STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525523	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexian Village of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47094 Based on interview and record review the facility did not report 3 (R5, R111, R45) of 5 allegation to the State Survey Agency, Nursing Home Administrator, or local law enforcement during the required timeframe. R5 had an allegation of abuse and it was not reported to the Nursing Home Administrator until two days later, the alleged employee continued to work at the facility during those two days, and law enforcement was not contacted about R5's potential abuse allegation. R111's family members had a physical altercation in front of R111 and other resident's in the facility main dining room during meal service. Local law enforcement was notified and removed 1 of the individuals involved. The Nursing Home Administrator was not notified about the altercation until two days later at which time it was reported to the State Agency. R45's allegation of abuse was not reported timely. Findings include: The facility policy entitled Abuse Prevention revised on 8/2024 documents . Reporting/Response: A. The community will immediately, but no later than 2 (two) hours after the allegation is made, if the events that cause the allegation involve abuse of [sic] result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in mistreatment, including injuries of unknown source and misappropriation of property, to the administrator and/or designee, State agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. The facility policy entitled Abuse Investigation and Reporting revised on 11/2023 documents: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, ., and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the [Facility Name] Abuse Prevention policy. Reporting: (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designee and to the following other officials or agencies: 1. The State licensing/certification agency responsible for surveying/licensing the community. 2. Other officials in accordance with State Law, including the Adult Protective Services where state law provides for jurisdiction in long term care facilities. B. Alleged violations involving abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported: 1. Abuse or serious bodily harm- Immediately but no later than 2 hours. *If the alleged violation involves abuse or results in serious bodily injury. 2. No serious bodily injury- As soon as practical, but no later than 24 hours*. If the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; does not result in serious bodily injury. 1) R5 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, vascular dementia without behaviors/psych/mood, hemiplegia following cerebral infarction affecting left nondominated side, type 2 diabetes with peripheral angioplasty/diabetic neuropathy/diabetic chronic kidney disease, peripheral vascular disease, major depressive disorder, weakness, heart failure, cognitive communication deficit, dysphagia, and contracture of the left wrist/hand/and muscle. R5's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R5 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R5 needing extensive assist with 2 staff assistance for toileting/personal hygiene, repositioning, and transferred using a Hoyer lift. R5 is always incontinent of bowel and bladder and wore adult briefs for protection. The facility assessed R5 to not have any behavior concerns. Surveyor reviewed the facility self- report for R5. The summary report for the allegation documents an allegation of possible retaliation to R5 on 7/8/2024, at approximately 8:00 PM when certified nursing assistant (CNA)-F came out of R5's room and stated R5 scratched her. Licensed Practical Nurse (LPN)-E documented R5's left side of her face appeared to be red and swollen upon assessment. On 7/10/2024, LPN-E notified the Social Services Director (SSD) of LPN-E's concern that CNA-F possibly retaliated on R5 for scratching CNA-F during cares. SSD reported the concern to the Nursing Home Administrator (previous NHA)-D. The initial report was submitted to the State survey agency on 7/10/2024, at 5:22 PM, 2 days after the accusation of CNA-F possibly retaliating against R5 on 7/8/2024. On 10/3/2024, at 12:12 PM, Surveyor interviewed LPN-E who stated LPN-E noted CNA-F coming out of R5's room and CNA-F stated R5 scratched CNA-F on the neck and CNA-F did not want to work with R5 anymore. LPN-E directed CNA-F to report it to the charge nurse on duty, Registered Nurse (RN)-G. LPN-E stated LPN-E went into R5's room and observed R5's face to be slightly red and appeared to be a little swollen. LPN-E stated LPN-E reported it to RN-G who stated R5's face is always like that. LPN-E stated when LPN-E returned back to work on 7/10/2024, LPN-E noted CNA-F was still working and went to SSD to report concern that R5 may have been retaliated on when R5 scratched CNA-F on the neck on 7/8/2024. Surveyor asked LPN-E if LPN-E reported the concern to anyone or notified police. LPN-E stated LPN-E thought RN-G was going to take care of it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/2024, at 12:23 PM, Surveyor interviewed previous NHA-D who stated, it was reported that R5's face is slightly reddened and swollen due to R5's history of having a stroke. When NHA-D interviewed R5, R5 would not respond to NHA-D. NHA-D stated CNA-F documented R5 scratched her when providing cares for R5 and that CNA-F was reassigned to another unit. NHA-D stated R5 scratched CNA-F, so police did not need to be contacted. Surveyor shared the concern with NHA-D that there was an allegation of possible retaliation made against CNA-F to R5 and it was not reported to NHA-D, to the State Agency or law enforcement agency timely. No further information was provided to Surveyor at this time. 2) R111 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction, type 2 diabetes mellitus with chronic kidney disease, cognitive communication deficit, and mild cognitive impairment. R111's admission MDS (Minimum Data Set) assessment dated [DATE] indicates R111 has moderately impaired cognition with a BIMS (Brief Interview of Mental Status) score of 8. The facility assessed R111 to not have any behavior concerns. Surveyor reviewed the facility self-report for R111. The summary of the report documents that on 6/22/2024 approximately around 5:00 PM/dinner time in the main dining room R111's wife and daughter were involved in a verbal altercation that escalated to physical altercation of hair pulling and clenched fists striking each other. Facility staff broke up the altercation, police were contacted. Local law enforcement removed one of the visitors. R111 and other residents were witness to the incident. The altercation was not reported to NHA-D until 6/24/2024, 2 days after the altercation happened. NHA-D submitted the initial report on 6/24/2024, at 5:43 PM. Surveyor noted RN (Registered Nurse)-E reported the altercation to the clinical on call staff member-Director of Quality Management (DQM)-I who did not report it any further. On 10/3/2024, at 11:55 AM, Surveyor interviewed DQM-I who stated DQM-I did not think it needed to be reported to the State Agency because the altercation did not include any resident's and no residents were harmed in the altercation. On 10/3/2024, at 12:23 PM, Surveyor interviewed NHA-D who stated NHA-D was made aware of the situation in the morning stand up meeting a couple days after the altercation and started an investigation right away. No further information was provided at this time. 38146 2) R45 admitted to the facility on [DATE] to a room on the 3rd floor and has resided in the same room since admission. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24, at 9:38 AM, R45 advised Surveyor that on 6/17/24 he reported to the facility that he was held down and changed against his will. R45 reported he had a leg cramp, so he slid his leg out of bed, and the right leg went with it, so he was half on/half off the bed with his feet on the floor and his butt on the bed. R45 put his call light on and when the nurse came in and saw his position, she left to get a Certified Nursing Assistant (CNA) to help. R45 reported they lifted his legs back in bed and the nurse said he needed to be changed. R45 reported he said no, adding he has an enlarged prostate and just dribbles urine, and because in a half hour he would let the next shift change him, as he was only damp and there was no need to be changed right now. R45 reported he explained all of this to the nurse, but she kept insisting. R45 could not recall the nurses name, except that she was from Nicaragua. R45 reported he kept saying no and that the nurse told the aide to hold him down. R45 stated: I was lying flat, and the aide was pressing down on each of my shoulders, holding me down. So now I'm fighting with her, trying to get up because she's holding me down and I'm saying no so many times. In the meantime, the nurse is changing me while the aid was holding me down. R45 reported he told the nurse that he wanted to talk to someone to report what happened. On 10/3/24, at 11:06 AM, Surveyor spoke with Previous NHA (Nursing Home Administrator)-D, NHA-A and Executive Director-C regarding the abuse allegation involving R45. Surveyor asked Previous NHA-D when the abuse allegation was reported to the State Agency. Previous NHA-D stated: I'm sure I reported it right away, I usually do. Executive Director-C looked at the computer and advised Surveyor it was reported on 6/19/24 and the 5 day was submitted on 6/25/24. Previous NHA-D stated: OK, so I reported it on the 19th. Surveyor advised Previous NHA-D of concern he was made aware of the abuse allegation on 6/17/24 and it was not reported until 2 days later on 6/19/24. Previous NHA-D stated: Well, I'm not sure that abuse even happened. If you're held down by your shoulders, you would have some evidence of it, some marks or something. Review of the Facility Self Report documented Previous NHA (Nursing Home Administrator)-D was notified of the allegation of abuse on 6/17/24. The abuse was not reported to the State Agency until 6/19/24. In addition, the CNA (Certified Nursing Assistant) statement documented R45 reported the abuse allegation to her on 6/15/24. The CNA did not report the allegation of abuse because he complains about everything. On 10/7/24, at 10:49 AM, Surveyor advised NHA-A of concerns regarding the Facility not reporting of R45's abuse allegation timely to the State Agency. NHA-A reported she was present when Surveyor was interviewing Previous NHA-D and understands. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure all allegations involving potential abuse, neglect, and misappropriation of resident property were thoroughly investigated for 3 (R5, R111, R45) of 5 Facility self-reports reviewed. R5's allegation of abuse reported on 7/8/2024 was not thoroughly investigated and residents were not protected from potential abuse during the abuse investigation. R111's family's verbal and physical altercation which occurred in the main dining room during meal time was reported on 6/22/2024 and was not thoroughly investigated. R45's allegation of abuse reported on 6/17/2024 was not thoroughly investigated. Findings include: The facility policy entitled Abuse Prevention revised on 8/2024 documents: . The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. Injury of Unknown Source is defined as an injury that meets both of the following conditions: 1. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident. 2. The injury is suspicious because of: a. the extent of the injury. b. the location of the injury. c. generally vulnerable or trauma. TRAINING: . 3. Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when associate and others must report their knowledge related to any alleged violation without fear of reprisal. IDENTIFICATION: . B. Associates or person affiliated with this community who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report suspected abuse or incidents of abuse to the administrator or designee. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy entitled Abuse Investigation and Reporting revised on 11/2023 documents: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, ., and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the [Facility Name] Abuse Prevention policy. POLICY INTERPRETATION AND IMPLEMENTATION Role of the Administrator or designee: . D. The Administrator or designee will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. Role of the Investigator: A. The individual conducting the investigation will, at a minimum: . 3. Interview the person(s)reporting the incident. 4. Interview any witnesses to the incident. 5. Interview the resident (if medically appropriate). 7. Interview associates members (on all shifts) who have had contact with the resident during the period of the alleged incident. 9. Interview other residents to whom the accused employee provides cares or services. 11. Review use of community camera/video footage of incident if available. 1) R5 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, vascular dementia without behaviors/psych/mood, hemiplegia following cerebral infarction affecting left nondominated side, type 2 diabetes with peripheral angioplasty/diabetic neuropathy/diabetic chronic kidney disease, peripheral vascular disease, major depressive disorder, weakness, heart failure, cognitive communication deficit, dysphagia, and contracture of the left wrist/hand/and muscle. R5's quarterly Minimum Data Set (MDS) dated [DATE] indicated R5 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R5 needing extensive assist with 2 staff assistance for toileting/personal hygiene, repositioning, and transferred using a Hoyer lift. R5 is always incontinent of bowel and bladder and wore adult briefs for protection. The facility assessed R5 to not have any behavior concerns. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility self-report for R5. The summary report for the allegation documents an allegation of possible retaliation to R5 on 7/8/2024 at approximately 8:00 PM when Certified Nursing Assistant (CNA)-F came out of R5's room and stated R5 scratched her. Licensed Practical Nurse (LPN)-E documented R5's left side of her face appeared to be red and swollen upon assessment. On 7/10/2024, LPN-E notified the Social Services Director (SSD) of LPN-E's concern that CNA-F possibly retaliated against R5 for scratching CNA-F during cares. SSD reported the concern to the Nursing Home Administrator (previous NHA)-D. The initial report was submitted to the State survey agency on 7/10/2024 at 5:22 PM, 2 days after the alleged incident occurred. Surveyor noted CNA-F continued to care for other residents including R5, law enforcement was not notified regarding the allegation of possible retaliation against R5, CNA-F was not following the care plan for R5 and was assisting R5 alone versus 2 staff members per R5's care plan, and education was not provided to all staff member in the facility. On 10/1/2024, at 3:14 PM, Surveyor observed R5 sitting in a Broda wheelchair in the dining room alone. Surveyor asked R5 if R5 felt safe and if there were any concerns with staff. R5 replied R5 was doing well and liked all the staff and the facility. Surveyor asked R5 if R5 was scared of any staff or was injured by any staff. R5 replied they had no concerns and did not recall having been injured by any staff. On 10/3/2024, at 9:18 AM Surveyor interviewed CNA-F who stated CNA-F was assisting R5 alone and did not have another staff member in the room when providing care for R5. CNA-F stated the rest of the shift CNA-F has another staff member present with R5's when care is provided. Surveyor asked CNA-F if CNA-F received education related to the incident with R5. CNA-F stated CNA-F was talked to about following the resident care cards. On 10/3/2024, at 12:12 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated LPN-E reported concerns to the Social Services Director (SSD) on 7/10/2024 when LPN-E came into work next and found out CNA-F was still on the schedule to work. Surveyor asked LPN-E if LPN-E received education regarding reporting such concerns. LPN-E stated LPN-E received education on reporting abuse. On 10/3/2024, at 12:23 PM, Surveyor interviewed previous NHA- D who stated CNA-F was taken off the schedule on 7/10/2024 when NHA-D heard about the concern that occurred with R5 on 7/8/2024. Surveyor asked NHA-D if law enforcement was contacted. NHA-D stated law enforcement was not contacted because CNA-F stated CNA-F was fine. Surveyor asked if law enforcement was contacted for the concern of possible retaliation against R5. NHA-D stated when NHA-D went to talk with R5, R5 did not talk with NHA-D and CNA-F denied retaliation against R5 and CNA-F walked out of the room after R5 scratched CNA-F. NHA-D stated there was not a need for law enforcement. Surveyor asked NHA-D if education was provided to staff regarding reporting abuse. NHA-D stated education was given to LPN-E and Registered Nurse (RN)-G regarding reporting abuse. Surveyor asked NHA-D how other staff was educated about abuse prevention and reporting and how is NHA-D aware other staff know the policy/protocols for reporting abuse. NHA-D replied NHA-D often goes onto the units and talks with staff and DON-B does monthly education with staff but not sure what DON-B covers. Surveyor requested the last time staff was educated on reporting/preventing abuse and CNA-F punch card times for the weekend of 7/8/2024 - 7/10/2024. Surveyor received CNA-F's punch cards and noted CNA-F was listed as working in the facility on: 7/8/2024: 2:29PM - 10:30 PM, 10:30 PM - 6:30 AM into 7/9/2024 (CNA-F worked a double shift) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/10/2024: 2:37 PM - 10:32 PM Surveyor noted CNA-F worked a full shift with residents on 7/10/2024 when NHA-D was aware of the allegation of possible retaliation against R5 and during the time the investigation was in progress. Surveyor was unable to interview NHA-D further due to NHA-D's term being up at the facility and leaving. On 10/3/2024, at 3:04 PM, Surveyor shared concerns with Assistant Director of Nursing (ADON)-M, Executive Director- C, and Nursing Home Administrator (NHA)-A regarding the Facility Reported Incident not being investigated thoroughly, CNA-F was allowed to continue to work with residents when an allegation was made for possible retaliation against R5, CNA-F was not following R5's care plan and assisted R5 with cares alone instead of 2 staff members, education was not provided to staff. No further information was provided at this time. 2) R111 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction, type 2 diabetes mellitus with chronic kidney disease, cognitive communication deficit, and mild cognitive impairment. R111's admission MDS (Minimum Data Set) assessment dated [DATE] indicates R111 has moderately impaired cognition with a BIMS (Brief Interview of Mental Status) score of 8. The facility assessed R111 to not have any behavior concerns. Surveyor reviewed the facility self-report for R111. The summary of the report documents on 6/22/2024 approximately around 6:00 PM/dinner time. R111's wife and daughter were involved in a verbal altercation that escalated to a physical altercation in the main dining room with residents present. Facility staff intervened, law enforcement was contacted and did escort 1 family member out of the building. Surveyor noted all staff with knowledge of the incident were not interviewed regarding the altercation between R111's family members. On 10/3/2024, at 12:23 PM, Surveyor interviewed previous NHA-D who stated the facility obtained a staff statement regarded the whole incident, so NHA-D did not feel the need to talk to other staff members regarding the situation. Surveyor asked NHA-D how other staff were provided educating about abuse prevention and how NHA-D aware other staff know the policy/protocols for reporting abuse. NHA-D replied NHA-D often goes onto the units and talks with staff and DON-B does monthly education with staff but not sure what DON-B covers. On 10/3/2024, at 3:04 PM, surveyor shared concerns with Assistant Director of Nursing (ADON)-M, Executive Director- C, and Nursing Home Administrator (NHA)-A regarding the facility reported incident not being investigated thoroughly, staff that observed or had knowledge of the altercation did not provide statements and education was not provided to staff to ensure they were aware of abuse reporting and need for a thorough investigation. 38146 2.) R45 admitted to the facility on [DATE] to room [ROOM NUMBER] on the 3rd floor and has resided in the same room since admission. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24, at 9:38 AM, R45 advised Surveyor that on 6/17/24 he reported to the facility that he was held down and changed against his will. R45 reported he had a leg cramp, so he slid his leg out of bed, and the right leg went with it, so he was half on/half off the bed with his feet on the floor and his butt on the bed. R45 reported he put his call light on and when the nurse came in and saw his position, she left to get a Certified Nursing Assistant (CNA) to help. R45 reported they lifted his legs back in bed and the nurse said he needed to be changed. R45 reported he said no (adding he has an enlarged prostate and just dribbles urine) and he told her no because in a half hour he would let the next shift change him, as he was only damp and there was no need to be changed right now. R45 reported he explained all of this to the nurse, but she kept insisting he needed to be changed. R45 reported he could not recall the nurses name, except that she was from Nicaragua. R45 reported he kept saying no and the nurse told the aide to hold him down. R45 stated: I was lying flat, and the aide was pressing down on each of my shoulders, holding me down. So now I'm fighting with her, trying to get up because she's holding me down and I'm saying no so many times. In the meantime, the nurse is changing me while the aid was holding me down. R45 reported he told the nurse he wanted to talk to someone to report what happened. R45 reported the allegation of abuse to Previous NHA (Nursing Home Administrator)-D. R45 reported he has been using Oxycodone and Bengay for shoulder pain ever since and has been going to therapy. R45 reported the therapist thinks it is a torn rotator cuff and he has an ortho appointment on 10/4/24. On 10/2/24, at 10:25 AM, Surveyor spoke with RN (Registered Nurse)-G who reported she is familiar with R45 but doesn't work with him very often. Surveyor asked RN-G to tell me about R45. RN-G stated: He once said he wants me to go back to Nigeria. He has a hard time understanding some of us sometimes and gets angry, he reports everything he gets mad about, like he don't want to be changed, even when his brief is wet, he says it's his right to not be changed. Surveyor asked if she has ever had an altercation or incident with R45. RN-G stated: No, but I heard about one time a few months ago, he was falling out of bed, and they repositioned him and changed him and he was mad because he didn't want to be changed. So now we don't change him if he don't want to. Surveyor asked RN-G if she knew what staff were involved with the alleged incident. RN-G stated: No, not really. I just heard about it, you know, with people talking. On 10/2/24, at 3:42 PM, Surveyor spoke with OTA (Occupational Therapy Assistant)-R who reported she has been seeing R45 for right should pain since 8/20/24. Surveyor confirmed OT (Occupational Therapy) Plan of Care started care on 8/20/24. Surveyor asked if she had any knowledge regarding the origin of his shoulder pain. OTA-R stated: He told me he was pinned down while they were forcibly changing him and he was fighting back, that's how he injured his shoulder. Surveyor review of R45's medical record revealed no documentation of pain or increased pain to his shoulder prior to 8/13/24 when progress notes documented: Reporting right shoulder pain with movement. NP (Nurse Practitioner) notified. Order for 2 view shoulder x-rays ordered. On 8/14/24, a 2 view x-ray shoulder: The right shoulder is normal. There is no erosion or osteophyte formation. There is no dislocation. The mineralization is normal. There are no fractures. The clavicle is normal. Impression: Normal right shoulder. On 8/28/24 NP note documents: Reports worsening pain within right shoulder and decreased movement right arm. Denies numbness or tingling. Reports thinks [sic] his rotator cuff is bad. No reported injuries or overuse, just worsening achy pain. Reportedly leans on shoulder quite a bit in bed, as it is his favorite position. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/24 Ortho consult: Right RC (rotator cuff) tear. Very high risk, no surgical option. Offered CSI (corticosteroid injection). Aggressive therapy right shoulder. Surveyor reviewed R45's facility abuse investigation. The manilla envelope included handwritten notes on each side by Previous Nursing Home Administrator (NHA)-D. The investigation documented: On 6/17/24, at approximately 11:17 AM, received an email from (Dir Quality Mgmt/IP) that (R45) wanted to speak with the Administrator. Arrived to room at approximately 11:25 AM. (R45) reported the other evening (believed that it was the prior Saturday) sometime before 10 PM (thought but was not sure) 2 CNA's proceed to change him without his permission. NHA asked Social Service Director to speak with (R45) as a second interview to see if the two interviews were consistent. Surveyor noted the facility abuse investigation included only 5 staff statements, one of which was the Social Worker (who did not provide care). Social Worker statement dated 6/17/24, at 4:03 PM: Stated he had an issue with a 3rd shift aid, female, short and big boned, could not recall name. On Saturday, June 15 early morning, he was in bed and caught a leg cramp and was half on the bed and half off the bed as a result. Stated he turned on call light, this female aide came and helped him back in bed but insisted on wanting to change him, stating he was wet. Resident told aid no I'm not wet and I don't need to be changed. Aid said, but I have to change you now. Aid left room and came back with another aid. Stated this aid was female, could not recall a description. Stated the aid and other aid held him down, where he was unable to move his shoulders and then they changed him anyway against his will. Stated he was calling them every bad name you could think of while they were changing him. He said to writer - this aid needs to go back to Nigeria, we don't need that import here. Pool CNA interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Stated she did not remember taking care of (R45) on those dates. She had not worked the A cluster on those dates or for many months. At this point the interview ended, it was obvious that this CNA did not know (R45) nor had she provided any care to him on the dates in question. RN-G interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Stated she did not provide any care to resident on these dates. Receive any complaint from resident on these dates? NO. Surveyor noted RN-G was not on the schedule for 6/15/24. Pool CNA interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Yes, on 6/15/24 worked the 3rd floor on noc (night) shift. Did not get to floor until about 11:15 PM. Shortly after, making rounds, went into residents' room. I recall that he was extremely wet, so I changed him and his bedding. While I was working with him, he mentioned that one of the other girls from the prior shift had come in several times to do a check and change. (R45) said she kept insisting that he need to be changed and he kept telling her no that he was not wet and that it could wait. He said that she is some girl from [NAME] and can't understand her half of the time. He said that eventually this aid came back with another aid and changed him without his permission. I asked if she reported this to anyone, she stated No, because he complains about everything. Surveyor noted the CNA statement alleges the incident occurred on the previous shift, however the facility did not interview all staff on the previous shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pool CNA interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Stated she did not remember taking care of resident on those dates. NHA concluded as it was very apparent that this CNA did not know (R45). On 10/3/24, at 1:22 PM, Surveyor spoke with Scheduler-S and asked to explain the schedule and how units and resident rooms are assigned. Surveyor was advised the rooms are assigned as Clusters. Nurses for A/E rooms 50-57, B 60-68, C/D 70-87B CNAs: A/E 50-57, C/E 70-78, 90, 92 and 94, B/E 60-68, 93 and 95, D/E 80-87 and 91. Surveyor noted the schedule on 6/15/24 documented 8 staff assigned to the 3rd floor on first shift. The abuse investigation included only 1 staff statement from this shift and there were no statements from the staff specifically assigned to R45's room (cluster). Surveyor noted the schedule on 6/15/24 documented 9 staff assigned to the 3rd floor on second shift. The abuse investigation included only 2 staff statements from this shift and there were no statements from staff specifically assigned to R45's room (cluster). Surveyor noted the schedule on 6/15/24 documented 6 staff assigned to the 3rd floor on third shift. The abuse investigation included only 1 staff statement from this shift. The CNA assigned to R45's room provided a statement that indicated R45 reported the incident occurred the previous shift. Surveyor notes this was not reported, and no staff were interviewed. On 10/3/24, at 10:31 AM Surveyor spoke with Dir Quality Mgmt/IP-I about R45's allegation of abuse. Dir Quality Mgmt/IP reported R45 said that he had something serious to report to someone above him. He did not ask details because he didn't want R45 to have to explain it twice and because he said it was serious, he wanted the NHA to hear it first-hand. Dir Quality Mgmt/IP reported he immediately told the Previous NHA-D that R45 had something serious to report. On 10/3/24, at 11:06 AM, Surveyor spoke with Previous NHA-D, NHA-A and Executive Director-C regarding R45's abuse allegation. Previous NHA-D stated: Let me start by saying (R45) does complain and it often has nothing to do with cares or anything, he's just prejudiced against color. He wasn't able to provide a name and we weren't able to determine which staff he was referring to in the allegation. Surveyor asked when he was notified of the allegation of abuse. Previous NHA-D reported the Social Worker was doing rounds and R45 told him about it, he immediately reported it to (Previous NHA-D) and he went to R45's room to interview him. Surveyor asked what the Social Worker reported. Previous NHA-D stated: That (R45) said he was held down and changed against his will. Surveyor advised Previous NHA-D that the investigation documents that he was advised by Dir Quality Mgmt/IP-I. Previous NHA-D stated: OK, then maybe it was (him), whoever I wrote down is the person that told me. Previous NHA-D stated: (R45)'s story changed so many times regarding the date and shift that it happened, between 2nd and 3rd shift - he kept saying something different. I reviewed the schedule for those aides assigned to him and interviewed them. They said they were in there 4-5 times to do cares, but he refused. Surveyor advised this information was not on the CNA's statements. Previous NHA-D stated: Maybe I forgot to write it down. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor advised Previous NHA-D there are only 4 interviews of staff assigned to the 3rd floor that had potential to provide care to R45, and that 1 staff interview documented R45 reported the incident occurred on the previous shift, but she did not report it. Surveyor asked why there were only 4 staff interviewed regarding R45's allegation of abuse. Previous NHA-D stated: Because I determined those were the staff that were assigned to (R45). Surveyor advised they were not the only staff assigned to the 3rd floor. Previous NHA stated: No, but I determined they were the only ones assigned to (R45). Surveyor asked if it is the expectation if call lights are on, or residents need help - would all staff to tend to all residents. Previous NHA-D stated: Of course. Surveyor advised Previous NHA-D of the fact that all staff working the floor have potential to have contact with, or provide cares, is there a reason statements were not obtained of all staff working. Previous NHA-D stated: I didn't think it was necessary adding Well, I'm not sure that abuse even happened. If you're held down by your shoulders, you would have some evidence of it, some marks or something. That was part of my investigation, I asked the DON (Director of Nursing) to do a full body assessment, and nothing was found. Surveyor advised Previous NHA-D the alleged assessment is not included in the investigation. Previous NHA-D stated: Maybe she forgot to write it down. Surveyor asked if camera footage was reviewed as part of the investigation. Previous NHA-D stated: No, I don't see how that would be relevant to the investigation. Surveyor confirmed with Previous NHA-D he only interviewed selective staff he thought were assigned and provided care to R45. Previous NHA-D stated: Yes, it wasn't necessary to get statements from everyone if they weren't assigned to him. Surveyor asked if the facility provided staff training and education on abuse and reporting related to R45's allegation of abuse. Previous NHA-D stated: Not specifically, but we're doing training all the time on abuse, staff is very aware of abuse and reporting requirements. We try to do training every month when we have a staff meeting. Surveyor asked if it is the expectation the CNA that R45 told about being changed without permission should have been reported. Previous NHA-D stated: Not really, staff says he complains about everything, and he is prejudiced against people of color. Surveyor advised Previous NHA-D of concern the facility did not complete a thorough investigation of R45's allegation of abuse. Staff working on the date alleged, who may have knowledge of the incident, were not interviewed. In addition abuse education and training was not completed with all staff. Previous NHA-D stated: I don't agree with you. I obtained statements from all staff that worked with (R45) on that date, and we do education on a monthly basis; staff are very well informed of abuse and reporting. Surveyor advised there were only 4 staff statements obtained, 1 of which was not on the schedule and 1 of which R45 reported that the abuse occurred on the previous shift (which was not reported) and no additional staff statements were obtained. Previous NHA-D stated: Again, the staff statements I obtained were the only staff that were assigned to (R45).Surveyor asked how the facility knows that no other staff provided care or have knowledge of the incident if all staff were not interviewed. Previous NHA-D stated: Well, you don't know this resident, we know him well - I sincerely doubt anything happened at all. If it happened the way he alleged, there would be some evidence, redness, bruising, something - there was nothing. Surveyor advised Previous NHA-D there is no evidence an assessment was completed to support this statement and R45 has reported right shoulder pain, has limited range of motion, is receiving therapy and has an ortho appointment for a suspected rotator cuff tear. Previous NHA-D stated: I'd be very surprised if there was any validation to that. On 10/7/24, at 10:49 AM, Surveyor advised NHA-A of concern R45's allegation of abuse was not thoroughly investigated. NHA-A reported she was present when Surveyor was interviewing Previous NHA-D and understands the concern. No additional information was provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not complete a Preadmission Screening and Resident Review (PASARR) for individuals with a mental disorder for 2 (R4 and R52) of 2 residents reviewed for PASARR screening. *R4 was admitted [DATE] and the Level I PASARR was completed indicating R4 would be in the skilled nursing facility for less than 30 days. R4 discharged from the facility 2/21/2024. A Level I PASARR was not resubmitted/updated indicating R4 was going to be at the facility longer than the 30 exemption period triggering a Level II PASARR to be completed. R4 was admitted again to the facility on [DATE] and a Level I PASARR was not completed. *R52 was admitted [DATE] to the facility and the PASARR Level I was not completed accurately to reflect R52's mental illness or psychotropic medications and a Level II PASARR was not completed. Findings include: The facility policy and procedure entitled PASARR (Pre Admission Screening & Resident Review) dated 1/2023 documents: PROCEDURE: A. Complete Level I screen of the PASAAR [sic] on new admissions. 1. Readmits do not require a PASAAR [sic] to be completed. 3. Those residents whose attending physician has certified, before admission to the community that the individual is likely to require less than 30 days of nursing facility services, do not require a PASAAR [sic] to be completed. B. The resident or resident representative will receive a written notice (copy of Level I screen) if the resident is suspected of having a serious mental illness or a developmental disability, and therefore will require a Level II Screen. C. Update the resident representative that the Level II Screen will determine if the resident does have a serious mental illness or developmental disability, as defined by federal regulation, and if so, if the resident is appropriate for risking community placement and if the resident needs specialized services or specialized psychiatric rehabilitative services to address his/her disability needs. F. A copy of the PASARR screens will be kept in the resident's medical records. 1.) R4 was admitted to the facility on [DATE] with a diagnosis of depression and was receiving the antidepressant medication Duloxetine. The PASARR Level I screen was completed on 12/29/2023 documenting R4 had a hospital discharge exemption of not requiring to be at the facility for greater than 30 days. R4 was sent to the hospital on 1/28/2024 and returned to the facility on [DATE] as a readmission and a continuation of the initial stay. A PASARR Level I screen was not submitted at that time, after the initial 30 days from admission had lapsed. R4 discharged from the facility on 2/21/2024. On 4/4/2024, R4 was admitted to the facility from the community. R4 had diagnoses of depression and anxiety. R4 was receiving Buspirone for anxiety and Duloxetine and Trazodone for depression. A PASARR Level I was not found in R4's medical record for the new admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/2024, at 3:00 PM, Surveyor requested from Previous Nursing Home Administrator (NHA)-D, Director of Nursing (DON)-B and interim Assistant DON (ADON)-M copies of R4's PASARR Level I and Level II screenings. On 10/3/2024, at 9:03 AM, the facility provided a copy of R4's PASARR Level I screen from 12/29/2023 with the 30-day exemption and no other PASARR screens were provided. On 10/3/2024, at 3:02 PM, during the daily exit, Surveyor clarified with Executive Director (ED)-C, interim ADON-M, and NHA-A that R4 did not have any other PASARR screens in the medical record besides the Level I screen that was completed 12/29/2023. ED-C stated that one screen was the only PASARR they found in R4's record. Surveyor shared the concern with ED-C, interim ADON-M and NHA-A R4 was admitted [DATE] with a PASARR having a 30-day exemption and R4 stayed longer than those 30 days and a revised Level I was not completed and submitted for a level 2 screening as well as no PASARR was completed on admission 4/4/2024 with diagnoses of depression and anxiety with psychotropic medications prescribed. In a phone interview on 10/7/2024, at 11:11 AM, Surveyor asked Admission Director (AD)-K what the facility process was for completing the PASARR Level I for new admissions. AD-K stated the PASARR screening was completed by AD-K until 1/2024 when Admissions-L took over completing the PASARR Level I screenings. AD-K stated AD-K would review the referral sent by the hospital and look for a psych diagnosis as well as medications and if there was a diagnosis and a psychotropic medication, then it was a positive PASARR Level I and it would be submitted for a Level II to be completed. AD-K stated if there was a diagnosis and no psychotropic medication or a psychotropic medication and no diagnosis, then it was a negative PASARR Level I and a Level II would not have to be done. AD-K stated if the resident was not expected to be in the facility for 30 days, then a Level II would not have to be completed, either. Surveyor asked AD-K if a resident had a 30-day exemption on the Level I screen but then stayed longer, who would be responsible to complete a revised PASARR Level I screen. AD-K stated the social worker would take over the responsibility of ensuring that was completed. Surveyor shared with AD-K the concern R4 had a 30-day exemption on the initial admission on 12/29/2023 and was not discharged until 2/21/2024 with no follow up PASARR Level I screen. AD-K stated the social worker at that time should have completed a new PASARR Level I screen. Surveyor noted that social worker was no longer employed at the facility and unavailable for interview. Surveyor shared with AD-K the concern R4 was admitted on [DATE] and no Level I screen was completed or found in R4's medical record. AD-K stated Admissions-L should have that information. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/7/2024, at 11:21 AM, Surveyor asked Admissions-L who completed the Level I PASARR screens for new admissions. Admissions-L stated Admissions-L completes the Level I screens. Surveyor asked Admissions-L if R4 had a Level I screen completed on admission 4/4/2024. Admissions-L reviewed the file in the computer where Admissions-L keeps admission records. Admissions-L showed Surveyor the file of names that Admissions-L had gathered admission information for such as immunization history and a copy of admission documents that had been signed on admission. Admissions-L stated R4 was not even on the list that Admissions-L had looked in to for any admission information including the Level I PASARR. Admissions-L stated Admissions-L had been on vacation at the time R4 was admitted and it appeared to Admissions-L that no one had entered any admission information into R4's medical record. Surveyor shared with Admissions-L that R4 was admitted from the Assisted Living side and not from the hospital. Admissions-L stated that may have added to the lack of admission information that had been gathered, but all of that information should have been gotten at that time including a PASARR Level I screen. Admissions-L stated Admissions-L would complete the PASARR Level I screen now and submit it as required. No further information was provided at that time. 38146 2) R52 admitted to the facility on [DATE] and has diagnoses that include Schizophrenia and Dementia. R52 currently receives Risperdal 0.5 mg (milligrams) by mouth twice daily for Schizophrenia, Lorazepam 0.5 mg three times daily for anxiety/agitation and Buspar 5 mg three times daily for anxiety. R52's Hospital Discharge Summary dated 10/11/23 includes diagnoses of Schizophrenia and Dementia. Review of R52's medical record revealed a Pasarr level 1 screen completed 10/11/23. Surveyor noted a check mark next to The resident is not suspected of having a serious mental illness or a developmental disability. Signature of staff member completing this screen: Admission Director-K. On 10/3/24, at 9:21 AM, Surveyor spoke with Admission Director-K. Surveyor reviewed the Pasarr level 1, noting R52 is checked for not suspected of having a serious mental illness or a developmental disability. Surveyor advised Admission Director-K that R52 has a diagnosis of Schizophrenia and asked why a Pasarr level 2 was not completed. Admission Director-K stated: I must've made a mistake and checked that in error. Surveyor confirmed because that box was checked, a Pasarr level 2 was not completed. Admission Director-K stated: Yes, I made a mistake, she should have had a level 2 completed. On 10/3/24, at 3:00 PM, the facility was advised of the above concern. No additional information was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on observation, interview, and record review the facility did not ensure residents had an individualized comprehensive plan of care. This was observed with 3 (R48, R55, and R57) of 17 resident comprehensive care plan reviews. * R48 did not have a comprehensive care plan for R48's oxygen/respiratory monitoring/needs. * R55 did not have a comprehensive care plan for bowel monitoring. * R57 did not have a comprehensive care plan for bowel or bladder incontinence. Findings include: The facility policy entitled, Care Planning- Interdisciplinary Team, last approved on 1/2024 documents: Our community's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. Policy Interpretation and Implementation A. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident comprehensive assessment (MDS). B. The care plan is based on the resident's comprehensive assessment and is developed by the Interdisciplinary team 1.) R48 was readmitted on [DATE] and has a diagnoses that includes malignant pleural effusion, and atrial fibrillation. R48's significant change minimum data set (MDS) dated [DATE] indicated R48 had intact cognition with a brief interview for mental status (BIMS) score of 15. R48's significant change MDS assessment dated [DATE] documented R48 was on continuous oxygen. Surveyor noted there was not a care plan initiated for respiratory/ oxygen needs. On 10/2/2024 at 3:15 PM, Surveyor interviewed director of nursing (DON)-B who stated a care plan should have been initiated if R48 was prescribed oxygen. Surveyor asked who usually initiated the care plans. DON-B stated the IDT team does and/or nursing when it is needed. On 10/3/2024 at 3:04 PM, Surveyor shared concern with assistant DON (ADON)-M, executive director- C, and nursing home administrator (NHA)-A that R48 did not have a care plan for R48's oxygen/respiratory needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/2024 at approximately 3:05 PM, Surveyor interviewed MDS coordinator-J who stated not sure why R48 would not have a care plan for R48's oxygen/respiratory needs, it must have been overlooked. MDS coordinator-J stated information is obtained from the residents' charts and asking questions to staff if needed. Surveyor shared concern that a respiratory/oxygen care plan was not initiated for R48. Crossreference with F695 regarding respiratory/ oxygen monitoring for R48. No additional information was provided. 2.) R55 was admitted to the facility on [DATE] with a diagnoses that includes chronic pain, unspecified abdominal pain, cognitive communication deficit, major depressive disorder, alcoholic cirrhosis of the liver, and history of infectious and parasitic disease. R55's quarterly MDS (Minimum Data Set) dated 7/3/2024 indicated R55 had intact cognition with a BIMS score of 15 and the facility assessed R55 needing supervision assistance with toileting and personal hygiene and was assessed always continent of bowel. On 10/1/2024, at 11:59 AM Surveyor observed R55 in the hallway self- propelling in a wheelchair. Surveyor asked how R55 was doing. R55 stated R55 was having issues with R55's bowels. R55 stated that the doctor was working with R55 to determine why R55 was having abdominal pain and issues with constipation/ diarrhea. R55 stated it has been going on for many years. Surveyor reviewed R55's care plan and noted that there was not a bowel monitoring care plan for R55. Surveyor also noted that R55 was receiving several medications for R55's bowel. Crossreference with F684 for bowel monitoring for R55. On 10/2/2024 at 3:15 PM, Surveyor interviewed director of nursing (DON)-B who stated a care plan should have been initiated for R55 due to the concerns with R55's bowels. Surveyor asked who usually initiated the care plans. DON-B stated the IDT team does and/or nursing when it is needed. On 10/3/2024 at 3:04 PM, Surveyor shared concern with assistant DON (ADON)-M, executive director- C, and nursing home administrator (NHA)-A that R55 did not have a care plan for R55's bowel management/concerns. On 10/7/2024 at approximately 3:05 PM, Surveyor interviewed MDS coordinator-J who stated not sure why R55 would not have a care plan for R55's bowel management/concerns, it must have been overlooked. MDS coordinator-J stated information is obtained from the residents' charts and asking questions to staff if needed. No additional information was provided. 38253 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) R57 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, congestive heart failure, diabetes, morbid obesity, and anemia. R57's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R57 was frequently incontinent of bladder and continent of bowel. The MDS documented a trial of a toileting program had not been attempted on admission/reentry or since urinary incontinence was noted in the facility. The Urinary Care Area Assessment (CAA) documented R57's Urinary Incontinence CAA triggered secondary to the level of assistance needed with toileting needs and actual incontinent episodes. Contributing factors included weakness, impaired mobility, and cognitive loss. Risk factors included skin breakdown, falls, and urinary tract infection. The CAA documented the care plan would be initiated/reviewed to improve/maintain current toileting skills and ability to transfer to the toilet, continence status, decrease fall and pressure ulcer risk, and decrease risk for urinary tract infections. No bowel or bladder care plan was initiated at that time. R57's Significant Change MDS assessment dated [DATE] documented R57 was occasionally incontinent of bladder and always incontinent of bowel. The MDS documented a trial of a toileting program had not been attempted on admission/reentry or since urinary incontinence was noted in the facility. The Urinary CAA documented R57's Urinary Incontinence CAA triggered secondary to always incontinent of bowel and bladder and dependence of staff for incontinent care. Contributing factors included weakness, impaired mobility, and cognitive loss. Risk factors included skin breakdown, falls, and urinary tract infections. The CAA documented the care plan would be continued to manage incontinence, reduce pressure injury and fall risk, and reduce the risk for urinary tract infections. No bowel or bladder care plan was initiated at that time. On 10/1/2024 at 10:35 AM, Surveyor met with R57. R57 stated staff on third shift used to come and change the incontinent brief at midnight, 2:00 AM, and 4:00 AM on a schedule, which R57 liked. R57 stated now the staff wait until R57 puts on the light to have them come and change R57's brief. On 10/3/2024 at 3:25 PM, Surveyor shared with interim Assistant Director of Nursing (ADON)-M the concern R57 was incontinent of bowel and bladder and R57 did not have a care plan to manage toileting. Interim ADON-M stated interim ADON-M would look into the concern. In an interview on 10/7/2024 at 9:07 AM, Certified Nursing Assistant (CNA)-N stated R57 does not have anything written down as to when R57 needs to have incontinence care completed. CNA-N stated R57 is a 2-person transfer and with working with other CNAs, CNA-N knows they do incontinence care before they get R57 up out of bed and after R57 is laid down. CNA-N reiterated nothing was written down in a care plan or care card that says how often cares need to be completed. In an interview on 10/7/2024 at 10:26 AM, Surveyor asked MDS Coordinator-J who puts in a care plan for bowel and bladder. MDS Coordinator-J stated the MDS nurses creates the care plan after the MDS cycle is complete. Surveyor shared with MDS Coordinator-J the concern R57 is incontinent of bowel and bladder and no care plan is in place for incontinence care. MDS Coordinator-J stated R57 was in and out of the hospital multiple times so maybe that is why nothing was done after the MDS assessment. Interim ADON-M did not provide any additional information after the discussion with Surveyor on 10/3/2024.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 (R55) of 2 residents reviewed. * R55 had concerns with feelings of abdominal pain and bloating and is on several bowel medications for management of constipation and diarrhea. The facility was not assessing or monitoring or assessing R55's bowel regimen. Findings include: The facility policy entitled Restorative Nursing- Toileting Program last approved 5.2023 documents: . Procedure: . B. Resident continence is assessed on admission, with significant change, and quarterly: 1. Check resident approximately hourly and document in the resident's medical record as continent, incontinent or soiled and level of assistance. 3. After 3 days analyze data: a. Complete the bowel and bladder evaluation in the resident medical record, to determine type of incontinence and most appropriate program. b. Determine patterns in frequency, volume, duration, and time of day. c. If resident is generally correct regarding wet/dry status, consider scheduled or prompted toileting. 1.) R55 was admitted to the facility on [DATE] and has diagnoses that include chronic pain, unspecified abdominal pain, cognitive communication deficit, major depressive disorder, alcoholic cirrhosis of the liver, and history of infectious and parasitic disease. R55's quarterly MDS (minimum data set) dated 7/3/2024 indicated R55 had intact cognition with a BIMS score of 15 and the facility assessed R55 needing supervision assistance with toileting and personal hygiene and was assessed always continent of bowel. On 10/1/2024 at 11:59 AM, Surveyor observed R55 in the hallway self- propelling in a wheelchair. Surveyor asked how R55 was doing. R55 stated R55 was having issues with R55's bowels. R55 stated that the doctor was working with R55 to determine why R55 was having abdominal pain and issues with constipation/ diarrhea. R55 stated it has been going on for many years. Surveyor asked R55 if R55 was able to use the bathroom themselves or needed assistance. R55 replied that R55 wears protection if R55 can not make it in time to use the bathroom. R55 replied R55 can tell at times when R55 needs to use the bathroom. Surveyor reviewed R55's medical record and noted R55 is ordered the following scheduled medications for bowel: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- MiraLAX powder 17 grams- one scoops in 8oz water daily for bowels- 17grams per dose for constipation. - Senna plus 8.6mg -50mg tablet- take 2 tablets PO (by mouth) every morning for constipation. - Simethicone 80mg chewable tablet by mouth three times a day after each meal for GI (gastrointestinal) - Linzess 145 mcg capsule- 1 capsule by mouth every day for gastropathy colonic polyp, evening shift. R55 was ordered the following as needed medications for R55's bowel: - Dulcolax 10mg rectal suppository every day as needed for constipation. - Lactulose 20grams/30 ml oral solution every 12 hours as needed for constipation. (Surveyor noted R55 last requested on 9/2/2024, 9/4/2024, and 9/9/2024. Surveyor reviewed R55's medication/treatment administration records (MAR/TARs) for September and October 2024 and noted there is not indication that staff is monitoring R55's bowel and if R55 is going every day or if scheduled and as needed medications were effective or not. Surveyor reviewed R55's care plan and noted R55 did not have a care plan for bowel monitoring. Cross reference F656. Surveyor reviewed R55's ADL care plan initiated on 2/7/2024 and indicated: Toileting- I (R55) am incontinent of bladder and incontinent of bowel. I use pullups. Surveyor reviewed R55's certified nursing assistant (CNA) worksheet and noted the following information for R55's toileting needs: - Limited assist with 1 person staff support. - Continent of bladder and continent of bowel. Use pullups. On 10/7/2024 at 9:03 AM, Surveyor interviewed registered nurse (RN)-G who stated R55 uses the bathroom by himself, and staff ask R55 if R55 has had a bowel movement that day. Surveyor asked if staff document the information anywhere. RN-G stated RN-G has a sheet that gets checked off. Surveyor asked RN-G if the assessments get documented in R55 medical record anywhere. RN-G stated it does but could not remember where at the moment. Surveyor asked where RN-G would look to see when R55 last had a bowel movement. RN-G stated RN-G would ask R55 or look in the assessment in which RN-G was unable to locate at the moment. Surveyor asked RN-G if R55 had concerns or issues with his bowels. RN-G stated that R55 is fixated on R55's bowels and states concern all the time and talks with psych about it. RN- G also stated that R55 has had a lot of workups on R55's bowels and no concerns are noted at this time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/202, at 9:15 AM, Surveyor shared concerns with executive director- C and Nursing Home Administrator (NHA)-A that R55 bowel regimen is not being monitored consistently with receiving several medications for R55's bowels and complaints of abdominal discomfort and bloating. Surveyor also shared that R55's ADL care plan does not match R55's CNA worksheet to determine if R55 is continent in bowel or incontinent in bowel. No additional information was provided as to why the facility did not ensure that R55 received treatment and care in accordance with professional standards of practice for his bowl and abdominal concerns.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on observation, interview, and record review, the facility did not ensure residents at risk for pressure injuries received necessary treatment and services consistent with professional standards of practice to prevent the development of pressure injuries and to promote healing for 2 of 2 residents (R5 and R48) reviewed for pressure injuries. * On 4/16/2024, R5 was noted to have an area of concern that was not comprehensively assessed and R5's pressure injury care plan was not revised until two days later on 4/18/2024. The area was then staged as an unstageable wound to R5's sacrum. Surveyor made observations on 10/1/2024 and 10/2/2024 of R5's care plan not being followed. * R48's air mattress, which was in place to reduce pressure and prevent pressure injuries, was observed not working appropriately on 10/1/2024 and 10/2/2024 and staff were initialing each shift that R48's mattress was checked and functioning properly. Findings include: The facility policy entitled Pressure Injury Assessment/Treatment last revised on 7/2024 documents: The purpose of this procedure is to provide guidelines for a consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and the prevention of acquiring additional pressure injuries. General Guidelines . A. The pressure injury treatment program should focus on the following strategies: . 3. Resolution of current pressure injuries and prevention of additional pressure injuries. 6. Education and quality improvement. Documentation- The following information should be recorded in the resident's medical record, treatment sheet, or designated wound form: . B. Wound appearance, including wound bed, edges, presence of drainage. E. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 1.) R5 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, vascular dementia without behaviors/psych/mood, hemiplegia following cerebral infarction affecting left nondominant side, peripheral vascular disease, dysphagia, history of a sacral stage 4 pressure injury (1/9/2023 - 6/18/2023) and contracture of the left wrist/hand/and muscle. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R5's quarterly minimum data set (MDS) dated [DATE] indicated R5 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R5 needing extensive assist with 2 staff assistance for toileting/personal hygiene, repositioning, and transferred using a Hoyer lift. Per the MDS, R5 is always incontinent of bowel and bladder and wore adult briefs for protection. The facility assessed R5 on 10/3/2024 to be a high risk for developing pressure injuries with a Braden scale score of 12. R5's Pressure ulcers/Skin prevention care plan was initiated on 11/2/2022 with the following interventions: (R5) is at risk for skin breakdown due to bowel and bladder incontinence, DM (Diabetes Mellitus), hemiparesis, and impaired mobility. - Provide peri-care after each incontinence episode and apply skin protectant. - Monitor for signs and/or symptoms of breakdown. - Use the following positioning/pressure reducing devices: wheelchair cushion and air mattress. Validate [sic] - Monitor skin under Left hand splint and tubi grips. Staff to assist to don left hand/wrist splint daily with AM cares and remove with PM cares. - Encourage and assist to elevate heels when in bed (May not comply). - Apply lotion to resident's feet during HS (bedtime) cares. - Apply lotion to arms and legs as needed. - Reposition off of right buttock at regular intervals and prn (as needed) when in bed. On 4/16/2024 at 14:58 (2:58 PM), R5's progress notes nursing documents resident's coccyx noted to be reopened, 3.0 cm X 0.4 cm X 0.1 cm (length X width X depth), washed with NS (normal saline), skin prep to surrounding skin, covered with foam dressing. NP (nurse practitioner), family, assistant director of nursing (ADON) notified, and order put in for wound treatment. Surveyor noted that there was not a comprehensive assessment done on the newly observed area to R5's coccyx describing what the area looked like or staging the area. Surveyor also noted there were no revisions made to R5's care plan. On 4/18/2024, at 12:15 PM Wound Nurse- H documented: - Full thickness wound, unstageable pressure injury - 3.0 X 2.0 X 0.1, oval shaped, 80% slough, 20% granulation tissue, moderate serosanguineous drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Clean with NS or wound cleanser, skin prep to surrounding tissue, apply medihoney and cover with foam dressing, change daily and prn. - R5 was seen by wound care team: at present R5 gets up in the morning and stays up all day. R5 is agreeable to getting back in bed after dinner and staying in bed until lunch the next day. Surveyor noted R5's pressure injury care plan was revised on 4/18/2024 with the following interventions: - Provide treatment as ordered. - Provide pain management prior to dressing changes. - Wound consult. - Dietary consult. - Pressure relieving cushion to wheelchair. - APM (Air pressure mattress) check settings, functioning, and inflation every shift. - Provide pericare after each incontinence episode and apply skin protectant. - Monitor labs as ordered and notify MD/NP (Medical doctor/ nurse practitioner) of all values. - Assist with repositioning every hour. Assist of ii [sic] using draw sheet to minimize friction and shearing. - Assess and evaluate wound size, depth, color, and drainage weekly with wound rounds. R5's wound continues to be assessed weekly with the following assessments: 4/25/2024: -Full thickness PI, Stage 3 - 2.6 X 1.4 X 0.1, 25% epithelial, 75% granulation, mod serosanguineous - Cleanse with NS or wound cleanser, skin prep surrounding tissue, apply collagen powder and cover with foam dressing. change 3x/week and PRN - wounds significantly improved 5/2/2024: - Full thickness wound, PI, stage 3 - 2.4 X 1.2 X 0.3, 100% granular, mod serosanguineous (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- cleanse with NS or wound cleanser, skin prep surrounding tissue, apply collagen powder and cover with foam dressing, change daily and PRN - improved 5/8/2024 - 2.1 X 1.2 X 0.4, 100% granulation, mod serosanguineous 5/16/2024 - 2.0 X 1.8 X 0.5, 100% granular, mod serosanguineous - up for lunch through dinner and then back to bed, strict side lying only 5/23/2024 - 3.0 X 1.0 X 0.4, 50% slough, 50% granulation, mod serosanguineous - unstageable 5/30/2024 - 2.5 X 0.8 X 0.7, 50% granulation, 50% slough 6/6/2024 - Full thickness PI, stage 3 - 2.5 X 1.2 X 0.6, 90% granulation, 10% slough, mod serosanguineous - cleanse with NS and wound cleanser, skin surrounding tissue, apply santyl ointment to wound base and cover with bordered dressing. change daily and PRN -stable Surveyor noted that R5's pressure injury care plan was revised 6/8/2024 with the following intervention: -Resident to stay in bed for breakfast and may get up for lunch and dinner as tolerated. 6/13/2024 - full thickness PI, stage 3 - 2.5 X 1.0 X 0.5, 100% granulation, mod serosanguineous (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- cleanse with NS and wound cleanser, skin prep surrounding tissue. apply collagen to wound base and cover with bordered dressing. change 3X weekly and PRN 6/20/2024 - full thickness PI, stage 3 - 3.0 X 0.9 X 0.5, 100% granulation, mod serosanguineous - improved, edges of wound scraped up to promote healing 6/27/2024 - 2.9 X 1.3 X 0.5, 100% granulation. mod serosanguineous - stable 7/3/2024 - full thickness PI stage 3 - 2.9 X 0.8 X 0.5, 100% granulation, mod serosanguineous 7/10/2024 (DON) - full thickness PI, stage 3 - 2.5 X 0.8 X 0.5, 100% granulation, mod serosanguineous 7/11/2024 (RN) - full thickness PI, stage 3 - 2.9 X 1.1 X 0.4, 100% granulation, mod serosanguineous 7/18/2024 - full thickness PI, Stage 3 - 2.7 X 0.9 X 0.4, 100% granulation, serosanguineous 7/25/2024 - full thickness PI, stage 3 - 2.8 X 0.9 X 0.4, 100% granulation, serosanguineous - Seen by wound team. No new orders at this time. Will continue with current plan of care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	8/1/2024 - full thickness PI, Stage 3 - 2.5 X 0.8 X 0.4, 100% granulation, serosanguineous -improved 8/8/2024 - full thickness PI, stage 3 - 2.3 X 0.8 X 0.3, 100% granulation, serosanguineous -improved 8/15/2024 - Full thickness, stage 3 - 2.4 X 0.8 X 0.3, 100% granulation, serosanguineous -stable 8/22/2024 - 2.0 X 0.7 X 0.3, 100% granulation, serosanguineous -improved 8/29/2024 - 2.0 X 0.6 X 0.3, 100% granulation, mod serosanguineous -improved 9/5/2024 - 1.7 X 0.5 X 0.1, 100% granulation, mod serosanguineous 9/12/2024 - 1.6 X 0.4 X 0.1, 100% granulation, mod serosanguineous -improved 9/19/2024 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 1.5 X 0.4 X 0.1, 100% granulation, mod serosanguineous - improved 9/26/2024 - 1.5 X 0.4 X 0.1, 100% granulation, serosanguineous -stable 10/3/2024 - 1.5 X 0.2 X 0.1, 100% granulation, mod serosanguineous - stable, improving slowly due to the scar tissue- harder to heal- wound NP has been doing little debridement or scratching of edged to increase wound healing- has been working On 10/1/2024 at 11:06 AM, Surveyor observed R5 in the dining room sitting in a Broda wheelchair reading a book. Surveyor asked R5 if R5 just got up for the day. R5 stated that R5 has been up all morning and was waiting for lunch. Surveyor asked R5 if R5 has been sitting in the Broda wheelchair all morning or if just got into the Broda wheelchair. R5 stated R5 was sitting in the Broda wheelchair all morning. Surveyor asked R5 if R5 has been repositioned in the Broda wheelchair or laid down in bed after breakfast. R5 replied No. On 10/2/2024 at 1:27 PM, Surveyor observed R5 in the dining room sitting in a Broda wheelchair finishing lunch. On 10/2/2024 at 3:21 PM, Surveyor observed R5 sitting in a Broda chair in the dining room, Surveyor asked if R5 had been lain down in R5's be at all since the morning. R5 replied no. On 10/2/2024 at 7:46 AM, Surveyor observed R5 sitting in the dining room in a Broda wheelchair. R5 stated R5 has been up in the chair for a while and was waiting for breakfast. On 10/2/2024 at 1:24 PM, Surveyor observed R5 sitting in a Broda wheelchair. Surveyor asked R5 if R5 laid down after lunch or had been repositioned in R5's wheelchair. R5 replied no. On 10/2/2024 at 3:15 PM, Surveyor shared concerns with Director of Nursing (DON)-B that Surveyor had observations 10/1/2024 and 10/2/2024 of R5 sitting in R5's Broda wheelchair all morning and afternoon and that R5's care plan intervention is that R5 is to be up for lunch and dinner meals as tolerated and in bed for breakfast for pressure injury healing. DON-B stated DON-B would have to look into it and talk with staff. On 10/3/2024 at 7:35 AM, Surveyor interviewed Wound Nurse- H who stated it was important for R5 to stay off R5's bottom area because of having a history of a pressure injury in the same spot as the one R5 has now and a lot of scar tissue was in the area, so it makes it hard for R5's current pressure injury to heal. (continued on next page)

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	525523	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexian Village of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/3/2024 at 3:04 PM, Surveyor shared concerns with ADON-M, Executive Director-C, and Nursing Home Administrator (NHA)-A that R5's pressure injury that was first observed on 4/18/2024 did not have a comprehensive assessment or care plan revisions until two days later on 4/18/2024 when R5's pressure injury was staged as unstageable and then staged as a stage 3 on 4/25/2024. Surveyor also shared observations on 10/1/2024 and 10/2/2024 of R5's care plan not being followed and R5 was observed in R5's Broda wheelchair from morning until evening and that R5's care plan is to be up in wheelchair for lunch and dinner then in bed for pressure injury healing. No additional information was provided as to why the facility did not ensure that R5 received necessary treatment and services consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing. 2.) R48 was readmitted to the facility on [DATE] with a diagnoses that include malignant pleural effusion, hydronephrosis, protein-calorie malnutrition, and atrial fibrillation. R48's significant change minimum data set (MDS) dated [DATE] indicated R48 had intact cognition with a brief interview for mental status (BIMS) score of 15 and the facility assessed R48 requiring total assistance with 1 staff member for all activities of daily living (ADL's). the facility assessed R48 on 9/12/2024 as being a moderate risk for pressure injury development with a Braden risk score of 14. R48's Pressure Ulcer/Skin Condition care plan was initiated on 9/12/2024 with the following interventions: - Braden scale to be completed. - Keep bed linens wrinkle free and do not use excess pads. - Observe skin for redness and breakdown during routine care. - Use pressure relieving devices, cushion in wheelchair, and off heels [sic], as indicated. - Follow community skin care protocol. - Treatments as indicated, see physician orders. - Pressure reducing mattress on bed, check function, and setting every shift. Set at 2. On 10/1/2024 at 9:51 AM, Surveyor observed R48 lying on R48's back in bed. Surveyor noted R48's air mattress to be off. Surveyor asked R48 if R48 was comfortable and if staff came in to help R48 reposition. R48 stated R48 was comfortable, and staff was just in to reposition R48 so R48 could eat breakfast. On 10/1/2024 at 3:16 PM, Surveyor observed R48 lying in bed sleeping. Surveyor noted R48's air mattress was off and not working. On 10/2/2024 at 7:50 AM, Surveyor observed R48 lying in bed on R48's back and air mattress was not on. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/2/2024 at 1:39 PM, Surveyor observed R48 sitting in a wheelchair. Surveyor noted that R48's air mattress was off. On 10/2/2024 at 3:15 PM, Surveyor showed DON-B R48's air mattress. DON-B looked at R48's air mattress and noted that the plug was not pushed in to the outlet all the way. DON-B pushed the plug in, and the air mattress started to work and inflated. Surveyor asked DON-B how DON-B can verify that staff is looking at R48's air mattress to make sure it is working appropriately and knows how to operate his air mattress. DON-B replied that it would be an order and on R48's medication/treatment administration record (MAR/TAR) to sign off on when done. On 10/2/2024, Surveyor reviewed R48's September and October 2024 MAR/TAR record and noted an order that was initiated on 9/12/2024 that states: -air mattress to bed. Check for proper inflation, function, and setting every shift. Surveyor noted that staff was initialing on 10/1/2024 and 10/2/2024 every shift that R48's air mattress was functioning properly. On 10/3/2024 at 3:04 PM, Surveyor shared concerns with ADON-M, Executive Director-C, and Nursing Home Administrator (NHA)-A that R48's air mattress was observed not working appropriately on 10/1/2024 and 10/2/2024 and staff were initialing each shift that R48's mattress was checked and functioning properly. No additional information was provided as to why R48 did not received the necessary treatment and services consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51014 Based on observation, interview, and record review, the facility did not ensure 3 of 4 residents reviewed (R38, R29, and R43) received adequate supervision and assistance, and that interventions were in place to prevent accidents. R38 sustained multiple falls resulting in injuries. A thorough investigation after every fall was not completed to determine root cause analysis. R38's care plan was not revised with recommended fall prevention interventions. R29 had a fall in their room on 9/24/24. Fall interventions were not in place at the time of the fall. R43's fall on 9/9/24 was not thoroughly investigated to determine the root cause. Findings include: The facility policy titled Falls Prevention dated revised, 7/2023, states (in part) .The intent of this policy is to provide and environment that is free from accident hazards, over which there is control, and provide supervision and intervention to residents to prevent avoidable accidents . II. Fall Risk Intervention. The Interdisciplinary Team shall identify individualized interventions to reduce the risk of falls. 1. Falling Star Program . C. If falling recurs despite initial interventions, associate shall implement additional, different interventions or indicate reason the current approach remains relevant. This documentation should be maintained in the clinical record. The facility policy, entitled, Falls dated revised, 7/2023, states (in part) .Policy statement: The purpose of this procedure is to provide guidelines for evaluation of a resident in the event a fall occurred and to assist associates in identification of potential causes of the fall. Policy Detail: Direct care associates shall evaluate the area where the fall occurred for possible contributors. The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The falls should be reviewed at the Daily Stand-up meeting following the fall for identification of any additional individualized interventions to reduce the risk of falls. An incident report shall be completed for the resident falls by a licensed nurse after the fall occurs. R38 was readmitted to facility on 10/21/23 with diagnoses that include Alzheimer's disease, unspecified protein-calorie malnutrition, and hip fracture that occurred as a result of a fall at the facility on 10/10/23. R38's quarterly MDS (Minimum Data Set) dated 6/8/24 documents R38 required partial to moderate assist for transfer. R38's quarterly MDS dated [DATE] indicates a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment and also documents R38 is occasionally incontinent of bowel and bladder. R38's ID (Interdisciplinary Notes) indicate falls occurred on 10/10/23, 1/16/24, 4/24/24, 4/25/24, 5/4/24, 7/23/24, and 8/20/24. R38's Care Plan dated 7/5/23, prior to R38's first fall on 10/10/23, documents: Potential for falls related to recent admission to community, recent fall, generalized weakness, confusion. Interventions include: -keep pathways clear/adequate lighting -keep bed at the appropriate height -keep personal items within reach -orient to room and call light -soft touch call light -bed against wall -body pillow when in bed to be aware of boundaries -floor strips next to bed and in front of toilet and recliner. -dump seat wheelchair with auto lock brakes -Falling Star program -Call don't fall signs in room -encourage to stay in areas of high visibility (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-activity assessment -educate family to notify staff of residents return from outings and of family departure -educate family to notify staff and to use call light when resident is in need of assistance -PT (Physical Therapy) to provide education regarding safe transfers -Transfer resident with a 1 assist stand by -Keep residents bed at transfer height -scoop mattress -bilateral grab bars -Make sure foot pedals are only on when being pushed -Assess for bleeding if resident falls due to use of anticoagulant Review of R38's medical record identify no falls documented prior to 10/10/23. Surveyor asked for all of R38's fall investigations. The facility Fall Investigation dated 10/10/23 documents: R38 was found on the floor in her room at 6:45 PM. A thorough investigation was completed, and care plan interventions were in place at the time of the fall. R38 sustained a hip fracture as a result and was admitted to the hospital. R38 was readmitted to the facility on [DATE] with a diagnosis of a hip fracture. The care plan was revised on 10/23/24 to include encourage to wear gripper socks if not wearing her shoes. R38's medical record documents an interdisciplinary (ID) note dated 1/16/24, indicating R38 sustained a fall on 1/16/24 at 3:30 AM. The ID note documents: Last seen prior to Fall: Not documented. Last Toileted: Not documented. Location of Fall: Room/self-transferring to bathroom. Who witnessed Fall: Unwitnessed. Hit Head: Yes. Neuros completed: Yes. Injury: Right elbow pain, right knee pain and back pain. Staff Statements: Not completed. Nurse Post Fall: Not completed. CNA (Certified Nursing Assistant) Post Fall: Not completed. hospitalized : Yes. Falls Risk assessment: Yes. Root Cause Analysis: Not completed. Interdisciplinary note dated 1/16/24 at 8:51 PM documents: Intervention: Bed commode since resident is always transferring self to bathroom. Surveyor was informed the facility does not have a fall investigation for R38's fall on 1/16/24. Surveyor notes the fall prevention intervention of bed commode was not added to R38's care plan. On 4/24/24, R38's medical record documents R38 had a fall at 9:30 AM. The facility's falls investigation documents R38 was last seen at 9:00 AM. Last Toileted: Not documented. Call light not used. Location of Fall: Room/fell out of wheelchair, trying to get up. Unwitnessed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Hit head, neurological checks completed. Pain, left elbow. R38 was transferred to the hospital for evaluation, no injuries. New interventions implemented: Get up in morning/offer to lay down after meals. Reeducated resident on not to self-transfer and education on call light use. Surveyor notes a thorough investigation of the fall was not completed to identify the root cause. There was no documentation as to when R38 was last toileted. The recommended intervention to get up in morning/offer to lay down after meals was not added to R38's care plan. In addition, education on call light use was not an appropriate intervention as R38 is assessed to have severe cognitive impairment. On 4/25/24, R38's medical record documents R38 had a fall at 4:35 PM in the dining room. The facility's falls investigation documents: Last toileted - unknown. Resident was unable to specify what caused the fall. New recommended intervention: Every one-hour checks during shift, 2 to toilet during shift. Surveyor notes the facility did not complete a thorough investigation to identify the root cause of the fall. R38's care plan was not revised to include every one-hour checks during shift and a 2-person toilet transfer as documented as the new fall prevention interventions. On 5/4/24, R38's medical record documents R38 had a fall at 11:30 AM. The facility's falls investigation documents: Unwitnessed - fell out of recliner trying to get into bed. The facility did not complete a thorough investigation to identify the root cause of the fall or if care plan interventions were in place at the time of the fall. There was no documentation of when R38 was last seen or toileted. IDT (Interdisciplinary Team) Root cause determination: Continue monitoring, reeducated on call light use. Surveyor noted no new interventions were implemented to prevent falls. Reeducation on call light use was not appropriate as R38 is assessed to have severe cognitive impairment. On 7/23/24 at 3:00 AM, R38 sustained her 6th fall. The fall investigation documents: Unwitnessed, found on floor. Skin tear left elbow. Appears resident was self-transferring without calling. Last seen prior to Fall: 2:30 AM - 2:45 AM. Last Toileted 12:00 AM. Footwear: Socks only. Footwear: Gripper socks. Surveyor noted the fall investigation did not indicate if care plan interventions were in place at the time of the fall (ie: body pillow for positioning). The investigation also is not clear as to R38's footwear at the time of the fall. Surveyor noted R38's care plan was revised with new fall interventions: Low bed and floor mats placed during HS (hour of sleep). Transfer height and grip strips during AM/PM. Resident needs floor mat and transfer height during bedtime. During AM/PM resident needs transfer height and only grip strips. Remove floor mat during AM/PM for fall preventions - implemented 7/25/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	As a result of the fall on 7/23/24, R38 was sent to the hospital for evaluation. She returned to the facility the same day. The hospital After Visit Summary dated 7/23/24 documents: X-ray wrist 3 or more views right. Findings: Acute, comminuted and impacted transverse distal radial metaphyseal fracture. Mildly displaced dorsal fracture fragments. Minimally displaced ulnar styloid process fracture. Impression: Acute distal radial and ulnar styloid process fractures. On 8/20/24, R38's medical record documents R38 had a fall at 11:30 AM. The investigation did not include a root cause analysis of the fall. There was no documentation of when R38 was last seen or toileted. The resident sustained no injuries. Surveyor noted R38's care plan was not revised, and no new interventions were implemented. On 10/1/24 at 9:50 AM, Surveyor interviewed RN (Registered Nurse)-G who stated R38 had multiple falls and pointed out the Call, don't fall signs throughout R38's room. On 10/1/24 at 9:45 AM, Surveyor observed R38's room noting fall interventions in place of a low bed, floor mat, non-skid strips on floor by bed, recliner, and bathroom, body pillows, call don't fall signs, and a soft touch call light. On 10/7/24 at 1:50 PM, Surveyor informed Executive Director-C and NHA (Nursing Home Administrator)-A of concerns regarding R38's falls: R38 sustained a fall on 10/10/23 resulting in a hip fracture. R38 sustained 6 subsequent falls, one of which occurred on 7/23/24 resulted in a wrist fracture. The facility did not complete thorough investigations to determine the root cause following every fall, and recommended interventions were not added to R38's care plan. In addition, recommended interventions to include reeducation on use of call light was not appropriate as R38 has a BIMS score of 0 indicating severe cognitive impairment. NHA-A reported going forward she plans to review all residents' fall interventions. No additional information provided. 21855 2.) On 10/01/24 at 10:46 AM, Surveyor observed R29 sitting in a recliner in their room. R29 wheelchair was next to the recliner. R29's medical record was reviewed by Surveyor. The (interdisciplinary notes) IDT documents a fall on 9/3/24. R29 had a fall while self transferring. R29 did not have any injury. The fall was assessed with a new intervention identified to keep the wheelchair by the bedside. R29 is able to self transfer and did not have their wheelchair next to their bed at the time of the fall. R29's medical record documents a fall on 9/23/24. R29 was self transferring from their bed. The Fall Investigation documents the wheelchair was across the room. R29 did not have any injury. Surveyor noted R29's fall prevention intervention of having the wheelchair next to the bed was not followed. R29's Fall plan of care due to a potential for falls related to recent admission to the community, history of recurrent falls, generalized weakness, poor safety awareness. Has right lower extremity deformity and prefers to wear their personal slippers instead of non-skid socks. This has a start date of 4/19/24. This includes the 9/3/24 fall prevention intervention to keep the wheelchair by bedside. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/02/24 at 11:00 AM, Surveyor observed R29 in a recliner in their room. R29's wheelchair was next to the recliner. On 10/02/24 at 1:02 PM, Surveyor interviewed (Director of Nurses) DON-B. DON-B stated R29 is aware they are supposed to ask for help. DON-B stated the wheelchair was not next to the bed on 9/23/24 at the time of the fall. DON-B stated they did talk to staff about following the plan of care. R29 does have care plan interventions to have their wheelchair next to the bedside. On 10/3/24 at 3:03 PM, at the facility exit meeting with (Executive Director) ED-C, Surveyor shared R29's fall intervention concerns. No further information was provided. 47094 3) R43 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction affecting the left dominant side, left foot drop, repeated falls, wedge compression FX (fracture) to lumbar back, major depressive disorder, and congestive heart failure. R43's quarterly minimum data set (MDS) dated [DATE] indicates R43 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 9 and the facility assessed R43 needing extensive assist with one staff member for bed mobility and requiring a Hoyer lift with 2 staff members for transferring. R43 is occasionally incontinent of bowel and bladder and uses a wheelchair in which R43 self-propels to places. R43 has a history of falls and the facility last assessed R43 on 7/11/2024 as being at moderate risk for falls with a fall risk score of 23. On 9/9/24 at 7:14 AM, R43's medical record documents R43 had an unwitnessed fall. The investigation summary documents R43 was observed by housekeeping staff sitting with R43's back against the bed yelling for help. R43 stated they rolled out of bed. Surveyor noted the facility's fall investigation does not include staff interviews regarding when R43 was last checked on or toileted, if objects such a call light were in reach of R43. The investigation does not state what R43 may have been reaching for or if R43's call light was activated at the time of the fall. The fall investigation does not state if immediate interventions were put in place and R43's Fall care plan was not revised. On 10/3/2024 at 10:51 AM, Surveyor observed R43 in the hallway in R43's wheelchair. Surveyor asked R43 if R43 has had any falls out of bed recently. R43 stated R43 could not recall if they had any falls recently. On 10/3/2024 at 3:04 PM, Surveyor shared concerns with Assistant Director of Nursing (ADON)-M, Executive Director-C, and Nursing Home Administrator (NHA)-A regarding R43's fall investigation on 9/9/2024 not being thorough as it did not identify the root cause of the fall, when R43 was seen and/or assisted by the staff or identify fall prevention interventions implemented to address the root cause of the fall. Surveyor requested if any other information pertaining to the fall could be located regarding staff interviews, how R43 was prior to the fall and when last checked on or toileted, what interventions were put in place and any revisions made to R43's fall care plan. Executive Director-C stated she would look into it and get any further information. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	No further information was provided to Surveyor.

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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** 38253 Based on interview and record review, the facility did not ensure residents with urinary incontinence were comprehensively assessed to receive appropriate treatment and services to prevent complications and restore continence to the extent possible for 1 (R57) of 2 residents reviewed for incontinence. *R57's admission, quarterly, and significant change Minimum Data Set (MDS) assessments documented R57 was incontinent of bowel and bladder. No comprehensive bowel or bladder assessments were completed to determine a toileting program to decrease incontinence and no care plan was initiated to provide incontinence care on a scheduled basis. Findings include: The facility policy and procedure entitled Clinical Protocol: Urinary Continence and Incontinence - Assessment and Management dated 1/2024 documents: Policy Interpretation and Implementation: A. As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary continence. C. Periodically (as required and when there is a change in voiding), staff will define each individual's level of continence, referring to the criteria in the Minimum Data Set (MDS) . D. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include: 1. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream, etc.); 2. Associated pain or discomfort (dysuria); and 3. Types of incontinence: a. Stress . b. Urge . c. Mixed . d. Overflow . e. Transient . f. Functional . E. The nursing staff and physician will identify risk factors for becoming incontinent or for worsening of current incontinence . F. The evaluation will include a review for medications that might affect continence . G. The staff and physician will summarize an individual's continence status. For residents deemed incontinent, this includes categorizing incontinence as urge, stress, overflow, mixed, or functional; and relevant causes, risk factors, and complications. H. The staff and physician will identify individuals with complications of existing incontinence, or who are at risk for such complications (e.g., skin maceration or breakdown, or perineal dermatitis). I. The physician will consider a more detailed assessment if new incontinence is identified or risk factors and reversible causes have not yet been sought or identified. The review should focus especially on possibly treatable causes such as medication side effects, severe constipation, or urinary tract infections (distinguished from asymptomatic bacteriuria). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P. The physician and staff will address treatable causes or contributing factors related to urinary incontinence, including: 1. Tapering, stopping, or changing medications that may be causing or exacerbating incontinence; 2. Managing pain and/or providing adaptive equipment to help mobilize individuals suffering from arthritis, contractures, neurological impairments, etc.; 3. Incorporating environmental interventions and assistive devices (e.g., grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, and/or walkers) to facilitate toileting; 4. Treating underlying conditions that may impair continence (e.g., delirium causing urinary incontinence related to acute confusion); and 5. Implementing a fluid and/or bowel management program to meet assessed needs. R. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. 1. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. 2. If the individual requires assistance from more than one person to transfer to the toilet, Staff will address his or her mobility problems before attempting a toileting assistance trial. 3. Incontinence care should be individualized at night in order to maintain comfort and skin integrity, and minimize sleep disruption. S. The staff will document the results of the toileting trial in the resident's medical record. 1. If the resident responds well, the toileting program will be continued. 2. If the resident does not respond and does not try to toilet, or for those with such severe cognitive impairment that they cannot either point to an object or say their own name, staff will use a check and change strategy. 3. A check and change strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. 1.) R57 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, congestive heart failure, diabetes, morbid obesity, and anemia. R57's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R57 was frequently incontinent of bladder and continent of bowel. The MDS documented a trial of a toileting program had not been attempted on admission/reentry or since urinary incontinence was noted in the facility. R57 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R57 did not have any pressure injuries on admission. The Urinary Care Area Assessment (CAA) documented R57's Urinary Incontinence CAA was triggered secondary to the level of assistance needed with toileting needs and actual incontinent episodes. Contributing factors included weakness, impaired mobility, and cognitive loss. Risk factors included skin breakdown, falls, and urinary tract infection. The CAA documented the care plan would be initiated/reviewed to improve/maintain current toileting skills and ability to transfer to the toilet, continence status, decrease fall and pressure ulcer risk, and decrease risk for urinary tract infections. No bowel or bladder care plan was initiated at that time. R57's current Activities of Daily Living (ADL) Care Plan has the following toileting interventions: - R57 needs extensive assistance with 2 person staff support; R57 uses a Hoyer lift. - R57 does not use any bowel/bladder appliances. - R57 is incontinent of bladder and bowel; R57 uses briefs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted R57 did not have a schedule for the frequency of incontinence care. On 6/29/2024, R57 was admitted to the hospital and readmitted to the facility on [DATE] with a Stage 3 pressure injury to the coccyx. No incontinence care revisions were made to R57's care plan and no assessment of voiding pattern was completed or development of a toileting schedule. R57's Quarterly MDS assessment dated [DATE] documented R57 was always incontinent of bladder and continent of bowel. The MDS documented a trial of a toileting program had not been attempted on admission/reentry or since urinary incontinence was noted in the facility. R57 was cognitively intact with a BIMS score of 15. Surveyor noted R57 had increased urinary incontinence compared to the Admission MDS on 5/28/2024 and no revision was made to R57's ADL Care Plan to address the increased incontinence of the bladder. No bowel or bladder care plan was initiated at that time. R57's Significant Change MDS assessment dated [DATE] documented R57 was occasionally incontinent of bladder and always incontinent of bowel. The MDS documented a trial of a toileting program had not been attempted on admission/reentry or since urinary incontinence was noted in the facility. R57 was cognitively intact with a BIMS score of 15. The Urinary CAA documented R57's Urinary Incontinence CAA triggered secondary to always incontinent of bowel and bladder and dependence of staff for incontinent care. Contributing factors included weakness, impaired mobility, and cognitive loss. Risk factors included skin breakdown, falls, and urinary tract infections. The CAA documented the care plan would be continued to manage incontinence, reduce pressure injury and fall risk, and reduce the risk for urinary tract infections. Surveyor noted R57 was now incontinent of bowel which R57 had not been on the Quarterly MDS assessment on 7/14/2024 and no revision was made to R57's ADL Care Plan to address the incontinence of the bowel. No bowel or bladder care plan was initiated at that time. On 9/6/2024, R57 was admitted to the hospital and readmitted to the facility on [DATE]. R57's Stage 3 pressure injury had healed while in the hospital. R57 had a history of excoriation to the coccyx due to incontinence while in the facility. R57 had no skin breakdown at the time of the survey. R57's Quarterly MDS assessment dated [DATE] documented R57 was always incontinent of bladder and always incontinent of bowel. The MDS documented a trial of a toileting program had not been attempted on admission/reentry or since urinary incontinence was noted in the facility. R57 was cognitively intact with a BIMS score of 15. Surveyor noted R57 had increased urinary incontinence compared to the Significant Change MDS on 8/21/2024 and no revision was made to R57's ADL Care Plan to address the increased incontinence of the bladder. No bowel or bladder care plan was initiated at that time. On 10/1/2024 at 10:35 AM, Surveyor met with R57. R57 stated staff on third shift used to come and change the incontinent brief at midnight, 2:00 AM, and 4:00 AM on a schedule, which R57 liked. R57 stated now the staff wait until R57 puts on the light to have them come and change R57's brief. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/2024 at 3:25 PM, Surveyor shared with interim Assistant Director of Nursing (ADON)-M the concern R57 was incontinent of bowel and bladder, Surveyor was unable to find a comprehensive incontinence assessment such as a bowel and bladder diary, and R57 did not have a care plan to manage toileting. Interim ADON-M had started working at the facility the previous week so was not sure what the process was for developing a toileting schedule and stated interim ADON-M would look into the concern. Surveyor reviewed R57's CNA Worksheet for 10/3/2024. The information regarding toileting was the same as on the ADL Care Plan. On 10/7/2024 at 9:07 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-N whom stated R57 was incontinent of both bowel and bladder and the CNAs usually check and change R57 every two hours but knows R57 does not get up out of bed until after breakfast. R57 had been observed to be lying in bed at that time. CNA-N stated R57 is checked and changed at the beginning of the shift, before R57 gets out of bed after breakfast, and then in the afternoon after lunch when R57 is put back to bed. CNA-N stated R57 does not have anything written down as to when R57 needs to have incontinence care completed. CNA-N stated R57 is a 2-person transfer and with working with other CNAs, CNA-N knows they do incontinence care before they get R57 up out of bed and after R57 is laid down. CNA-N reiterated nothing was written down in a care plan or care card that says how often cares need to be completed. On 10/7/2024 at 10:26 AM, Surveyor asked MDS Coordinator-J how a resident's incontinence status was determined. MDS Coordinator-J stated a bowel and bladder assessment is completed within three days of admission on every shift. Surveyor asked MDS Coordinator-J where that information was documented. MDS Coordinator-J stated the CNAs may have a form but was not sure. Surveyor asked MDS Coordinator-J where the data comes from to complete Section H (Bladder and Bowel) of the MDS. MDS Coordinator-J stated MDS Coordinator-J looks at the CNA charting or will go to the unit and ask staff if there is no documentation by the CNAs on continence status. Surveyor asked MDS Coordinator-J who puts in a care plan for bowel and bladder. MDS Coordinator-J stated the MDS nurses creates the care plan after the MDS cycle is complete. Surveyor shared with MDS Coordinator-J the concerns R57 is incontinent of bowel and bladder and no care plan is in place for incontinence care, no comprehensive bowel or bladder assessment was documented, R57's incontinence status per the MDS assessments have shown a decline in continence, and R57 has a history of skin breakdown attributed to incontinence with no interventions to address the frequency of incontinence care. MDS Coordinator-J stated R57 was in and out of the hospital multiple times so maybe that is why nothing was done after the MDS assessment. Surveyor asked MDS Coordinator-J if R57 had a trial toileting program at any time. MDS Coordinator-J was not sure and would let Surveyor know. Interim ADON-M did not provide any further information after the discussion with Surveyor on 10/3/2024. MDS Coordinator-J did not provide any further information after the discussion with Surveyor on 10/7/2024. No additional information was provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51014 Based on interview and record review the facility did not ensure that residents maintained acceptable parameters of nutritional status, such as usual body weight for 1 of 2 (R40) residents reviewed for weight loss. * R40 sustained weight loss which was not identified by the facility and the Dietician was not notified. Findings Include: The facility policy, entitled Weight Monitoring dated revised 1/2023 documents (in part) . . It is the policy of (facility) that appropriate nutritional care shall be provided to residents who have a significant weight change. A significant weight change is identified as a weight loss or gain of 5% in 30 days, 7.5% in 90 days or 10% in 180 days. Policy interpretation and implementation states: A report should be generated from the electronic medical record (EMR) system to identify all residents with a significant weight change in 30 days, 90 days, and/or 180 days. At the weekly Resident at Risk Review huddle, the IDT (Interdisciplinary Team) should discuss residents who trigger for a significant weight loss and who lose more than 5 lbs (pounds) since the last weight. The RD (Registered Dietician) should make recommendations for nutritional interventions based on the information obtained from the weekly Resident at Risk Review huddle meetings. RD recommendations should be reviewed and initiated by nursing associates. A nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD has requested a nutritional evaluation. The facility policy entitled Dialysis dated revised 12/2019, documents (in part) . .It is the policy of this community to provide coordination of care with the resident's dialysis provider. Policy interpretation and implementation states: The community will coordinate care with the dialysis provider in developing an appropriate plan of care to include but not limited to, fluid restriction and weights as ordered by MD (Medical Doctor)/NP (Nurse Practitioner) and a communication tool is utilized to receive a report on the resident to the community after each dialysis session. A verbal report is accepted, and the licensed nurse will document this in the resident's medical record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R40 was admitted to the facility on [DATE] with a diagnosis of encephalopathy, end stage renal disease, heart and kidney failure, dependence on renal dialysis, type 2 diabetes and kidney disease. R40's Quarterly MDS (Minimum Data Set) dated 9/11/24, indicated a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. Section K documented no to both questions if R40 had a loss or gain of 5% in last month or 10% in last 6 months. R40's Care Plan dated 9/11/24, documents: Will have nutritional needs met and will not have an unplanned significant weight change over the next review period. Interventions include, offered diet as prescribed, monitor weight on dialysis days (Tuesday, Thursday, Saturday). Monitor for signs and symptoms of hypo/hyperglycemia, encourage healthy snacks and DO NOT GIVE POTATO CHIPS, provide Mrs. Dash with meals, encourage only one healthy snack per day, provide education on healthy eating habits, fluid breakdown: 10 oz (ounces) breakfast, 10 oz lunch, 10 oz dinner, and 4 oz at each medication pass. R40's Physician Orders document: Weight to be completed on dialysis days - ordered 8/11/24. Communication form to take and complete before dialysis, and return and complete from dialysis - ordered 8/22/24. Surveyor review of R40's weights in the EHR (electronic medical record) document weights in pounds documented: 5/23/24 = 319.6 5/25/24 = 300 Surveyor noted a weight loss of 19.6 lbs/6.13%. 6/1/24 = 258.3 Surveyor noted a weight loss of 41.7 lbs/13.9%. 6/29/24 = 287 Surveyor noted a weight gain of 28.7 lbs/11.11%. 7/2/24 = 254.2 Surveyor noted a weight loss of 32.8 lbs/11.43%. Subsequent weights were stable through September 2024. Review of R40's medical record revealed no evidence the Physician or Dietician was notified regarding R40's weight loss and/or gain on the above dates. R40's dialysis communication forms were reviewed revealing the form was not consistently completed as evidenced by 22 missing forms over a 3-month period. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 10:19 AM, Surveyor interviewed Registered Dietician (RD)-T who stated the dialysis facility weighs residents for the pre and post weights. RD-T was not sure what the form is called but it should be recorded on a form. Once the form is completed, it is scanned into the EHR. RD-T reported she reviews the forms on each resident's dialysis days during the normal work week and coordinates with the Dialysis Dietician at least monthly, or more often if there is a drastic change. The Director of Nursing (DON) or the ADON (Assistant) then notifies RD-T of significant weight gain or loss daily during the Monday through Friday stand down afternoon meeting. If there is a significant change over the weekend, RD-T is notified Monday morning by the DON or ADON. If there is a significant change, RD-T talks to resident to determine if supplement is needed or to see if other adjustments to menu are needed. On 10/3/24 at 11:41 AM, Surveyor interviewed RD-T to address R40's weight loss/gain entered in the EHR and asked if she was notified of these significant losses/gains. RD-T stated she was hired sometime in June but was a contract employee before that and doesn't recall anything specifically. She will research any actions taken during this time and get back to Surveyor. On 10/3/24 at 1:46 PM, RD-T provided Surveyor Dialysis Communication forms for the period of 5/25/24 through 7/2/24 and indicated weights did not have significant gain or loss, therefore no changes or interventions were needed. Surveyor noted the facility weights entered in R40's EHR differ significantly compared to the weights entered on the Dialysis Communication Forms. Surveyor review of the forms provided document: 5/25/24 dialysis form: Weight before - 263.2, after - 259.5. Weight in EHR 300. 6/1/24 no dialysis form: Weight in EHR 258.3. 6/29/24 dialysis form: Weight before - 259, after 255.8. Weight in EHR 287. 7/2/24 dialysis form: Weight before 257.3, after 255.3. Weight in EHR 254. On 10/7/24 at 10:55 AM, Surveyor interviewed RD-T who reported she started looking at the dialysis communication forms about 6 weeks ago and anyone not on dialysis she looks at the EHR weights. On 10/7/24 at 1:50 PM Surveyor advised Executive Director-C and Nursing Home Administrator-A of concerns regarding R40's weight loss. R40's medical record included documented weights that indicated significant loss and/or gain with no evidence the Physician or Dietician was notified. Executive Director-C reported the facility believed those weights entered were not correct. Surveyor advised there was no documentation indicating staff questioned the weights after noting a significant loss/gain from previous weight entered. No additional information was provided as to why the facility did not ensure that R40 maintained acceptable parameters of nutritional status.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based in observation, interview, and record review the facility did not ensure the necessary services to provide respiratory care were consistent with professional standards of practice for 1 (R48) of 1 resident reviewed for respiratory care. * R48's oxygen tubing and humidification were not labeled and dated. On 10/1/2024, R48's humidification was below the line/tubing so R48 was unable to benefit from humidification while R48's oxygen was running, R48's oxygen was set for 3 L (liters)/minute (Liters per minute) during survey and R48 order was for 2L/minute, and R48 did not have orders in place for care of oxygen supplies. Findings include: The facility policy, entitled Oxygen Administration last approved on 12/2022, documents: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: A. Verify that there is a physician's order for this procedure. Review the physician's orders or community protocol for oxygen administration. Steps on the procedure: . K. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. L. Label and date the humidifier bottle and oxygen tubing. N. Periodically re-check water level in humidifying jar. Documentation: After completing oxygen setup or adjustment, the following information should be recorded in the resident's medical chart. A. The date and time that the procedure was performed. C. The rate of oxygen flow, route, and rationale. E. The reason for PRN (as needed) administration. F. Assessment data obtained before, during, and after the procedure. 1.) R48 was readmitted to the facility on [DATE] with a diagnoses that includes malignant pleural effusion, and atrial fibrillation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R48's significant change minimum data set (MDS) dated [DATE] indicated R48 had intact cognition with a brief interview for mental status (BIMS) score of 15 and the facility assessed R48 needing total assistance with all activities of daily living (ADL's) with 1 staff member. On 10/1/2024 at 9:48 AM, Surveyor observed R48 lying in bed with oxygen via nasal canula (N/C) running at 3 L/min and the humidification water had a water level that was lower than the tubing, so the water was not bubbling indicating R48 was not getting humidification with R48's oxygen. The tubing and humidification bottle were not labeled and dated to when it was changed or put on. Surveyor asked R48 if R48 was on oxygen at all times. R48 stated he did have oxygen on all the time. Surveyor asked R48 if R48 knew when the tubing and humidification bottle got changed or filled, R48 was not sure when the tubing and humidification bottle got changed or filled. On 10/1/2024 at 3:16 PM, Surveyor observed R48 lying in bed. R48's oxygen was set at 3L/min and the water level in the humidification chamber was still lower than the tubing. The tubing and humidification also were not labeled. On 10/2/2024 at 7:50 AM, Surveyor observed R48 lying in bed. R48's oxygen was set at 3L/min and the tubing and humidification chamber were not labeled. Surveyor reviewed R48's physician orders and noted the following physician order: 1. Oxygen at 2 liters/minute per N/C to keep sats (saturations) above 90% as needed. (Ordered: 9/12/2024) Surveyor noted that R48's oxygen order is for as needed and to be set at 2L/min. R48 currently had R48's oxygen running at 3L/min. On 10/2/2024 at 3:15 PM, Surveyor showed director of nursing (DON)-B Surveyors concerns that R48's oxygen tubing and humidification are not labeled, the humidification was running below water line on 10/1/2024, and R48's order is for 2L/min as needed to keep sats above 90% but could not locate documentation for R48 requiring oxygen all the time and at 3L/min. DON-B stated that 3rd shift should be changing and labeling tubing and humidification and staff sign it out on the medication/treatment administration records (MARs/TARs). DON-B stated DON-B would look into R48 oxygen order and talk with staff. Surveyor reviewed R48's September 2024 and October 2024 MAR/TAR. Surveyor noted that the MAR/TAR did not have a place to indicate what R48's vital signs are such as R48's pulse oximetry (PO2) or respirations. Surveyor also noted that there are no orders for R48's tubing and humidification to be changed, labeled, and dated or to fill R48's humidification bottle. Surveyor did not see documentation regarding R48's requiring the need for R48's PRN oxygen or vital signs that would indicate R48's oxygen level was below 90% to require the oxygen per R48's physician order. Surveyor did not see documentation regarding an increased need in oxygen for R48 to need 3 liters versus the ordered 2 liters of oxygen. Crossreference to F656 regarding R48 not having a respiratory/oxygen care plan in place. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/2024 at 3:04 PM, Surveyor shared concerns with assistant director of nursing (ADON)-M, executive director-C, and nursing home administrator (NHA)-A Surveyors concerns that R48's oxygen tubing and humidification are not being labeled/dated or monitored, R48's sats are not being monitored/documented, and R48's oxygen needs do not correlate with the physician order. On 10/7/2024 at 8:03 AM, Surveyor observed R48 lying in bed. R48's oxygen was running at 3L/min, and the water was almost below the water line for R48's humidification. R48's oxygen tubing and humidification were still not labeled and dated. Surveyor noted that R48 did not have orders to monitor R48's vital signs such as PO2 and respirations to indicate an increased need for oxygen per R48's oxygen order. No additional information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not store and prepare food in accordance with professional standards for food service safety potentially affecting 65 of the 66 residents in the facility. *Observations were made in the main kitchen of food open to air in the freezer, boxes of food stored on the floor, milk in the refrigerator past the expiration date, the dishwasher was in disrepair, and staff not wearing beard coverings while working in the kitchen preparing food. Findings include: The facility policy and procedure entitled Food Purchasing and Storage dated ,d+[DATE] documents: Policy Interpretation and Implementation: . H. Foods stored in walk in-refrigerators and freezers shall be stored above the floor on shelves, racks, dollies, or other surfaces that facilitate cleaning. J. Food must be date marked if it is prepared on site and refrigerated, or commercially processed after the original container is opened. Food shall be dated with the current date and be used or discarded per State Food Code regulations. 1.) On [DATE] at 8:36 AM, Surveyor did a preliminary walk through of the facility kitchen with Kitchen Manager (KM)-O. The walk in freezer had unopened full boxes of food stored on the floor of the freezer. A box of hamburger patties with a plastic bag lining the box was open to the air. A bag of shredded cheese had a hole in the corner of the bag exposing the cheese to the air. KM-O stated there should not be boxes on the floor and KM-O was not aware the bag of cheese had a hole in it. KM-O stated it looked like someone had grabbed something next to the bag of cheese and accidentally caused a hole in the bag. KM-O removed the cheese from the freezer and discarded. The walk in refrigerator that KM-O called the bread and milk refrigerator had an over-filled crate of individual whole milk cartons that had expired on [DATE]. KM-O removed the crate of milk from the refrigerator and stated KM-O would discard all the milk cartons. KM-O brought Surveyor to the prep area of the kitchen and stated the prep tables had to be moved because there were pipes in the ceiling above that leaked all over the prep tables. KM-O stated this occurred about six weeks prior and the pipes were fixed, but the ceiling still had two large openings that were covered with plastic. Surveyor observed the two openings in the ceiling that measured approximately 10 feet by 5 feet and 4 feet by 2 feet. The plastic covering the holes were gapped and air was continually blowing causing the plastic to [NAME]. Surveyor observed the prep tables to the side of the ceiling openings with the air blowing in the direction of the prep tables. KM-O brought Surveyor to the dish washing area and explained the dish machine continually leaked onto the floor causing approximately one inch of standing water. Surveyor observed a kitchen staff member using a squeegee to push standing water into a drain in the corner of the room. The floor was slippery to walk on. The dish machine rollers that enable the dish racks to slide into the dishwasher were corroded with most of the rollers in a pile at the end of the dishwashing station. The rollers were unusable making the task of washing dishes difficult. KM-O showed Surveyor the log for cleaning the ice machine for 2024. Not all the months had initials and KM-O stated the ice machine should be cleaned monthly and the log indicated that had not been done consistently. (continued on next page)

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	525523	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexian Village of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 2:58 PM, Surveyor shared with Previous Nursing Home Administrator (NHA)-D, Director of Nursing (DON)-B and interim Assistant DON (ADON)-M the observations in the kitchen and the concerns those observations brought. Previous NHA-D did not have any knowledge of the kitchen ceiling having large openings or who was responsible to fix the ceiling. Previous NHA-D was not aware the dish machine was leaking or in disrepair. On [DATE] at 10:08 AM, Surveyor observed four male kitchen staff members in the kitchen with beards that did not have beard covers on. Surveyor observed a bin of flour with the scoop in the bin and a bin of all-purpose flour with a bowl in the bin. Surveyor shared these observations with KM-O and KM-O showed Surveyor the flour bin with the scoop in the flour had a hook on the inside top of the bin where the scoop should hang but thought the scoop may have been bumped and landed in the flour or someone may have put the scoop directly in the flour in the bin. KM-O did not know why there was a bowl in the all-purpose flour bin. Surveyor observed unbaked formed cookie dough in the freezer that was open to the air. On [DATE] at 3:02 PM, Surveyor shared with Executive Director (ED)-C, interim ADON-M, and NHA-A the observations in the kitchen regarding no beard nets on male staff members with beards, a scoop and a bowl in the flour bins, and unbaked formed cookie dough open to the air in the freezer. No additional information was provided as to why the facility did not store and prepare food in accordance with professional standards for food service safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observations, interviews, 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 4 of 4 (R24, R44, R48 and R60) residents reviewed for infection control. * The shared glucometer on Medication Cart A & D was not cleaned between residents' use. * R48's catheter bag was observed lying on floor on 10/2/2024. Findings include: The facility policy and procedure titled Obtaining a Fingerstick Glucose Level documents (in part) . . The following equipment and supplies will be necessary when performing this procedure. A. Disinfected blood glucose meter (glucometer) with sterile lancet; or single-resident use spring loaded device or automatic or safety type lancet. Steps in the procedure: A. Place the equipment on a clean field. C. Always ensure that blood glucose meters intended for reused are cleaned and disinfected between resident uses. Q. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Caviwipes disinfecting towelettes label documents (in part) . .Caviwipes are effective against the following microorganisms on hard, non-porous surfaces when used as directed: Mycobacterium, Bacteria, Pathogenic Fungi, Drug-Resistant Bacteria, Enveloped Viruses. For use as a disinfectant - contact time: Use 1 towelette to visibly wet the surface. Repeated use of the product may be required to ensure that the surface remains visibly wet for 1 minute. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) On 10/2/24 at 8:13 AM, Surveyor observed Licensed Practical Nurse (LPN)-P prepare medications for R44. LPN-P removed the glucometer, lancet and alcohol wipe from the top drawer of the medication cart. LPN-P applied gloves and proceeded to poke R44's finger to obtain a blood sample. After obtaining R44's blood sugar, LPN-P placed the glucometer on R44's dresser with no barrier underneath. LPN-P removed his gloves, picked up the glucometer, placed it on the top of the medication cart and sanitized his hands. Surveyor asked LPN-P if he had any other resident blood sugars to do. LPN-P stated: No, she was my last one. Surveyor asked how many other residents on the unit get their blood sugars taken. LPN-P stated: Maybe 3 or 4 altogether. Surveyor asked if residents have their own glucometers or if the same glucometer is shared between residents. LPN-P stated: Upstairs I think some residents have their own, but on this floor we use one for everyone. Surveyor asked LPN-P if this was the same glucometer he used to check all residents blood sugars this morning. LPN-P stated: Yes, I don't have anyone left to do. Surveyor noted the glucometer remained on top of the medication cart and asked LPN-P if he cleans the glucometer. LPN-P stated: Every morning before I start, I wipe the med (medication) cart and everything down. LPN-P showed Surveyor a container of Cavi disinfecting wipes. Surveyor asked LPN-P if he cleans the glucometer. LPN-P stated: I wipe that down every morning too, with the Cavi wipe. Surveyor asked LPN-P if he cleans the glucometer with the Cavi wipe between residents' use. LPN-P stated: No, I give it a good wipe down before I start passing meds in the morning. On 10/2/24 at 10:57 AM, Surveyor asked DON (Director of Nursing)-B what is the expectation for cleaning of the glucometers. DON-B stated: Cavi wipes. Surveyor advised DON-B of observation and interview the shared glucometer used on med cart A&D was not cleaned after and between residents' use. Surveyor asked for a list of residents on the unit requiring blood sugar testing. On 10/2/24 at 12:41 PM, DON-B advised Surveyor he did education with all staff on glucometer cleaning and the facility policy. DON-B reported he will also be providing extra glucometers for the 2nd floor, so the glucometer does not need to be shared. Surveyor review of residents utilizing the shared glucometer from med cart A&D identified R24, R44 and R60. Surveyor review of the residents' medical records revealed no communicable disease. On 10/3/24 at 8:38 AM, during observation of the 2nd floor med cart A&D, Surveyor noted there was not a Cavi wipe disinfecting container in or on the med cart. Surveyor observed a glucometer in a black pouch in the top drawer of the med cart. Surveyor observed LPN (Licensed Practical Nurse)-Q walk to the med cart and place a silver glucometer on the top of the cart. Surveyor asked LPN-Q if she had any other blood sugars to do. LPN-Q stated: Yes, I just checked (R60) just now, I have one more person to do. Surveyor asked what other residents she had checked blood sugars. LPN-Q stated: (R24) in room [ROOM NUMBER], I just did (R60) and now I have (R44). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN-Q picked obtained a lancet and several alcohol wipes from the med cart. LPN-Q picked up the silver glucometer from the top of the med cart. (Surveyor noted the glucometer had not been cleaned with a Cavi wipe). LPN-Q entered R44's room, washed her hands and applied gloves. LPN-Q wiped the glucometer with an alcohol wipe for 15 seconds. LPN-Q poked R44's finger and obtained the blood sample. After obtaining the blood sugar, LPN-Q placed the glucometer on the bedside table without a barrier underneath, removed her gloves and then placed the glucometer in her pocket. LPN-Q then sanitized her hands and proceeded to walk down the hall. While walking, LPN-Q removed the glucometer from her pocket and when she reached the med cart, she placed the glucometer on top of the med cart. Surveyor confirmed LPN-Q had no other resident blood sugars to do. Surveyor asked if residents have their own glucometers or if they are shared between residents. LPN-Q stated: I think this cart we have to share. Surveyor confirmed with LPN-Q she used the same glucometer for all 3 residents (R24, R44 and R60). Surveyor asked what the process was for cleaning the glucometer. LPN-Q stated: I clean it with an alcohol wipe between residents, I usually wipe it down for about 30 seconds. On 10/3/24 at 1:53 PM, Surveyor spoke with Executive Director-C and shared observations and concerns the shared glucometer was not cleaned between residents use. Executive Director-C reported she will address the concern right away. 47094 The facility policy entitled Catheter Care, Urinary last approved in 1/2024 documents: The Purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control . B. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. 2. Be sure the catheter tubing and drainage bag are kept off the floor. 2.) R48 was readmitted to the facility on [DATE] with a diagnoses that includes malignant pleural effusion, hydronephrosis, benign prostatic hyperplasia, urine retention, obstructive and reflux uropathy. R48's significant change minimum data set (MDS) dated [DATE] indicated R48 had intact cognition with a brief interview for mental status (BIMS) score of 15 and that the facility assessed R48 to need total assistance with all activities of daily living (ADL's) with 1 staff member. R48 had a suprapubic catheter in place and was continent of bowel. On 10/2/2024 at 7:49 AM, Surveyor observed R48 lying in bed. R48's catheter bag was on the right side of R48's bed lying on the floor, the catheter bag had about 100 ml of urine in the catheter bag. Surveyor asked R48 when the aide was last in the room to check on R48. R48 could not remember when the aide was into check on R48. On 10/2/2024 at 1:41 PM, Surveyor observed R48 sitting up in a wheelchair. Surveyor asked R48 when R48 was assisted into the wheelchair. R48 stated R48 was assisted into the wheelchair before noon meal around 11:30 AM. Surveyor asked if anyone came into R48's room before that to take care of R48's catheter or pick it up off the floor. R48 stated R48 did not believe anyone came into the room to assist R48 until they got R48 up before no one meal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/2024 at 3:15 PM, Surveyor shared concern with director of nursing (DON)-B regarding Surveyors observation on R48's catheter bag being on the floor in the morning and R48's statement that R48's catheter bag was left on the floor until noon mealtime. DON-B stated expectation is for staff to check and make sure catheter bags to not fall onto the floor and will talk with and reeducate staff. No additional information was provided.