves perform hand hygiene then put on new gloves and put on the new dressing. On 06/10/25 at 9:35 AM, Surveyor explained the process observed yesterday with the site care with RN G. Surveyor then asked RN G, Where in this procedure should you have performed hand hygiene and glove change? RN G replied, Oh I see what you're asking, yes I should have removed my gloves and performed hand hygiene before I put the new dressing on the site.