STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525524	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anne's Salvatorian Campus	3800 N 92nd St Milwaukee, WI 53222

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on observation, interview, and record review the facility did not ensure 1 (R16) of 1 resident reviewed for self-administration of medications was assessed prior to staff leaving medications at bedside for a resident. On 11/12/24, at 10:57 AM, R16 was observed to have multiple mediations sitting on her bedside table in a medication cup. R16 was not assessed to self-administer her medications and did not have an order from the facility provider for R16 to self- administer medications. Findings include: R16 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R16's diagnoses include End Stage Renal Disease (ESRD), Diabetes, Cerebrovascular disease, dependence on dialysis, heart failure, dementia, and Transient ischemic attack (TIA). R16's Quarterly MDS (Minimum Data Set) completed on 11/6/24 documents that R16 is independent with eating, oral hygiene, toileting hygiene, rolling left to right, and toilet transferring. R16 was documented as having a BIMS (Brief Interview for Mental Status) score of 15, indicating that R16 is cognitively intact. On 11/12/24, at 10:57 AM, Surveyor interviewed R16 who was sitting on the edge of her bed eating breakfast at her bedside table. Surveyor observed a medicine cup with R16's name on it with multiple medications in it. Surveyor acknowledged the cup of medications and stated she will take them soon. Surveyor reviewed R16's medical record and notes R16 did not have an order to self-administer medications and did not have an assessment completed to evaluate for self-administering medications. On 11/12/24, at 11:27 AM, Surveyor interviewed R16 who states she took her medications that were on her bedside table. Surveyor asked R16 if staff always leave her medications in her room for self-administration. R16 states some staff leave her medications in her room and it depends on which nurse is working. On 11/12/24, at 3:33 PM, Surveyor notified Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B of findings above. Additional information was requested if available. None was provided.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50700 Based on observation, interview and record review, the facility did not ensure residents received services in the facility with reasonable accommodation of resident needs of 1 (R7) resident) of 12 sampled residents reviewed for accommodations of needs. *R7's call light was observed to be out of reach of R7. Findings include: R7 was admitted to facility on 08/22/2023 from a hospital with admitting diagnoses of urinary tract infection, Multiple Sclerosis and Quadriplegia. R7's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed and documented R7 had a Brief Interview for Mental Status score of 15 which would indicate R7 is cognitively intact for daily decision-making skills. On 11/11/2024, surveyor reviewed R7's Care plan/call light. Focus includes, R7 is a high risk for falls r/t Deconditioning, Incontinence, Paralysis Tasks include, be sure R7's call light/pendant is within reach and encourage R7 to use it for assistance as needed. R7 needs prompt response to all requests for assistance. On 11/11/2024, at 10:05 AM, Surveyor interviewed R7, and R7 acknowledges using the call light for needs, if R7 needs to get a-hold of staff. R7 was asking surveyor for something more to drink, staff feeds and turns and changes brief as needed. Surveyor went to the hall several times to look for staff and none found at this time. The call light was out of reach for R7 to function and surveyor pressed the call light at 11/11/24 10:12 AM. R7 was thirsty and wanted water from refrigerator. CNA-V entered the room on 11/11/2024, at 10:18 AM. Surveyor explained that Surveyor had to press the call-light as it was out of reach for R7, CNA-V addressed resident's needs, giving a drink of water, then started to leave the room. Surveyor asked CNA-V if they could place the call light within reach of R7. CNA-V grabbed the call light but didn't know where or how to place the call light to be within reach of R7 or to connect it to the bed. R7 explained to CNA-V how to complete task, where to place it and how to connect the call light to the bed. R7 had to explain in detail how to place it so R7 could use, the call light was placed on the pillow a few times but still not in an area where R7 could reach it and R7 had to explain to CNA-V to move it closer, move it closer, because resident couldn't reach it. CNA-V also needed help from R7 to explain how to clip it to the pillowcase, so it wouldn't fall off. On 11/11/2024, at 10:21 AM surveyor interviewed CNA-V and was told by CNA-V that CNA-V usually works on the assisted living side of the facility. On 11/13/2024, at 09:34 AM, Surveyor interviewed Director of Nursing (DON)-B on call light use and if it's expected that staff should know how to place the call light in reach and connect it securely for R7. CNA-V had to have R7 explain how to place the call light for R7 to function. DON-B states that the staff should know to place call light in R7's reach and should know how to place it. We will train staff on this prior to working on the floor. I know his call light is different with the fact that he must use the pressure plate with his head to initiate but all staff should know how to place it in reach and connect it, even if staff is coming from assisted living side. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/2024, at 02:37 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and NHA-A stated CNA-V should know this from CNA classes, it teaches them that call lights should be in reach. NHA-A stated they can't speak to what happened prior to June, but staff now should be aware of that. All staff should know to place the call light in the R7's reach and know how to connect it to the pillow, we train them on this prior to working on the floor. I know this call light is different with the fact that R7 must use the pressure plate with his head to initiate but all staff should know how to use even if coming from assisted living side. They should know how, standard expectations of any CNA whether they came from assisted living or not, should know this, this shouldn't be a surprise to them, that they should know this. The above findings were shared with NHA-A and DON- B on 11/14/2024 at the daily exit meeting. No additional information was given at this time.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interview and record review, the facility did not ensure residents the right to formulate an advance directive for 1 of 1 (R22) residents reviewed for advanced directives. R22's code status was not clearly indicated in the medical record. Findings include: R22 admitted to the facility on [DATE] and has diagnoses that include Diabetes Mellitus Type 2 with Chronic Kidney Disease, Atrial Fibrillation, Venous Insufficiency, Depression, Hypothyroidism, Urine Retention, Congestive Heart Failure, Peripheral Vascular Disease, Anemia, Acquired absence of left leg below knee and Atherosclerotic Heart Disease. R22's Annual MDS (Minimum Data Set) dated 8/13/24 documents a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. R22's care plan initiated 7/27/23 documents: Full Code. Interventions: SW (Social Worker) will follow up with resident and family as needed or as requested by resident or family. The Facility Policy and Procedure titled Code Status with a review date of 8/10/23 documents (in part) . .Policy: Facilities will discover, maintain, and execute a individual's code status by following the documented wishes of each individual. Procedure: A. Discovery: 1. Upon admission, a designated staff member will discover any current code status directives that a individual may have in place. 2. The designated staff member will review the current code status for accuracy with the individual and/or individual representative. 3. If a individual does not have any code status directives in place, the staff member will provide materials to individual and/or individual representative. B. Maintenance: 1. Full code a. If a individual wishes to be a full code, the individual's wishes will be maintained within the medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Do-Not-Resuscitate (DNR). a. If an individual wishes to be a DNR, the individual's wishes will be maintained: i. Provider signed DNR order ii. Within the medical record iii. On a state DNR form iv. by wearing a facility approved DNR bracelet, until the state DNR bracelet is acquired. b. If a individual does not wish to maintain their DNR bracelet, the risk agreement will be reviewed with the individual and/or individual representative. This choice will be documented in the care plan. C. Execution: 1. Staff will identify a individual's code status by: a. Identification of a DNR bracelet on the individual b. Documentation within the medical record 2. The individual's medical record will be the primary reference in case of an emergency to verify code status. Surveyor review of R22's medical record revealed R22's code status was not clearly indicated. Surveyor was unable to determine whether R22 was a Full Code or DNR. There was no physician's order for code status and the code status was not indicated on the dashboard of PCC (Point Click Care) or the MAR (Medication Administration Record). On 11/11/24 at 3:48 PM, Surveyor spoke with LPN (Licensed Practical Nurse)-P. Surveyor asked where she would look to find R22's code status in the event of an emergency or code. LPN-P stated, Residents don't really wear bracelets anymore, not like they did long ago, now I look here. (LPN showed Surveyor R22's PCC dashboard which indicated: Code Status (Advanced Directives). LPN-P clicked on Advanced Directives which opened to a POAHC (Power of Attorney Health Care) pdf (portable document format) dated 10/9/2023. LPN-P stated, Oh, his doesn't really say what he is, so I don't know. I'll have to ask the DON (Director of Nursing) about it. Surveyor asked LPN-P, if (R22) coded at this time, you would not know what his code status is? LPN-P stated, I know he is a full code, that I remember, but if I looked here, no - I would not be able to verify it. On 11/12/24 at 9:12 AM, Surveyor and DON-B looked at R22's PCC dashboard together. DON-B reported it is not entered correctly, and it should be easily read. DON-B opened the POAHC.pdf and noted R22 did not have a DNR form completed. DON-B reported the facility will do a facility-wide audit. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 10:39 AM, Surveyor spoke with NHA (Nursing Home Administrator)-A who reported she understands the confusion. NHA-A reported the dashboard does not list R22's actual code status, even though it may be in the documents. NHA-A reported the facility is going through everyone to make sure it's clearly listed. Surveyor reviewed R22's PCC dashboard, which now lists Full Code. Surveyor review of POAHC.pdf documents: The following are any specific desires, provisions or limitations that I wish to state: DNR (signed by R22 on 10/9/23). NHA-A informed Surveyor that residents and/or family are told upon admission that if they wish to be DNR they need to sign the state DNR form. If they do not sign the form indicating their wishes, they will be considered a full code until the state DNR form is signed. Surveyor asked NHA-A: So to clarify, (R22) wishes to be DNR, but the facility will treat him as full code until the form is signed. NHA-A states, Yes, some people are slow about getting the form back to us. Surveyor confirmed with NHA-A that R22 has resided in the facility since July, 2023 and even though he expressed and signed wishes for DNR on 10/9/23, the facility considers R22 to be a full code because the facility did not receive the signed DNR form. NHA-A stated, Yes, his wife is slow at things, she'll be coming in today. On 11/12/24 at 12:44 PM, Surveyor was provided progress noted dated 11/12/24 at 10:56 AM which documented: Discussed with POA - DNR requested. Call with (Medical Doctor). Approved order for DNR. Surveyor noted R22's PCC dashboard now indicates DNR. NHA-A reported a facility wide audit will be conducted to confirm code status is clearly visible on the dashboard. On 11/13/24 at 3:00 PM, the facility was advised of concern R22's code status was not clearly indicated in the event of an emergency or code. R22 expressed and signed wishes for DNR on 10/9/23 and the facility did not obtain a signed DNR form. No additional information was provided.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 38146 Based on observation and interview the facility did not ensure residents' right to personal privacy and confidentiality of his or her personal and medical records for 2 of 2 (R38 and R41) residents reviewed. R38's medication cards and MAR (Medication Administration Record) were left on the medication cart unattended and in open view of residents or visitors. R41's MAR was left on the medication cart unattended and in open view of residents or visitors. The facility Policy and Procedure titled Medication Administration General Guidelines dated May 2018 documents (in part) . Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. B. Administration 2) Medications are administered in accordance with written orders of the prescriber. 16) During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained always for all resident information (e.g., MAR) (by closing the MAR book/covering the MAR sheet or computer screen) when not in use. On 11/12/24 at 7:36 AM, Surveyor observed RN (Registered Nurse)-O prepare medications for R38. After preparing R38's medications, RN-O placed R38's medication cards on top of the medication cart and walked toward R38's room. Surveyor noted RN-O left the computer screen open in full view of R38's MAR. RN-O and Surveyor stayed in R38's room for several minutes while waiting for the resident, who was in the bathroom brushing her teeth. RN-O informed R38 she would return when she is finished in the bathroom. RN-O walked back to the medication cart and put R38's medication cards in the drawer. On 11/12/24 at 8:07 AM, Surveyor observed RN-O perform blood sugar testing for R41 in his room. While in R41's room, Surveyor noted RN-O left the computer screen open in full view of R41's MAR. On 11/13/24 at 3:30 PM, NHA (Nursing Home Administrator)-A was advised of concern medication cards were left on the medication cart and the computer screen was left open in full view of the MAR, unattended during observation of medication pass. No additional information was provided.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not ensure 6 (R3, R5, R16, R22, R28, R38) of 6 residents reviewed that required hospitalization s were given written reason for transfer to the hospital and the facility did not send this notification to the Ombudsman. R3 was transferred to the hospital on 3/3/24 for a change in condition. R3 or their representative did not receive written notification of transfer to the hospital and the State Ombudsman was not sent a copy of this notice. R5 was transferred to the hospital on 9/24/24 for a change in condition. R5 or their representative did not receive written notification of transfer to the hospital and the State Ombudsman was not sent a copy of this notice. R16 was transferred to the hospital on 7/30/24 for a change in condition. R16 or their representative did not receive written notification of transfer to the hospital and the State Ombudsman was not sent a copy of this notice. R22 was transferred to the hospital on 7/30/24 for a change in condition R22 or their representative did not receive written notification of transfer to the hospital and the State Ombudsman was not sent a copy of this notice. R28 was transferred to the hospital on 6/7/24 for a change in condition. R28 or their representative did not receive written notification of transfer to the hospital and the State Ombudsman was not sent a copy of this notice. R38 was transferred to the hospital on 10/14/24 for a change in condition. R38 or their representative did not receive written notification of transfer to the hospital and the State Ombudsman was not sent a copy of this notice. Findings include: 1.) R16's medical record indicates, R16 transferred to the hospital on 7/30/24 due to a change in condition. 2.) R38's medical record indicates, R38 transferred to the hospital on 10/14/24 due to a change in condition. On 11/12/24, at 1:19 PM, Surveyor interviewed Social Services- Q who indicates she is not responsible for written notification of transfer and notification to the Ombudsman. Social Services- Q states Referral Specialist- M is responsible for written notification of transfer and notification to the Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24, at 1:22 PM, Surveyor interviewed Referral Specialist- M who stated she is only responsible for bed holds and does not take care of the written notification of transfer and notification to the Ombudsman. Surveyor asked Referral Specialist- M who is responsible for the written notification of transfer and the notification to the Ombudsman. Referral Specialist- M states the staff on the floor take care of the transfer notice form. On 11/12/24, at 3:33 PM, Surveyor asked Nursing Home Administrator (NHA)- A, who is responsible for the written notification of transfer forms and notification to the Ombudsman. NHA- A indicated Social Services- Q is responsible for the written notification of transfer forms and notification to the Ombudsman. Surveyor notified NHA- A, Social Services- Q states she is not responsible and Social Services- Q directed Surveyor to speak with Referral Specialist- M. Surveyor notified NHA- A that Referral Specialist- M states she is not responsible and directed Surveyor to floor staff who complete the written notification of transfer forms along with notification to the Ombudsman. NHA- A indicates Referral Specialist- M verifies the written notification of transfer forms however, NHA- A then stated ideally the facility would have nursing floor staff complete the written notification of transfer forms along with notification to the Ombudsman and management would verify completion of this task. Surveyor requested a copy of the facility's policy and procedure for the written notification of transfer forms and notification to the Ombudsman. Surveyor notified NHA- A of concerns with R16 and R38 not having written notification of transfer forms along with no notification to the Ombudsman. Survey requested additional information if available. None was received. 38146 3.) R22 admitted to the facility on [DATE] and has diagnoses that include Diabetes Mellitus Type 2 with Chronic Kidney Disease, Atrial Fibrillation, Venous Insufficiency, Depression, Hypothyroidism, Urine Retention, Congestive Heart Failure, Peripheral Vascular Disease, Anemia, Acquired absence of left leg below knee and Atherosclerotic Heart Disease. R22 was hospitalized on [DATE]. Facility progress notes document: 7/30/24 at 9:05 AM: Called to Res (residents) room by CNA (Certified Nursing Assistant) stating that Res. had a large amount of blood on his diaper and around his penis. Catheter bag was full of [NAME] blood,100 cc (cubic centimeters). Blood in catheter tubing. No movement of blood in tubing. Resident A&O (alert and oriented) X 3. Denies pain/discomfort. Abdomen soft & non-distended. Incontinent of a large amount of SF (soft formed) stool. T (temperature) 98.6 p (pulse) 60 R (respirations) 16 B.P, (blood pressure) 90/40 checked X 2. Receives Eliquis 5 mg (milligrams). Call placed to NP (Nurse Practitioner) to update. Bell ambulance called to transport to (hospital) ER (emergency room) R/T (related to) bleeding in catheter and around penis, Foley not patent and low B.P. Attempted to call POA (Power of Attorney) and message left to call writer for update on above. Surveyor noted R22 was subsequently admitted to the hospital for acute on chronic hematuria and Leukocytosis from urinary obstruction. Surveyor located no evidence a transfer notice was provided to the resident or resident's representative. The facility advised Surveyor a transfer notice was not provided. On 11/13/24 at 3:00 PM, the facility was advised of concern a transfer notice was not provided to R22 or his representative related to his 7/20/24 hospitalization . No additional information was provided. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49435 4.) R3 was admitted to the facility on [DATE] with diagnosis that include Dementia, Type 2 Diabetes. Alcoholic cirrhosis of the liver, chronic kidney disease with heart failure, and Pulmonary edema. R3's progress note dated 3/3/2024 at 11:19 PM documents: swelling noted to abdomen, hips, legs, and feet. 5+ pitting edema noted. resident was asymptomatic and vital[s] within normal range. family requested for resident to be sent out to hospital. resident left to [Local hospital] at [7 PM] for further evaluation. R3 was admitted to the hospital from 3/4/24 through 3/6/24 with acute hepatic encephalopathy. Surveyor reviewed R3's medical record and was unable to locate evidence of a transfer notice provided to R3. On 11/13/24 at 10:38 AM, Surveyor asked Nursing Home Administrator (NHA)-A for evidence that a transfer notice was provided to R3. NHA-A stated that NHA-A would get the transfer notice. At 11/13/24 at 11:08 AM , NHA-A informed surveyor that NHA-A did not think the facility had a transfer notice for R3. NHA-A asked Surveyor if Surveyor was looking for a bed hold? Surveyor said no, Surveyor is looking for written notification of transfer when R3 was sent to the hospital. NHA-A stated, we will look for that. On 11/13/24 at 2:44 PM, Surveyor informed Director of Nursing (DON)-B, NHA-A, and Clinical Nurse Coordinator (CNC)-C of the concern that R3 was not provided a written transfer notice when R3 was sent to the hospital on 3/4/24. No further information was provided as to why R3 was not given a written transfer/discharge notice that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman. 5.) R5 was admitted to the facility on [DATE] with diagnosis that include Chronic Kidney disease, Type 2 Diabetes, Dementia, Stroke history, Encephalopathy and Adult Failure to Thrive. R5's progress note dated 9/24/2024 at 3:33 PM, documents: Resident was transferred to [Local] hospital today via ambulance accompanied by EMT due to lethargy, poor appetite, and critical labs. The [Assistant Director of Nursing] and family updated. R5 was admitted to the hospital from 9/24/24 through 10/2/24 with severe sepsis in setting of bilateral parotitis. Surveyor reviewed R5's medical record and was unable to locate evidence of a transfer notice provided to R5. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 10:38 AM, Surveyor asked Nursing Home Administrator (NHA)-A for evidence that a transfer notice was provided to R5. NHA-A stated that NHA-A would get the transfer notice. At 11/13/24 at 11:08 AM , NHA-A informed surveyor that NHA-A did not think the facility had a transfer notice for R5. NHA-A asked Surveyor if Surveyor was looking for a bed hold? Surveyor said no, Surveyor is looking for written notification of transfer when R5 was sent to the hospital. NHA-A stated, we will look for that. On 11/13/24 at 2:44 PM, Surveyor informed Director of Nursing (DON)-B, NHA-A, and Clinical Nurse Coordinator (CNC)-C of the concern that R5 was not provided a written transfer notice when R5 was sent to the hospital on 9/24/24. No further information was provided as to why R5 was not given a written transfer/discharge notice that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman. 6.) R28 was admitted to the facility on [DATE] with diagnosis that include Hemiplegia, Hemiparesis, Type 2 Diabetes, Chronic Kidney disease, disease with heart failure, Muscle weakness, and Depression. R28's progress note dated 6/7/2024 at 9:16 PM documents, in part: Resident is alert and oriented with confusion. Did not eat breakfast, lunch, or dinner. Writer tried to feed the resident, but she could not swallow. Resident became more restless, more slurred speech also noted . Writer updated the [Nurse practitioner (NP)] on call . The NP stated the resident is to be sent to hospital. The resident transferred to [Local] hospital at [9 PM]. The [Assistant Director of Nursing] updated, message left for resident's [Power of Attorney] to call facility for update. R28 was admitted to the hospital from 6/7/24 through 6/13/24 with Encephalopathy. Surveyor reviewed R28's medical record and was unable to locate evidence of a transfer notice provided to R28. On 11/13/24 at 10:38 AM, Surveyor asked Nursing Home Administrator (NHA)-A for evidence that a transfer notice was provided to R28. NHA-A stated that NHA-A would get the transfer notice. At 11/13/24 at 11:08 AM , NHA-A informed surveyor that NHA-A did not think the facility had a transfer notice for R28. NHA-A asked Surveyor if Surveyor was looking for a bed hold? Surveyor said no, Surveyor is looking for written notification of transfer when R28 was sent to the hospital. NHA-A stated, we will look for that. On 11/13/24 at 2:44 PM, Surveyor informed Director of Nursing (DON)-B, NHA-A, and Clinical Nurse Coordinator (CNC)-C of the concern that R28 was not provided a written transfer notice when R28 was sent to the hospital on 6/7/24. No further information was provided as to why R28 was not given a written transfer/discharge notice that included the date of transfer, reason for transfer, location of transfer, appeal rights and contact information of the State Long-Term Care Ombudsman.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not submit for a completion of a Level 2 Pre-Admission Screening and Resident Review (PASARR) assessment for 2 (R9 and R38) of 2 residents reviewed for Level 2 PASARR Screens. R9 and R38 did not have a completed Level 2 PASARR screen for residents with mental illness or developmental disability. Findings include: 1.) R9 was admitted to the facility on [DATE] and has a diagnosis that includes Schizoaffective disorder, Bipolar, intellectual disabilities, dementia, and Altered Mental Status (AMS). R9's Admission Minimum Data Set (MDS) assessment, dated 10/25/24, documents a Brief Interview of Mental Status (BIMS) score of 0, indicating R9 has severe cognitive impairment. R9's November 2024 Medication Administration Record (MAR) documents: Seroquel 50 mg (milligram). Give one tablet by mouth twice daily for psychosis/schizophrenia. Quetiapine Fumarate 400 mg. Give one tablet by mouth at bedtime for psychosis. Deutetrabenazine ER (extended release) 6 mg. Give one tablet by mouth 2 times a day for psychosis. Benztropine Mesylate 2 mg. Give one tablet by mouth two times a day for Parkinson. Surveyor reviewed R9's medical record which documents a Level I PASARR being completed, however, Surveyor is unable to locate documentation of a Level 2 for R9. 2) R38 was admitted to the facility on [DATE] and has a diagnosis that includes Down Syndrome and generalized muscle weakness. R38's MDS dated [DATE], documents a BIMS score of 14, indicating R38 is cognitively intact. On 11/13/24, at 12:35 PM, Surveyor interviewed Referral Specialist- M who indicates she is responsible for completing the Level I and Level 2 PASARR screenings for residents in the facility. Referral Specialist- M states every resident has a PASARR Level I completed, and the PASARR results are sent in a portal. Referral Specialist- M indicates she completes a Level 2 PASARR screening if she receives an email stating the resident requires a Level 2 PASARR. Surveyor notified Referral Specialist- M a Level I for R38 was scanned in the medical records and requested a Level 2. Referral Specialist- M indicates she did not receive an email to complete a PASARR Level 2 for R38 and states it was not completed. On 11/14/24, at 7:51 AM, Surveyor notified Nursing Home Administrator (NHA)- A of no Level 2 PASARR being completed on R9 and R38. Surveyor requested additional information. None 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 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** 42037 Based on observation, interview and record review, the facility did not complete neurological checks in accordance with policy and procedure for 2 (R25 & R 28) of 2 residents reviewed for unwitnessed falls. *R25 did not receive neurological checks in accordance facility's policy and procedure for 5 unwitnessed falls. *R28 did not receive neurological checks in accordance facility's policy and procedure for an unwitnessed fall. Findings include: Policy and Procedure Surveyor reviewed Facility's Policy and Procedure titled Neurological Observation dated 3/16/17 with a revision date of 6/13/23 documents the following: Licensed Nurse will monitor and record an individuals Neurological status as indicated .Neurological observation is to be done per the following Neurological Check Schedule, unless otherwise specified by a physician's order: 1. At the time of the event, 2. Every (Q) 15 minutes x 4, 3. Q 30 minutes x 4, 4. Q 1 hour x 4, 5. Q 4 hours x 4, 6. Then every shift up to 72 hours. 1.) R25 was admitted to the facility on [DATE] with diagnoses of dementia, psychotic disturbance and mood disturbance. R25's Significant Change MDS (Minimum Data Set) assessment dated [DATE] indicated R25 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 2 and requires extensive assistance with bed mobility and transfers. The facility identified R25 to be at high risk for falls. On 11/12/24, Surveyor requested the last 3 months of fall investigations for R25. Surveyor reviewed unwitnessed fall investigations for R25 dated 8/24/24, 10/13/24, 10/20/24, 10/25/24 and 10/28/24. Surveyor noted that neurological checks were not initiated for R25's 8/24/24, 10/13/24 and 10/20/24 unwitnessed falls. Surveyor reviewed R25's unwitnessed fall investigations for 10/25/24 and 10/28/24. Surveyor noted that R25's neurological checks for their 10/25/24 and 10/28/24 falls were not fully completed. On 11/14/24 at 10:10 AM, Surveyor conducted interview with DON (Director of Nursing)-B. Surveyor asked DON-B if residents who sustain unwitnessed falls should have neurological checks initiated. DON-B replied that they would expect staff to initiate neurological checks for any resident who experience an unwitnessed fall or possible head injury. On 11/14/24 at 11:20 AM, Surveyor conducted interview with NHA (Nursing Home Administrator)-A. Surveyor shared concerns related to R25 sustaining unwitnessed falls on 8/24/24, 10/13/24, 10/20/24, 10/25/24 and 10/28/24 with staff either not initiating or completing neurological checks in accordance with facility's policy and procedure. The facility did not supply any additional information to Surveyor 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	49435 2.) R28 was admitted to the facility on [DATE] with diagnosis that include Hemiplegia, Hemiparesis, Type 2 Diabetes, Chronic Kidney disease, disease with heart failure, Muscle weakness, and Depression. R28's Minimum data set (MDS) assessment dated [DATE] documents R28 has a moderate cognitive impairment. R28 needs substantial/maximal assistance for mobility and transfer. R28's fall risk care plan with an initiation date of 8/9/23 documents the following pertinent interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Reacher provided. Therapy to eval and treat. R28's Fall risk evaluation completed on 5/7/24 documents a score of 14 indicating R28 is at risk for falls. R28's progress note dated 6/5/2024 at 11:35 PM documents: At [6:45 PM] called into room by [Certified Nursing Assistant (CNA)] on duty reporting of Resident rolled off her bed. Observed Resident Right side-lying position on the floor. [Right] arm partially supporting her head, [Left Upper Extremity] with 2nd and 3rd digits tapping rhythmically on the floor to the beat of the music playing at the time. [Bilateral (both) Lower Extremities] flexed. Appeared to have comfortably positioned herself like so. Able to move all extremities without difficulties. Denied hitting her head or any other body part. No [signs or symptoms] of pain or discomfort. No guarding noted. When asked what [resident] was doing, Resident replied, I was trying to pick something off the floor. Resident did not use call light which was noted clipped on [resident's] gown. Thorough Head-to-Toe performed did not reveal injury. Assisted Resident up and off the floor using Hoyer lift, then back into bed. No raised or open areas, no bruising. Neuro-checks initiated. [Vital signs within normal limits]. [On-call Provider], [Director of Nursing (DON)] and [Assistant Director of Nursing (ADON)-E] notified. Multiple attempts to reach [Power of Attorney] no response . R28's fall investigation included the root cause of R28's fall was rolling off the bed while reaching for an item. R28 did not sustain any injury because of this fall. R28's fall risk care plan was updated with the following intervention after the fall that occurred on 6/5/24: Bed in low position and fall mat [due to resident] rolling out of bed. Surveyor reviewed R28's electronic medical record and did not locate documentation that neuro-checks had been completed after R28's unwitnessed fall. On 11/14/24 at 8:03 AM, Surveyor interviewed CNA-U. Surveyor asked what CNA-U would do if a resident had an unwitnessed fall. CNA-U stated that CNA-U would get the nurse or have someone get the nurse. CNA-U stated that CNA-U would give a statement for the fall investigation. CNA-U indicated that CNA-U would focus on making the resident comfortable and the nurse does the rest. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 7:59 AM. Surveyor interviewed Registered Nurse (RN-O). Surveyor asked what RN-O would do if a resident had an unwitnessed fall. RN-O stated that RN-O would do a thorough assessment. RN-O would inform ADON-E, Director of Nursing (DON)-B and the resident's family, if indicated. RN-O would let the resident's provider know about the fall and get any orders from the provider. RN-O stated that if the fall is unwitnessed, RN-O would start Neuro-checks. RN-O would get the fall packet. RN-O stated that fall packet will help staff complete everything that is needed after a fall. Surveyor asked where neuro checks are documented. RN-O stated they are completed on paper and then they go to ADON-E after they are completed. On 11/14/24 at 7:56 AM, Surveyor interviewed ADON-E. Surveyor asked what documentation is completed after an unwitnessed fall. ADON-E stated that the fall packet is completed. Surveyor asked what is included in the fall packet. ADON-E stated that there are blank statement sheets for staff to fill out as witness statements. Neuro check paper documentation is in the fall packet. A sheet with multiple questions like why the resident fell , what interventions were in place, last time the resident was seen, etc. is included in the fall packet. Surveyor asked where the neuro check documentation is stored after the neuro checks are completed. ADON-E stated that ADON-E or DON-B will collect the completed documentation. Surveyor asked for the documentation of neuro checks for R28. ADON-E stated ADON-E will locate the neuro-check documentation. On 11/14/24 at 8:30 AM, ADON-E returned to Surveyor and indicated that ADON-E was unable to find documentation of R28's neuro-checks after R28's unwitnessed fall on 6/5/24. On 11/14/24 at 10:05 AM, Surveyor interviewed DON-B. Surveyor asked what is expected after a resident has an unwitnessed fall. DON-B stated the nurse should start completing neuro-checks, complete vital signs, complete a head-to-toe assessment, notify the resident's provider and power of attorney if applicable. Surveyor informed DON-B that R28 had an unwitnessed fall on 6/5/24 and the facility does not have evidence that neuro-checks were completed. Surveyor asked if DON-B would expect that documentation of neuro-checks be completed and available. DON-B stated yes. On 11/14/24 at 8:36 AM, Surveyor informed Nursing Home Administrator (NHA)-A that R28 had an unwitnessed fall on 6/5/24 and the facility does not have documentation that neuro-checks were completed. No further information was provided as to why the facility did not complete neurological checks in accordance with policy and procedure for R28 after an unwitnessed falls.

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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 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** 49435 Based on observations, interviews, and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 1of 2 residents (R5) reviewed for pressure injuries. R5, who was assessed to be at risk for pressure injuries, developed a stage 2 coccyx pressure injury on [DATE]. Facility staff did not complete a thorough assessment with measurements of the pressure injury until [DATE]. R5's care plan was not updated with new offloading interventions after the development of the coccyx pressure injury. On [DATE], R5 developed a Deep Tissue Injury (DTI) to R5's right heel. R5's care plan was not updated with new interventions after the development of the right heel deep tissue injury. The facility wound Nurse Practitioner (NP)-G completed weekly assessments of R5's two pressure injuries. On [DATE], NP-G was unable to complete the weekly assessment. The facility Wound Nurse, who is the Assistant Director of Nursing (ADON)-E, completed R5's wound assessment. ADON-E completed measurements but did not complete a thorough assessment that included a thorough description of the wound bed. On [DATE], R5's coccyx pressure injury declined to an unstageable pressure injury. R5's care plan was not updated with new interventions after the coccyx wound worsened. R5 was hospitalized from [DATE] through [DATE] with sepsis related to bilateral parotitis (inflammation and infection of both parotid glands [salivary glands located in front of the ears]). While hospitalized , R5's pressure injuries were both staged as unstageable. R5 was readmitted to the facility on [DATE] on hospice. Facility staff determined that hospice staff would be responsible for assessing and treating R5's pressure injuries. Communication between the facility and hospice staff was not clear. Hospice Nurse, Registered Nurse (RN)-J told Surveyor that RN-J was not aware that RN-J was the only staff member caring for R5's pressure injury. NP-G was no longer involved in R5's care. From [DATE] through [DATE], R5's coccyx pressure injury was not measured, and a thorough assessment was not documented by the facility staff or hospice staff. From [DATE] through [DATE], hospice staff measured R5's heel wound 3 out of the 6 weeks, but a thorough assessment of the pressure injury was not completed. On [DATE], R5 developed a wound to R5's right lateral leg. The facility staff or hospice did not complete an assessment of R5's wound with measurements or a description of the wound bed. RN-J measured the new wound for the first time on [DATE] and determined the wound was a laceration. Facility staff and Hospice staff did not determine the root cause of the new wound to R5's right lateral leg and did not update R5's care plan with new interventions. On [DATE], R5 died while in hospice at the facility. Findings include: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility policy titled, Pressure injury prevention and managing skin integrity with a review date of [DATE], documents, in part: Policy: Prevention measures are put in place to reduce the occurrence of pressure injuries . Risk Assessment: . Based on the individual's Braden Scale Score, pressure reduction interventions will be implemented by nursing and documented in the individual's medical record . Identify Interventions: The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown . Identification of risk factors present or acquired that compromise skin integrity will be considered. Weekly Wound Rounds: Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds. Registered Nurse (RN) or designee will: Conduct weekly skin evaluation. Update the [Primary Care Provider] with any decline in wound appearance, or as necessary. Update the Care plan with any new interventions as applicable . R5 was admitted to the facility on [DATE] with diagnosis that include Chronic Kidney disease, Type 2 Diabetes, Dementia, Stroke history, Encephalopathy and Adult Failure to Thrive. R5's Significant Change Minimum Data Set assessment dated [DATE] documents R5 has a moderate cognitive impairment. R5 is dependent for bed mobility, hygiene cares, and transfers. R5 has a catheter and is always incontinent of bowel. R5 is at risk for pressure injury development but does not have any unhealed pressure injuries. R5's Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE] documents a score of 15 making R5 at risk for developing a pressure injury. R5's potential for pressure ulcer development care plan, with an initiation date of [DATE], documents the following interventions: The resident will have intact skin, free of redness, blisters, or discoloration by/through review date. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. The resident requires pressure reducing mattress on bed and pressure reducing cushion in [wheelchair]. R5's potential impairment to skin integrity care plan, with an initiation date of [DATE], documents the following interventions: Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. Use a draw sheet or lifting device to move resident. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. R5's progress note dated [DATE] documents, in part: Resident was recently hospitalized for [Altered Mental Status] and delirium. Resident was in hospital from ,d+[DATE] to ,d+[DATE]. [By mouth] intake has decreased. Intake was ~75% most meals, intake is now 38% on average. Writer notified [Registered Dietician] of decrease in intake .Resident receives diabetic house supplement [Every day]. Resident has house snack order in the evening for [Diabetes] and will often snack at other times. Resident might be enrolling in hospice after evaluation. No wounds. Surveyor noted R5's meal consumption was significantly decreased, hospice was being considered due to R5's health decline, and R5 did not have any wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R5's progress note dated [DATE] at 11:27 AM documents: This writer informed that resident had an open area to her coccyx. writer updated resident's daughters and house Nurse Practitioner. Resident will be put on wound rounds to be seen by wound NP on [DATE]. Surveyor reviewed R5's Electronic medical record and did not locate an assessment that included measurements or a thorough description of the coccyx wound bed. Surveyor noted that a comprehensive assessment of R5's coccyx pressure injury was not completed by facility staff on the day the coccyx pressure injury was found. R5's initial Wound Evaluation completed by NP-G dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer) Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 1 x 0.7 x 0.1 cm . Plan: Cleanse with [Normal Saline] or wound cleanser, then apply skin prep to the peri wound and cover with bordered foam. Change 3 [times]/week. Continue offloading measures. Surveyor reviewed R5's MD orders. Surveyor noted that the treatment for R5's coccyx wound was entered as a MD order on [DATE]. On [DATE], R5's potential impairment to skin integrity care plan focus was updated with stage 2 open area to coccyx. Surveyor noted the only offloading measures on R5's care plan was an air mattress and cushion in wheelchair. No additional offloading measures like turning and repositioning were implemented after the development of the coccyx pressure injury. On [DATE] 08:26 AM Surveyor interviewed Certified Nursing Assistant (CNA)-F. Surveyor asked what CNA-F would do if CNA-F identified a new wound on a resident. CNA-F stated that CNA-F would report it to the nurse. Surveyor asked if CNA-F was familiar with R5's wound care. CNA-F stated that CNA-F would reposition R5 every 2 hours. CNA-F stated that staff would float R5's heels when R5 was in bed. CNA-F stated aside from that, the nurses took care of the wound care. On [DATE] at 8:04 AM, Surveyor interviewed Registered Nurse (RN)-H. Surveyor asked if RN-H could explain what a nurse should do if a new wound is found on a resident. RN-H stated that RN-H would measure and assess the wound. RN-H stated that not all nurses would do this because they are not all comfortable, but RN-H stated that she would definitely measure and assess the wound. RN-H would call the MD, Risk management team and the Power of Attorney, if applicable. RN-H would put the resident on the 24-hour board and implement an intervention. RN-H stated that it depends on the wound, but would implement repositioning, floating heels, etc. depending on where the wound was found. RN-H stated after finding a wound, the resident would be included in the weekly wound rounds. Surveyor asked if RN-H was familiar with R5 and the development of R5's pressure injuries. RN-H stated that the facility had been speaking with R5's family and they were talking about hospice before the wounds developed. RN-H stated R5's family were not agreeable to hospice in June or July of this year. RN-H stated that staff were implementing repositioning and propping up R5's heels as interventions after R5's wound developed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:41 AM, Surveyor interviewed ADON-E. Surveyor asked what the process is when a nurse finds a new wound on a resident. ADON-E indicated the nurse should measure the wound, cover the wound and report it to the MD, Power of Attorney, and the management team. ADON-E stated that the resident would be added to the weekly wound rounds and the NP would do a thorough assessment of the wound and recommend treatment. Surveyor asked what interventions were in place to prevent the development of a pressure injury for R5. ADON-E stated that R5 was on an air mattress, had a cushion on R5's chair and stated R5 was always using a blue floater pillow for floating R5's heels. Surveyor asked if those interventions should be listed on R5's care plan. ADON-E stated yes. On [DATE] at 8:18 AM, Surveyor interviewed Director of Nursing (DON)-B and Clinical Nurse Coordinator (CNC)-D. Surveyor asked what the process is when a nurse finds a new wound on a resident. DON-B stated the nurse should do an assessment, notify the doctor, power of attorney and wound care nurse (ADON-E). Surveyor asked what the initial assessment should include. DON-B indicated the wound should be measured and have a description of the wound bed including the surrounding skin, drainage, and odor. DON-B stated that an intervention should be placed to address the area of concerns. Surveyor noted that staff stated that turning and repositioning, as well as floating heels was possibly implemented but the interventions were not present on R5's care plan so that all staff caring for R5 were aware of plan. R5's MD order dated [DATE] documents: Reduced sugar House supplement between meals twice daily. R5's Wound Evaluation completed by NP-G dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 1.5 x 3.0 x 0.1 cm . Status: deterioration. Plan: Cleanse with [Normal Saline] or wound cleanser, then apply skin prep to the peri wound and cover with bordered foam. Increase frequency of changes to daily and [as needed]. Continue offloading measures. Surveyor reviewed R5's MD orders and noted that the frequency of dressing changes was updated to daily and [as needed]. On [DATE], R5's potential impairment to skin integrity care plan was updated with the following intervention: [Treatment] per MD order. Surveyor noted no additional offloading measures like turning and repositioning were entered on R5's care plan after the coccyx pressure injury deteriorated. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 0.2 x 0.8 x 0.1 cm . Continue offloading measures. Right lateral heel (DTI). Absorbing fluid filled blood blister measuring 5 x 7.5 x UTD cm . Status: New. Plan: Apply skin prep followed by ABD pad and secure with kerlix, change 3 [times]/week. Prevalon boot to be worn whenever in bed. Surveyor noted the coccyx wound improved and the treatment remained the same. Surveyor noted R5 developed a new pressure injury to R5's right lateral heel. Surveyor reviewed R5's MD orders and noted the treatment for R5's right lateral heel wound was entered as a MD order on [DATE]. (continued on next page)

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	525524	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE], R5's potential impairment to skin integrity care plan focus was updated with DTI to right lateral heel. Surveyor reviewed R5's Care plan and noted that no new interventions were placed after R5 developed the new pressure injury to R5's Right heel. Surveyor noted NP-G recommended a Prevalon boot to be worn whenever in bed and this intervention was not added to R5's care plan. On [DATE] at 10:41 AM Surveyor interviewed ADON-E. Surveyor asked about interventions for R5's heels. ADON-E stated that ADON-E believed that R5 had a Prevalon boot in place. Surveyor asked if that intervention should be listed on the care plan. ADON-E stated yes. Surveyor informed ADON-E that R5's care plan was not updated with an intervention after R5 developed the heel pressure injury and after NP-G recommended a Prevalon boot. ADON-E stated, I remember, it was there. On [DATE] at 8108 AM, Surveyor interviewed DON-B. Surveyor about R5's right heel pressure injury. Surveyor asked if interventions that the wound NP recommends should be added to R5's care plan. DON-B stated that repositioning and floating of heels should have been added to R5's care plan. DON-B indicated that after the heel injury developed, the Prevalon boot should have been added to R5's care plan as directed by NP-G. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 0.8 x 1.8 x 0.1 cm . Status: deteriorating . Continue offloading measures. Right lateral heel (DTI). Absorbing fluid filled blood blister measuring 5 x 5.5 x UTD cm . Prevalon boot to be worn whenever in bed. Avoid use of shoes. Surveyor noted R5's coccyx pressure injury deteriorated. Surveyor noted the treatment remained the same and no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury improved. Surveyor noted NP-G added that R5 should avoid the use of shoes. Surveyor reviewed R5's care plan and noted that this intervention was not added to R5's care plan. R5 had wound evaluations completed on [DATE] and [DATE]. Surveyor noted both of R5's pressure injuries were documented as improving. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 1.0 x 0.3 x 0.1 cm . Status: deterioration . Continue offloading measures. Right lateral heel (DTI). Blood blister evolved to an eschar measuring 3.8 x 4.2 x UTD cm. Eschar is intact/adherent and without fluctuance . Plan: Apply betadine daily, leave [Open to air]. Prevalon boot to be worn whenever in bed. Avoid use of shoes. Surveyor noted R5's coccyx pressure injury deteriorated. Surveyor noted the treatment remained the same and no additional offloading interventions like turning or repositioning were added to R5's care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted R5's right lateral heel pressure injury improved. Surveyor noted Prevalon boots and that R5 should avoid use of shoes was documented again by NP-G. Surveyor noted that neither of these interventions were added to R5's care plan. R5's progress note dated [DATE] at 12:49 PM documents, in part: . wound NP was not in house today, but this writer did see resident's wound and did treatments. treatment in place in [electronic medical record], staff will continue to follow [plan of care]. On [DATE] at 10:41 AM, Surveyor interviewed ADON-E about wound rounds on [DATE]. ADON-E stated that it was over Labor Day weekend an ADON-E completed the assessments on R5. Surveyor informed ADON-E that Surveyor could not find any documentation in R5's medical record indicating the measurements and assessment of R5's pressure injuries. ADON-E stated that ADON-E has the assessment on paper in ADON-E's office. ADON-E returned to Surveyor with a one-page spreadsheet of all the wounds that ADON-E assessed on [DATE]. ADON-E's documentation of R5's pressure injuries dated [DATE] documents: Coccyx 1.5 x 1.8. Right heel 2. 8 x 2. Surveyor noted ADON-E's documentation did not include a comprehensive assessment on R5's pressure injuries. Surveyor noted both the coccyx pressure injury and the right lateral heel pressure injury deteriorated. Surveyor noted the treatment remained the same to both areas and R5's care plan was not updated with new interventions. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer evolved to unstageable). Full thickness wound with 100% slough at the base. Wound measuring 2.5 x 1. 5 x UTD cm . Status: deterioration. Plan: Cleanse with [Normal Saline] or wound cleanser, then apply skin prep to the peri wound medihoney to the base of the wound followed by Alginate and cover with bordered foam, change daily and [As needed]. Continue offloading measures. Right lateral heel (DTI). 100% eschar measuring 5 x 6 x UTD cm . Eschar is intact/adherent and without fluctuance . Prevalon boot to be worn whenever in bed or use of heels up cushion. Avoid use of shoes. Surveyor noted the coccyx pressure injury deteriorated and was staged as unstageable. Surveyor noted the treatment to the coccyx was changed and a new MD order for treatment was placed in R5's electronic medical record. Surveyor noted no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury treatment remained the same. Surveyor noted that NP-G's documentation included Prevalon boot or the use of heels up cushion and that R5 should avoid the use of shoes. Surveyor noted that none of these interventions were added to R5's care plan. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer evolved to unstageable). Full thickness wound with 100% slough at the base. Wound measuring 2.5 x 2. 0 x UTD cm . Status: deterioration. Continue offloading measures. Right lateral heel (DTI). 100% eschar measuring 5 x 6 x UTD cm. Eschar is intact/adherent with slight lifting at the margins, without fluctuance. Prevalon boot to be worn whenever in bed or use of heels up cushion. Avoid use of shoes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that R5's Coccyx pressure injury deteriorated, and the treatment remained the same. Surveyor noted no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury treatment remained the same. Surveyor noted that NP-G's documentation included Prevalon boot or the use of heels up cushion and that R5 should avoid the use of shoes. Surveyor noted that none of these interventions were added to R5's care plan. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer evolved to unstageable). Full thickness wound with 100% soft light brown necrotic tissue at the base. Wound measuring 7 x 4.0 x UTD cm . Continue offloading measures. Right lateral heel (DTI). 100% eschar measuring 4 x 6 x UTD cm. Eschar is intact/adherent with slight lifting at the margins, without fluctuance . Prevalon boot to be worn whenever in bed or use of heels up cushion. Avoid use of shoes. Surveyor noted R5's Coccyx pressure injury deteriorated from 2.5 x 2 to 7 x 4 in one week. The treatment remained the same and no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury treatment remained the same. Surveyor noted that NP-G's documentation included Prevalon boot or the use of heels up cushion and that R5 should avoid the use of shoes. Surveyor noted that none of these interventions were added to R5's care plan. R5's progress note dated [DATE] at 12:02 PM documents, in part: [By mouth] intake has decreased to ~25%. At the time of last nutrition assessment 3 months ago, PO intake was 38% on average. R5's progress note dated [DATE] at 3:33 PM documents: Resident was transferred to [name of local hospital] today via ambulance accompanied by EMT due to lethargy, poor appetite, and critical labs. The ADON and family updated. R5 was admitted to the hospital from [DATE] through [DATE] with Severe sepsis in setting of bilateral parotitis. While hospitalized , R5 had an x-ray completed of R5's right lower extremity and Vascular Surgery visited R5. R5's X-ray results dated [DATE] documents a final result of: suspicious for osteomyelitis given overlying wound. R5's Vascular Surgery Consult dated [DATE] documents, in part: [R5] with functional decline and poor [by mouth] intake in the past 4 months who is bed/wheelchair bound at this point . The heel wound appears to be a pressure wound . The eschar is hard and well adhered to the heel. Given these findings of the heel wound, no surgical debridement is recommended . Suggestion of osteomyelitis on [x-ray]- it is highly unlikely that this is contributing to [R5's] [altered mental status] and overall deconditioning . Given the patient's age, multiple co-morbidities and her current altered status with sepsis that is being treated, no surgical intervention is recommended . Recommend heel off-loading shoe. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted Vascular Surgery signed off on R5's care and noted that R5 should have a heel off-loading shoe. R5 was readmitted to the facility on [DATE] with hospice care. R5's progress note dated [DATE] 2:34 PM documents, Hospice will take over wound care for resident [related to] hospice services. On [DATE], R5's potential impairment to skin integrity care plan focus was updated with Hospice will do all wound care on admission to hospice. Surveyor noted that a heel off-loading shoe was not placed as an intervention as recommended by the Vascular Surgery MD. Surveyor reviewed R5's electronic medical record and did not locate any measurements or assessments of R5's wound from [DATE] until [DATE]. R5's progress note dated [DATE] 10:15 PM documents, in part: An open area noted to resident [right] lateral leg. No bleeding noted. Dressing applied. No s/s of infection noted. ADON and hospice updated. Message left for family to call facility for update. Surveyor reviewed R5's electronic medical record and did not locate any further documentation of the new right lateral leg wound including measurements and a comprehensive wound bed assessment. R5's care plan was not updated with this new wound and a new interventions was not place. Surveyor noted a wound treatment with a start date of [DATE] was put in place for the right lateral leg wound and staff were completing treatments for this new wound. On [DATE] at 10:41 AM Surveyor interviewed Assistant Director of Nursing (ADON)-E. Surveyor asked what the plan was for R5's wound care after R5 returned to the facility on [DATE]. ADON-E stated that the hospice nurse, RN-J, told ADON-E that RN-J would complete all R5's wound care needs. ADON-E stated that RN-J would do all the dressing changes and assessments. If needed, the facility staff would fill in the gaps when RN-J was not in the facility on the weekends. Surveyor asked ADON-E if hospice was completing the assessments of R5's wounds. ADON-E stated that no assessments or measurements were in the electronic health record, but ADON-E reached out to the hospice company on [DATE] to get the documentation of the assessments. ADON-E stated that hospice did not have the documentation and stated that they did not document on the wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:27 PM, Surveyor interviewed RN-J, the hospice nurse, regarding R5's wound care. RN-J stated that RN-J remembered having a conversation about completing R5's wound care with the Director of Nursing (DON)-B. RN-J stated that RN-J remembers saying that RN-J would complete the wound care treatments and take care of any MD orders associated with R5's wound care. RN-J stated that RN-J was not aware that RN-J was the only staff member who would be getting measurements of the wounds or assessing the wounds. RN-J stated that in other facilities, RN-J will work with the Wound Doctor or Nurse Practitioner. RN-J stated that during the conversation, RN-J recommended that DON-B follow up about having the facility Wound Nurse Practitioner (NP)-G continue to follow R5's wounds. Surveyor asked about the wound that developed on [DATE]. RN-J stated that the wound was not a pressure injury, but it was a laceration. Surveyor asked if it was a laceration, how the laceration occurred. RN-J stated that it could have happened from a transfer or from a pillow. RN-J was not sure how the injury happened but stated again that it was a laceration/skin tear not a pressure injury. RN-J stated that RN-J did get measurements of the laceration when she did an assessment on [DATE], but that was the first-time measurements were completed. Surveyor asked if hospice or the facility determined the cause of the new wound. RN-J was not sure if a cause was identified. Surveyor asked if any measurements or assessments were completed on R5's pressure injuries/wounds from [DATE] through [DATE]. RN-J gave the following assessment information from RN-J's notes: [DATE]- Coccyx unstageable pressure injury was not measured or assessed. Right heel pressure injury was unstageable and measured 7 x 5.5 cm. Wound had eschar and was moist with red, pink, and black areas. Small amount of drainage. Right lateral leg laceration measured 7 x 1.5. Wound had a small amount bloody drainage and was moist with red and pink wound bed. [DATE]- Coccyx unstageable pressure injury was not measured. Facility RN was doing wound care, so RN-J looked at the wound and documented the coccyx wound to be moist with red, pink, and yellow areas. Small amount serosanguineous drainage. Right heel unstageable pressure injury measured 7.5 x 4.5 cm. Moist, black with no drainage. Right lateral leg laceration measured 8 x 3.5. Wound was pink and yellow with a small amount of tan drainage. [DATE]- Coccyx unstageable pressure injury was not measured or assessed. Right heel unstageable pressure injury measured 7.5 x 4.5 cm. Dry. Black. No drainage. Right lateral leg laceration measured 8 x 3. 5 Clean. Wound was scabbed and edges were attached. No drainage was noted. Surveyor asked if there were any changes that were made to R5's MD orders regarding treatment of the pressure injuries. RN-J stated that R5 already had previous treatment orders in place before R5's hospitalization and those treatment orders continued the entire time RN-J cared for R5's wounds. RN-J stated that RN-J was more focused on R5's comfort. RN-J stated that R5 was not eating or drinking so the pressure injuries were not going to heal but RN-J wanted to make sure that R5 was comfortable. Surveyor asked what interventions were in place for R5's skin integrity. RN-J stated R5 had the following interventions on the hospice care plan: Air mattress. Incontinent care. Assess skin and pressure areas. SNF (skilled nursing facility) to perform wound care. Surveyor asked if RN-J's hospice care plan included any offloading measures for R5. RN-J stated that RN-J remembers R5 having a pillow offloading her coccyx area. RN-J stated that RN-J was not sure if R5 was turned every 2 hours because that would be the facility staff responsibility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that the facility communication of the wound care plan was not communicated clearly to RN-J. Surveyor noted that none of the wound measurements given to Surveyor in the interview with RN-J were located anywhere within R5's electronic medical record. Surveyor noted that without facility and hospice staff knowing the status of R5's wound, staff would not be able to tell if the wounds were deteriorating or not. Surveyor noted that the new wound on R5's Right lateral leg was designated a laceration by RN-J. Surveyor noted that a treatment was put in place but there was not a root cause analysis completed for the [DATE] wound. Surveyor noted that the right lateral leg wound was not thoroughly assessed or measured until 5 days after its development and was not thoroughly assessed or measured weekly. R5's care plan was not updated with a new intervention after the development of this new wound. Surveyor noted that R5's Coccyx pressure injury was not assessed or measured after R5 was placed on hospice. Surveyor noted that R5's Right heel pressure injury was not assessed on admission to the facility. The right heel was not assessed or measure from [DATE] through [DATE]. The [DATE] assessment completed by RN-J did not include a thorough wound bed assessment including the percentage of eschar, slough, or granulation tissue present. The right heel was not assessed or measured from [DATE] through [DATE]. The [DATE] and the [DATE] assessment completed by RN-J did not include a thorough wound bed assessment including the percentage of eschar, slough, or granulation tissue present. On [DATE] at 9:12 AM, Surveyor interviewed NP-G. NP-G stated that NP-G initially saw R5 after R5 developed a coccyx/sacral pressure injury and cared for R5 until R5 went on hospice. NP-G stated that R5's overall condition was declining and R5 was refusing oral intake. Surveyor asked if NP-G knew what interventions were in place to prevent a pressure injury from developing. NP-G stated that R5 was on an air mattress and believed that R5 had other offloading interventions as well. NP-G stated that NP-G did not expect R5's wounds to heal. NP-G stated that wounds do not heal with poor nutrition. NP-G stated that the facility and R5's family had discussions about hospice care, but the family did not agree to that. NP-G stated that NP-G talked to R5's family about Arterial studies and more aggressive care after R5 developed the Right heel pressure injury, but the family was not agreeable to an aggressive plan. NP-G stated that the goal was limit the risk of infection and continue with treatments on the pressure injury areas. NP-G stated on [DATE] when R5 was transferred to the hospital, R5 had taken a fast downward spiral. NP-G stated R5 was not acting like herself. NP-G stated when R5 returned to the facility NP-G was no longer involved in R5's care. Surveyor asked if R5's wound care and assessments schedule would need to change since R5 was on hospice. NP-G stated that taking care of R5's wound would be no different if R5 was on hospice or not. NP-G stated that you still need to do assessments and change treatments as needed while a resident is on hospice. NP-G stated that at other facilities, NP-G continues to care for resident's wounds even when the resident is put on hospice. NP-G did not know why the decision was made for hospice to care for R5's pressure injuries. On [DATE] at 11:08 AM, Surveyor interviewed Nursing Home Administrator about R5's wounds after R5 was placed on hospice. NHA-A indicated that NHA-A did not like that R5's wound care assessments and measurements were missed. NHA-A stated that NHA-A was not happy with the hospice care team. NHA-A indicated that NHA-A had spoken to t[TRUNCATED]

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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** 42037 Based on observation, interview, and record review, the facility did not ensure the safety of 3 of 4 residents (R25, R28, and R2) reviewed for accidents. *R25 sustained 5 unwitnessed falls including a fall with a left femur fracture at the facility on 10/13/24. R25 was observed on survey to not have adequate supervision in effort to prevent additional falls or accidents for R25. The facility did not complete root cause analysis for each fall to develop interventions to prevent future falls. *R28 did not receive adequate supervision or assessment by the facility regarding their ability to smoke independently. *R2 sustained a fall that was not thoroughly investigated by the facility. *Facility staff did not ensure medications were safely stored on 1 of 2 units reviewed for medication administration and storage. Findings include: 1.) R25 was admitted to the facility on [DATE] with diagnoses of dementia, psychotic disturbance, and mood disturbance. R25's 6/11/24 quarterly Minimum Data Set (MDS) documents R25 does not have any behaviors, including refusal of cares. R25 is assessed as requiring supervision for going from a sitting to standing position, and transfers. R25's Brief Interview for Cognitive Status (BIMs) indicates a score of 02 indicating severe cognitive impairment. R25's annual Minimum Data Set (MDS) dated [DATE] also documents R25 has no behaviors including refusal of cares. R25 is assessed as requiring supervision for going from a sitting to standing position, and transfers. The facility identified R25 to be at risk for falls with a fall risk assessment score of 15 on 6/27/24. A score of 10 or greater indicates high risk. R25's 10/13/24 and 10/15/24 fall risk assessments scored a risk score of 8 indicating R25's fall risk had actually decreased despite multiple falls and a fall with major injury. R25's 10/20/24 fall risk evaluation scores R25 at a 7 and the 10/28/24 evaluation scores R25 at a risk value of 15 again indicating high risk for falls. R25's Care plan initiated and revised on 5/8/23 has a focus area of: The resident has had an actual fall with major injury Poor Balance (sic), Unsteady (sic) gait, dementia. The goal initiated 5/8/23 and revised on 9/22/23, 9/23/23 and 10/21/24 is for the resident's right fractured wrist to resolve without complication by due date. An additional goal indicates initiated on 5/8/23 with revision on 10/31/24 to have (R25's) left hip fracture resolve without complications by the review date. The target date is 1/28/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions include: 5/8/23 - continue interventions on the at-risk plan. 6/28/24 - Fall: 6/27/24: give resident pull-ups instead of briefs 8/26/24 - fall intervention 8/24/24: offer assistance with getting up. 5/8/23 - Monitor/document/report PRN (as needed) x (times) 72h (72 hours) to MD (medical doctor) for s/sx (signs/symptoms): pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. 5/8/23 - Neuro-checks x 3 days 5/8/23 - Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound. 5/8/23 - PT (physical therapy) consult for strength and mobility. 5/16/23 - Resident will be on a toileting schedule due to attempts to self-ambulate to restroom - RESOLVED 6/27/24. R25's plans of care reference for R25: Staff to assist with routine toileting and skincare for incontinence - initiated 5/8/23, revised 11/13/24 Staff to assist with turning and repositioning - initiated 5/8/23, revised 11/13/24 R25's care plan for incontinence references bowel incontinence with no reference to urine continence status: Check resident every two hours and assist with toileting as needed - initiated 5/15/23 Observe pattern of incontinence, and initiate toileting schedule if indicated - 5/15/23 Provide pericare after each incontinent episode - 5/15/23 R25's activities of daily living (ADLs) care plan documents for interventions: Toilet use: independent - initiated 5/8/23, revised on 6/21/24 Transfer: Independent - initiated 5/8/23, revised on 6/21/24 On 11/12/24, Surveyor requested the last three months of fall investigations for R25. R25 sustained falls on 8/24/24, 10/13/24, 10/20/24, 10/25/24 and 10/28/24. (continued on next page)

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	525524	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anne's Salvatorian Campus	3800 N 92nd St Milwaukee, WI 53222

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R25's fall investigation report dated 8/24/24 indicates this was an unwitnessed fall. Other information documents: self-transfers and ambulates without assistance, unaware of own safety needs. The report documents R25 requires assistance with ambulation. Predisposing physiological factors identified include confusion, impaired memory, none is checked, along with weakness/fainting. Notes document: Writer was called into Res. (resident) room by CNA (Certified Nursing Assistant) @ (at) 0845 as Res. Was sitting on the floor in front of her bed. Res. Stated she had tried to get into her W/C (wheelchair) and slid off the bed. Denies injury. Denies pain/discomfort. R.O.M. (range of motion) WNLS (within normal limits) VSS (vital signs stable) & documented in AOD. Assisted to standing position with gait belt and assist of 2 staff members then assisted into he (sic) W/C. Neuro checks thus far this shift have been negative. Res. Refuses help with cares, transfers, mobility and toileting. (Name of Nurse Practitioner [NP]) called and updated on above, NNO (no new orders). Intervention: offer assistance to (sic) with getting out of bed. Surveyor noted the fall investigation indicates R25 refuses assistance however, the identified intervention is to offer assistance. Surveyor also noted the fall data collection tool dated 8/14/24 indicates R25 did not use her call light prior to the fall. The intervention does not identify how staff are to supervise R25 to offer the assistance identified as an intervention. The unwitnessed fall report dated 10/13/24 includes for an incident description: 05:42 Resident had an unwitnessed fall during shift. Resident is alert and able to make needs known. No apparent injuries noted from fall, neuro checks negative, ROM WNL, VS (vital signs) stable. Call placed out to hospice, POA (power of attorney) and (name of medical group) updated. Text messages sent to both ADON (Assistant Director of Nursing) and DON (director of Nursing). Offers no c/o (complaints of) pain or discomfort. Writer (sic) was notified by CNA that resident was found sitting upright on the floor in room in front of bed. Mental status: oriented to person, oriented to situation. Injury type: No injuries observed post incident. Predisposing physical factors: none. Predisposing Physiological factors: checked is confusion, gait imbalance, impaired memory, weakness/fainted. Predisposing situational factors identified include other(describe). Other info (information) documents poor judgement. Statements taken indicate just the staff person creating the report. The section of the report to document vitals only documents a pulse of 78 and pain level of 0; other vitals have none entered. The report documents other weights and vitals current in this shift with no time specified. These vitals indicate R25's blood pressure was 150/92 and was flagged as a high blood pressure. Pulse was 100, blood sugar and height: non entered, O2 (oxygen sats (saturations): 98 on room air, 0 for pain level. Progress notes document: 10/13/24, 07:15: Nurse's Note: Note text: Resident had an unwitnessed fall during sift. Resident is alert and able to make needs known. No apparent injuries from fall, neuro checks negative, ROM WNL, VS stable. Call placed out to hospice, POA, and (name of medical provider) updated. Text messages sent to update both ADON and DON. Offers no c/o pain. 10/13/24, 16:36 (4:36 pm), note text: Resident is alert and oriented. She is not able to bear weight on her left foot following the fall. The right upper leg is swollen. She is reporting much pain in the leg. Morphine was administered for the pain. (Name of hospice group) triage nurse was notified. POA notified. They have decided that resident wait for a hospice nurse to assess her in 2 hrs. (hours) who will then decide if she needs mobile x ray. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/13/24, 16:51 (4:51 pm) note text: Her blood pressure is also high. 10/13/24, 21:18 (9:18 pm) - hospice note - note text: Res found sitting at the side of her bed this morning at 0542. She has been demonstrating pain in her LLE (left lower extremity) per staff since then and has not been using her legs to self-propel her w/c. Upon arrival res is in the hallway with (family) She was given prn morphine for pain. She has no foot pedals because she propels with her feet. Her (name of POA) pulled the w/c backwards to her room as she was unable to keep her feet up. Res speech is difficult to understand which is normal per (POA family member). Writer discussed treatment options with them. They do not wish to send res to ER and have no intentions on pursuing aggressive treatment should there be a fracture, but they still want x-rays done. They are in agreement to have mobile Xray come to the facility tomorrow. Staff assisted res into bed for assessment. Res able to lift her buttocks off the bed to remove her pants. Stated pain was minimal until writer attempted to have her raise her foot up and bend her knee toward her waist. She had facial grimacing and guarding. Limited ROM to LLE. Difficult to determine rotation or shortening as she has difficulty keeping her legs flat. No abnormalities palpated but there is swelling in her upper thigh and left hip. RLE (right lower extremity) no discomfort or ROM limitations. Spoke with (name of). She will update the NOC (nights) RN (Registered Nurse) when she come in and they will monitor pain and use prn morphine as needed. SN (shift nurse) to call (name of family member) when x-ray results are available. 10/14/24, 06:39 - nurse's note - note text: F/U (follow up) UWF (unwitnessed fall) and right foot wound . neuro checks negative., slept through the night, no SOB (shortness of breath) or distress noted, minimal swelling noted to left hip, vss, denies pain or discomfort when asked. 10/14/24, 13:06 (1:06 pm) - nurse's note - note text: F/U UWF: Res assessed earlier in shift by writer: Alert and c/o pain to L (left) hip/leg area. Unable to move L leg. Writer called x-ray and inquired about if x-ray results for L-hip/femur leg were complete. X-ray stated not ordered. Writer ordered STAT x-ray to L-hip, L-femur, L-knee, LLE, & foot DX (diagnosis) f/u fall, pain & swelling to area. Res was medicated with 20 mg (milligrams) of MS (morphine sulfate). (Name of medical group) APNP (Advanced Practice Nurse Practitioner) (name of) here and aware. X-ray obtained and showed L-femur intertrochanteric FX (fracture). (Name of hospice group/name of staff) called and updated. (Name of staff) stated she will update hospice MD and POA and report possible orders to writer . R25 was non weight bearing post fracture. Surveyor noted the fall information for R25's 10/13/24 fall does not include a root cause analysis or details to show what R25 was doing prior to the fall. Surveyor noted the fall on 8/24/24 included many of the same identified predisposing physiological factors that contribute to R25 falling but were not assessed further or addressed to help prevent R25's 10/13/24 fall. The fall intervention dated 8/26/24 is for staff to offer assistance to R25 to get up from bed. The fall details do not indicate if this was offered to R25 or what staff were doing regarding supervision to be able to implement this intervention when R25 wanted to get up from bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R25 fell on [DATE] with the unwitnessed fall report documenting a time of 15:30 (3:30 pm). Incident description documents: Resident was found by writer on the floor next to wheelchair lying on her back, resident was assessed, no noted injuries, alert and awake. A&O (alert & oriented) to self. 139/89, 100, 97.6, 16 RR (respirations), 94% and resident stated she has no pain. Resident stated she was trying to get in bed, no call light on, and resident was dry. Resident had on one gripper sock on left foot right foot open to air. DON updated at 3:40 pm. Hospice on call nurse called at 3:51 pm (name of) no new orders await call back on 1/21/24 for regular hospice nurse. POA (name of) called and updated at 3:35 pm. Immediate action taken assessed for pain/injuries, called hospice with updates, vitals checked. No injuries noted at time of incident. Mobility is identified as wheelchair bound. Mental status is oriented to person. No predisposing environmental factors identified. Predisposing physiological factors documented include confusion, gait imbalance, impaired memory, and weakness/fainting. Surveyor noted these are the same predisposing physiological factors identified on R25's last two previous falls. Predisposing situation factors documents: none along with improper footwear, ambulating without assist. Notes within the unwitnessed fall report include details as documented in the description. Added documentation includes Intervention: Assist resident with getting into bed. Surveyor noted R25 has a previous intervention to offer assistance with getting up from bed. Both interventions do not include what the level of supervision should be to ensure this intervention is implemented as R25 has not demonstrated use of the call light during previous falls and R25 has a known history of self-transferring. Surveyor noted this fall is 7 days post R25's last fall with a resulting hip fracture and non-weight bearing status. Review of R25's actual fall care plan does not include this identified intervention as being added to the plan of care. Review of the fall data collection tool dated 10/24/24 documents for the question what should we do to try to decrease the incident of another fall or at least prevent an injury? Educate is documented by staff. There is no indication R25 was educated about her risks related falling. Surveyor noted R25 has a BIMs of a 2 and staff document R25 is only oriented to herself. R25's Significant Change MDS (Minimum Data Set) assessment dated [DATE] indicated R25 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 2 and required extensive assistance with bed mobility and transfers. On 10/25/24 at 11:45 am R25 had another unwitnessed fall. The incident description documents: Res found by (name of housekeeper) lying on the floor of her bathroom. Res states she was trying to get on the toilet. Neuro check negative. VSS. Resident denied LOC (loss of consciousness). Denied pain/discomfort. Assisted from floor to w/c with assist of 2 and gait belt NWB (non-weight bearing) maintained to LLE. Res wearing slippers. Intervention was to wear non-skid socks. DON CM (case manager) updated on above. (Name of hospice) case manager (name of) called by writer and updated on above. (Name of CM) stated that she will update the family and MD on above. (Name of CM) stated that she will come to the facility for a res visit also stated she will order gripper socks for her. Residential (sic) stated she wanted to use the toilet. Immediate action taken documents: Resident unable to sit on toilet. Incontinent care was given. Non-skid slippers also. (sic) initiated. Resident also monitored in a supervised area. Mental status indicates R25 was oriented to person, situation and place at the time of the fall. No injuries observed post fall. Predisposing environmental factors checks other (describe) no description of the environmental factor is documented. Predisposing physiological factors documented is incontinent. Predisposing situation factors identified are improper footwear and other with other info documented as unable to self-transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A note dated 10/25/24 in the unwitnessed fall report documents details as above however it also documents Intervention: Assist resident with toileting/toileting schedule. Surveyor review of R25's care plan does not include the referenced interventions of non-skid footwear, monitor in a supervised area and assist with toileting were not added to R25's care plan. Surveyor noted the intervention to monitor n a supervised area is the first reference to supervision for R25 despite multiple falls. Surveyor also noted the intervention for R25 to be on a toileting program had been a previous intervention that was resolved on 6/27/24. The post fall data collection tool dated 10/25/24 documents R25 had a last wellness check at 9:45 am and was last toileted at 10:00 am. The fall occurred at 11:5 am. The answer to the question of what we should do to try to decrease the incident of another fall or at least prevent injury documents non-skid footwear. A 10/28/24 23:28 (11:28 pm) unwitnessed fall report documents for incident description: Resident found lying on the floor on her back in her room. She stated she was trying to get up and fell off of the chair. Resident stated she hit the top of her head on the floor. Swelling noted, but resident denies any pain. Assisted to bed by Hoyer lift. Hospice updated; hospice nurse visited the resident. She stated she should just be monitored . Immediate action taken documents: Assisted to bed by Hoyer lift. Hospice updated; hospice nurse visited the resident. She stated resident should just e monitored. R25's mental status at the time of the fall is oriented to person and place. No injuries noted post incident. No predisposing environmental factors are identified. Predisposing physiological factors include confusion, gait imbalance, impaired memory, none, weakness/fainting. Predisposing situation factors include ambulating without assist. A note dated 10/28/24 in the unwitnessed fall report documents details as above. The note includes an intervention: For no apparent reason acute injury, determine and address causative factors of the fall. Additional note dated 10/29/24: IDT (interdisciplinary team) review: bed in the lowest position. Continue current interventions. Continue Q (every) 2-hour checks for safety. Surveyor noted this was documented by Nursing Home Administrator (NHA)-A. Surveyor noted this is the first reference to R25 receiving supervision every 2 hours. Surveyor noted having R25's bed in the lowest position is not included as an intervention on R25's care plan. The post fall data collection tool dated 10/28/24 documents the time of the fall as being 22:00 (10:00 pm). For the question was there anything different about the resident prior to the fall (change in transfer status, ambulation status, cognitive status)? No is documented. However, checked is gait, cognitive, and decrease in transfer or ambulate from baseline. The data tool documents the last wellness check as being at 21:30 (9:30 pm). Last time the resident was toileted is blank. R25 was continent. Why do you think the resident fell ? Staff document she was trying to walk. The question what should we do to try to decrease the incident of another fall or at least prevent injury? Documented is Resident should be encouraged to call for help. Surveyor noted the call lights was not activated by R25 for this fall as it was also not activated in previous falls. Surveyor also noted R25 has an extreme cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note dated 10/28/24 documents received a message from (initials of staff) that pt (patient) had a fall out of w/c in her room near doorway. Unwitnessed. At approximately 2000 (8:00 pm) and pt states she hit her head, arrived to pts room. Pt restless, had gown off. Stated she needed to go to the bathroom. Pt placed on bedpan. Pt has bump to frontal area of head. Area soft and squishy. Redness noted. No bruising at the time of assessment. No other injuries noted during assessment. Ice applied. Recommend medicating pt prior to cares and movement. Facial grimacing noted with turning. Pt did deny pain . Will order scoop mattress, fall mat and broad (sic) chair per facility request. Surveyor noted these interventions were not added to R25's care plan that was presented to Surveyor during the survey. On 11/13/24 at 8:20 AM, 8:30 AM, 8:45 AM, 8:55 AM, 9:05 AM, 9:15 AM and 9:35 AM Surveyor observed R25's room door to be closed. Upon knocking and entering R25's room No staff were noted to be present and R25 was found to be unsupervised in her room with her door closed. Surveyor noted previous referenced intervention to monitor R25 in a supervised area was not being implemented. Surveyor also noted all of R25's falls occurred in R25's room when not supervised. On 11/14/24 at 10:10 AM, Surveyor conducted an interview with DON (Director of Nursing)-B. Surveyor asked DON-B if R25 is at risk for falls. DON-B responded that they do recall R25 falling and sustaining a fracture before. Surveyor asked DON-B if a resident who is at risk for falls should be unsupervised in their room with the door closed. DON-B told Surveyor that it would depend what the resident's care plan says. Surveyor asked if a resident with a fall investigation intervention to redirect and to use their call light would be appropriate for a resident who has a fall risk assessment score of 15 and a BIMS score of 2, indicating a severe cognitive impairment in addition to fall risk. DON-B responded that they would need to look into this further and let Surveyor know if they find more information. No additional information was supplied by DON-B for the remainder of the Survey. On 11/14/24 at 11:20 AM, Surveyor conducted an interview with NHA (Nursing Home Administrator)-A. Surveyor shared concerns related to R25's unwitnessed fall on 10/13/24 which led to a left femur fracture and current observations of R25 not receiving adequate supervision by staff in an effort to safeguard R25 from additional falls or accidents or concerns related to inappropriate fall interventions such as redirecting R25 to utilize her call light with her fall risk score of 15 in addition to a severe cognitive impairment as evidenced by a BIMS score or 02. The facility did not supply any additional information to Surveyor at this time. 38146 2.) R2 admitted to the facility on [DATE] and has diagnoses that include Peripheral Vascular Disease, Diabetes Mellitus with Diabetic Neuropathy, Spastic Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Hypertension, Fibromyalgia, Osteoarthritis, Anxiety Disorder, Depression, Anemia, Abdominal Aortic Aneurysm, Cardiac Pacemaker, Cellulitis of lower limb, R2's Admission MDS (Minimum Data Set) dated 9/2/24 documents a BIMS (Brief Interview for Mental Status) score of 14, indicating no cognitive impairment. Section GG0170 documents Mobility: Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed - Dependent. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Toilet transfer: The ability to get on and off a toilet or commode - Dependent. R2's Care plan Focus area documents: Risk for falls r/t (related to) Deconditioning, Gait/balance problems, Incontinence - date initiated 5/23/23. Anticipate and meet the resident's needs - date initiated 5/23/23. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance - date initiated 5/23/23. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility - date initiated 5/23/23. Fall intervention 6/2/23: PT (Physical Therapy)/OT (Occupational Therapy) eval - date initiated 9/1/23. Fall intervention for 5/27/24: Maintenance to audit all shower chairs for safety - date initiated 5/28/24. 10/21/24 Intervention: Carefully inspect sling and properly place on resident before use of Hoyer lift - date initiated 11/1/24. On 11/11/24 at 11:12 AM, during initial interview with R2, she reported having had 2 falls. R2 reported 1 fall occurred when she was going to the shower, she fell through the shower chair onto the ground. R2 stated, The whole seat let loose and I fell on the ground. R2 reported she could not remember the date, that it was maybe 5 months ago. R2 reported the 2nd fall was from the sit to stand. R2 reported the machine made a strange noise when she first got into it, she could not explain what it was and didn't say anything. R2 reported she was taken to the bathroom and when she was finished, the CNA (Certified Nursing Assistant) raised her up slightly so I was standing up more to clean me. She didn't have the seat belt strap around me. The strap on one side came off and I fell landing on my bottom, I felt like my back was jarred. R2 reported no other injuries and did not want to go to the hospital because it takes 6 hours to be seen. Surveyor review of R2's medical record revealed a facility progress note dated 5/27/24 at 9:30 PM which documented: Late Entry: Resident is alert and oriented, able to make needs known. The resident was sitting in a shower chair, going to take a shower. The chair got broken. Resident lowered to the floor by the Aide. Was able to move all extremities. Assessment done; no injury noted. Surveyor review of R2's medical record revealed a facility progress note dated 10/21/24 at 4:23 PM which documented: Resident had a fall in the bathroom during morning shift today at 11 am. Witness and resident informed nurse that she was being assisted at the bathroom when she started to slide off the 'Sit to Stand' Transfer and was safely lowered to the floor. Upon assessment, resident was found lying on her back. No lacerations, indentations, swelling or bleeding observed. Resident denied hitting the head on the ground. Alert and oriented times four. Moves all extremities without complains of pain or discomfort. Reported slight pain at the lower back. Resident declined going to the hospital for checkup and notification to family. She was assisted back to her wheelchair and is comfortably seated on her wheelchair. Neuro checks negative. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 9:07 AM, Surveyor asked DON (Director of Nursing)-B for R2's fall investigations and was provided the following: Fall Data Collection Tool - date of fall 10/21. Where did the fall happen? Residents bathroom. Being toileted. Why do you think the resident fell ? Lowered to the floor. What should we do to try to decrease the incident of another fall or at least prevent an injury? Carefully inspect sling. CNA statement: On 10/21/24 (resident) was lowered to the floor in the bathroom of residents bed room. After being lowered to the floor the resident was checked over by nurse. Resident had no injuries or skin issues. Resident was asked if she wanted to get sent out to the hospital and she stated no. Surveyor noted the fall investigation did not include an interview or statement from R2. R2 reported to Surveyor the seat belt strap was not around her and the strap on one side came off and she fell landing on her bottom. The fall investigation question of why do you think the resident fell documented lowered to the floor but did not indicate why R2 was lowered to the floor. The fall investigation question of what should we do to try to decrease the incident of another fall or at least prevent an injury documented Carefully inspect sling indicated there was a problem with the sling that contributed to the fall. Surveyor noted R2's care plan was updated with: Carefully inspect sling and properly place on resident before use of Hoyer lift - date initiated 11/1/24. Fall data collection tool - date of fall 5/27/24. Time of fall 9:30 PM. Where did the fall happen? At the resident door. The resident was in the shower chair while the aid was pushing the chair. Why did the resident fall? Maybe the resident weight or the chair was already broken. What should we do to try to decrease the incident of another fall or at least prevent an injury? Buy new chairs or inspect the chairs before use. CNA statement: Shower chair collapsed while trying to roll it to the shower room. Supported resident from behind with my arms underneath hers. I lowered her sliding her body down easy to the floor while supporting her head. Resident did not hit her head. I made sure she had a pillow under her head until the nurse arrived. The nurse and I then transferred her after assessment to flat bed and shower chair to proceed with shower. Surveyor noted the fall investigation did not include an interview or statement from R2. R2 reported to Surveyor that the whole seat let loose and she fell on the ground. The CNA statement indicated she lowered R2's sliding body down easy to the floor. The investigation did not include a determination if the shower chair is safe to use as a transport for residents from their room to the shower room. Surveyor noted R2's care plan was updated with: Maintenance to audit all shower chairs for safety - date initiated 5/28/24. On 11/12/24 at 12:12 PM, Surveyor asked CNA-L to accompany to the shower room. Surveyor observed 3 shower chairs and 1 reclining shower chair - all have wheels. Surveyor asked about R2. CNA-L stated, I know she had a shower last week. Surveyor asked which residents use the shower chairs. CNA-L stated, Anyone who can sit upright can get a shower. Surveyor pointed out that all the shower chairs have wheels. CNA-L stated, Yes, we take the shower chair to their room, transfer them onto it and then we wheel them down to the shower room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 12:23 PM, Surveyor reviewed R2's fall investigations with NHA (Nursing Home Administrator)-A. Surveyor advised the fall investigations were not thorough to determine a root cause analysis. The fall on 10/21/24 documented R2 was lowered to the floor, however it was not clear as to what happened and why R2 was lowered to the floor. R2 reported to Surveyor she did not have the seat belt strap around her, the strap on one side came off and she fell landing on her bottom. The fall investigation did not include a statement from R2. The intervention was to carefully inspect the sling, indicating there was a problem with the sling that contributed to the fall. There was no evidence all slings were inspected or education was provided to all staff regarding safe transfer from the stand up lift. The fall on 5/27/24 documented the shower chair collapsed while trying to roll it to the shower room and the resident was lowered easy to the floor. R2 Resident reported to surveyor the seat let loose and she fell to the floor landing on her buttocks. The fall investigation did not include a statement from R2. There was no evidence the chairs were inspected or determined they are safe to be used as transport for distance to shower room. On 11/12/24 at 1:11 PM, NHA-A provided risk management forms that documented: 5/27 sitting in shower chair going to take a shower. The chair got broken. Resident lowered to floor by the aide. Resident was unable to give description. Notes: Maintenance to audit all shower chairs for safety. Surveyor located no evidence all shower chairs were audited for safety. 10/21 Resident had fall around 11 am. Resident reports that she was being assisted to the bathroom when she started sliding from sit to stand transfer and was safely lowered to the floor by witness. Intervention: Carefully inspect sling and properly place on resident before use of Hoyer lift. Surveyor located no evidence all slings were inspected or staff were educated and audits completed with staff on safe transfers using the sit to stand. On 11/12/24 at 1:51 PM, Surveyor asked Facility Services Manager-I if he has done audits on all shower chairs within the last 6 months. Facility Services Manager-I stated, No. About a month ago I got a slip asking me to take a look at one that wasn't rolling properly. Surveyor asked if he was aware of any shower chairs that were broken or involved in a fall. Facility Services Manager-I stated, No. There was one that was broken awhile ago, the back wasn't reclining or staying up, we ended up throwing it out. Facility Services Manager reported he is not aware of any shower chair involved in a fall. Surveyor asked if he had any information regarding the manufacturer recommendations regarding the shower chair, if it can or should be used for transport. Facility Services Manager-I stated, I would say that it shouldn't, it's not a wheelc [TRUNCATED]

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	525524	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anne's Salvatorian Campus	3800 N 92nd St Milwaukee, WI 53222

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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** 38146 Based on interview and record review, the facility did not ensure that residents who are continent of bladder and bowel received services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain for 1 of 2 (R22) residents reviewed for bowel and bladder. R22 had a decline in bowel continence following admission to the facility. The facility did not comprehensively assess R22's decline and no new interventions were implemented. The facility was not documenting or monitoring R22's bowel movements. Findings include: R22 admitted to the facility on [DATE] and has diagnoses that include Diabetes Mellitus Type 2 with Chronic Kidney Disease, Atrial Fibrillation, Venous Insufficiency, Depression, Hypothyroidism, Urine Retention, Congestive Heart Failure, Peripheral Vascular Disease, Anemia, Acquired absence of left leg below knee and Atherosclerotic Heart Disease. R22 was hospitalized and readmitted several times while residing in the facility. The facility Policy and Procedure titled Bowel and Bladder Management reviewed 8/10/23 documents (in part) . .Policy: Prevention measures are put in place to promote bowel and bladder health. Procedure: A. Assessment: 1. Staff will assess newly admitted individuals for past and present bowel and bladder patterns which may include medication review, medical diagnoses, and/or diet. B. Care planning: 1. Staff will adopt a person-centered interdisciplinary care plan and implement interventions/approaches to bowel and bladder management to meet the goals of the individual. 2. Care plan will be reviewed quarterly, or as needed. C. Monitoring: 1. Staff will document bowel movements. 2. Care Plan will be reviewed quarterly, or as needed. 3. Abnormal bowel and bladder patterns will be reported to the nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Staff will review individuals that do not have a recorded bowel movement within the past 3 days and provide appropriate interventions as needed. The facility form titled Standard Bowel/Bladder Protocol (not dated) documents (in part) . .Problem: Individual has potential for or identified bowel/bladder incontinence. Goal: Reduce skin breakdown, decrease episodes of incontinence as able, maintain regular bowel pattern, and minimize UTI (Urinary Tract Infection) signs and symptoms. RN (Registered Nurse): Bowel and bladder assessment upon admission, with COC (Change of Condition), annually and PRN (as needed). Determine and establish need for bowel/bladder training program and request order for OT (Occupational Therapy) to assist in process. Monitor bowel pattern, abdominal distension, bowel sounds, need for laxatives PRN. CNA (Certified Nursing Assistant): Provide toileting on demand or as otherwise requested/scheduled. If individual unable to express need, toilet or change every 2-3 hours. Monitor bowel consistency, odor, amount, color (red/black). Report concerns to licensed nurse. Therapy: OT consult as needed for bowel/bladder training. R22's Admission Continence Evaluation dated 1/29/24 documents: Does the resident have a history of bowel incontinence? NO Was the resident continent of bowel at the time of admission? YES Bowel continence - Select the one category that best describes the resident: Always continent Perception of need to defecate: Present R22's Admission Continence Evaluation dated 3/6/24 documents: Does the resident have a history of bowel incontinence? YES Was the resident continent of bowel at the time of admission? NO Bowel continence - Select the one category that best describes the resident: Always incontinent. R22's Quarterly Continence Evaluation dated 4/29/24 documents: Does the resident have a history of bowel incontinence? NO Was the resident continent of bowel at the time of admission? NO Bowel continence - Select the one category that best describes the resident: Always incontinent Perception of need to defecate: Diminished (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Quarterly MDS (Minimum Data Set) dated 5/3/24 documents: Bowel continence - Select the one category that best describes the resident - Always incontinent. Is a toileting program currently being used to manage the resident's bowel continence? No Surveyor noted there was no evidence of an assessment regarding R22's decline in bowel continence and no evidence a toileting program was implemented to maintain bowel continence. R22's Annual MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 14, indicating no cognitive impairment. Indwelling catheter (including suprapubic catheter and nephrostomy tube) - Yes Bowel continence - Select the one category that best describes the resident - not assessed. Is a toileting program currently being used to manage the resident's bowel continence? No Constipation present? No Surveyor review of POC (Point of Care) revealed there was no section or evidence of facility documentation of R22's bowel movements or continence. On 11/12/24 at 9:04 AM, Surveyor advised DON (Director of Nursing)-B of concern R22 admitted to the facility continent of bowel, and is now incontinent. Surveyor advised DON-B there is no evidence the facility is documenting or monitoring R22's bowel movements or continence, and there is no evidence the facility assessed R22's decline in bowel continence and no new interventions were implemented. On 11/13/24 at 9:00 AM, DON-B stated, Apparently it (recording of bowel movements) wasn't activated in POC to enter BM's (bowel movements). I don't know why, I thought it automatically activates. So we're not able to determine when or why he became incontinent of BM as there are no records. On 11/13/24 at 3:00 PM, the facility was advised of the following concern: R22's admission continence evaluation dated 1/29/24 indicated R22 was always continent of bowel. Subsequent continence evaluation dated 3/6/24 and Quarterly MDS dated [DATE] documents R22 as always incontinent. There is no evidence the facility recognized R22's decline in bowel continence and completed a comprehensive assessment or implemented a toileting program to maintain bowel continence. In addition, there is no evidence the facility is recording or documenting R22's bowel movements. No additional information was provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on observation, interview, and records review the facility did not ensure 1 (R16) of 1 resident who receive dialysis had physician orders, monitoring, and communication with dialysis facility. R16 was admitted to the facility needing dialysis and did not have physician orders regarding the care and treatment of dialysis. The facility did not monitor R16's dialysis access site daily. There wasn't consistent communication between the facility and the dialysis facility. R16 did not have a comprehensive care plan that addressed dialysis. Findings include: The facility's hemodialysis policy dated 3/20/2018, last reviewed documents: The care for an individual receiving dialysis will be coordinated and communicated between the Skilled Nursing Facility (SNF) staff and the relevant dialysis staff. A. An individual care plan will be developed/revised in the SNF in collaboration with information provided by the relevant dialysis facility. Individual record will reflect up to, and including: 1. Identification of individualized risk factors and potential complications related to dialysis. 2. Choices or preferences including advance directives, if any. 3. Medical status including status of comorbid. 4. Identification of the type of dialysis, where provided and by whom, how often and if the treatment is in accordance with the dialysis prescription. 5. Identification of appropriate personal protective equipment (PPE) for type of dialysis treatments and care provided, identification of infection control practices to use prior to, during and/or after the treatments, including equipment and/or supplies. 6. Laboratory tests needed to manage and monitor dialysis. 7. Pertinent immunizations and communicable disease status are on file and available upon request. 8. Communication and coordination with the dialysis team to meet nutrition and hydration needs. 9. Psychosocial needs such as anxiety, depression, confusion, or behavioral symptoms that might interfere with treatments and interventions to address the identified needs. B. Individual record will reflect the coordination and collaboration with the relevant dialysis facility including exchange of pertinent information before, during, and post dialysis including emergency protocol contact information. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R16's diagnoses include End Stage Renal Disease (ESRD), Diabetes, Cerebrovascular disease, dependence on dialysis, heart failure, dementia, and Transient ischemic attack (TIA). R16's Quarterly MDS (Minimum Data Set) completed on 11/6/24 documents that R16 uses a walker and wheelchair for ambulation. R16 is independent with eating, oral and toileting hygiene, rolling left to right, toilet transfer, and sit to standing. R16 requires supervision with dressing, shower hygiene, and chair to bed transferring. R16 requires substantial/maximal assistance with tub transferring and receives dialysis. R16 was documented as having a BIMS (Brief Interview for Mental Status) score of 15, indicating that R16 is cognitively intact. R16's care plan, dated 1/23/24, documents: (R16) needs dialysis related to renal failure (date initiated 2/16/24). Interventions include: Encourage (R16) to for the scheduled dialysis appointments. (R16) receives dialysis (date initiated 2/16/24). Monitor labs and report to doctor as needed (date initiated 2/16/24). Monitor/document/report as needed (PRN) any signs and/or symptoms of infection to access site: redness, swelling, warmth, or drainage (date initiated 2/16/24). Monitor/document/report PRN for signs and/or symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds (date initiated 2/16/24). Monitor/document/report PRN for signs and/or symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock (date initiated 2/16/24). (R16) has fluid overload or potential fluid volume overload related to kidney failure on hemodialysis (date initiated 3/27/24). Interventions include: Ensure (R16's) snacks and beverages offered at activities comply with diet restrictions (date initiated 3/27/24). Monitor vital signs as ordered. Notify MD of significant abnormalities (date initiated 3/27/24). Monitor/document/report PRN any signs or symptoms of fluid overload (date initiated 3/27/24) Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated (date initiated 3/27/24). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 10:57 AM, Surveyor interviewed R16 who states dialysis staff manage her dialysis site. Surveyor asked R16 if the facility staff ever check or monitor her dialysis site, and R16 states facility staff never look at it. Surveyor reviewed R16's medical records and notes R16 did not have orders for R16's dialysis days, access site, and any daily monitoring of her dialysis site. Surveyor notes R16's care plan does not address where R16's access site is or how the facility staff will provide care and treatment to the site. On 11/12/24, at 11:30 AM, Surveyor interviewed Registered Nurse (RN)- O, who states she monitors R16's dialysis site for bleeding and checks R16's dressing. Surveyor asked RN- O where she documents R16's dialysis site monitoring/checks, and RN- O states it does not appear on R16's medical record for her to document her findings. RN- O indicates staff prepare medical records for R16 to take with her on dialysis days. RN- O states R16 will sometimes return from dialysis with communication papers but not all the time. Surveyor asked RN- O how she would know how dialysis would go for R16 if she did not return with any documentation. RN- O states R16's dialysis facility will sometime call the Assistant Director of Nursing (ADON) if there are findings or concerns at dialysis. On 11/12/24, at 12:01 PM, Surveyor interviewed Director of Nursing (DON)- B who states residents who receive dialysis should have a dialysis care plan, monitoring and documentation of the dialysis site, and communication with the dialysis center. DON- B states dialysis will sometimes call the facility with updates after residents receive dialysis. DON- B States dialysis doesn't always call the facility; however, the facility will assume dialysis occurred without events if the resident returns without paperwork or a phone call from the resident's dialysis center. Surveyor notified DON- B of concerns with R16 not having dialysis orders, the facility not monitoring or documenting R16's dialysis site, and R16's care plan does not address where R16's access site is or how the facility staff will provide care and treatment to the site. Surveyor also expressed the facility does not having ongoing communication with the dialysis center on R16's dialysis treatments. Surveyor requested additional information if available. None was provided.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observation, interviews and record review, the Facility did not regularly assess the risk of entrapment and review the risk & benefits for 1 (R5) of 1 Residents observed having bed rails. Examples of bed rails include but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. R5, who is dependent on staff for mobility, was observed to have a half side rail/grab bar on the right side of the bed and did not have a completed side rail risk assessment since 9/18/2023. R5 was not included in the monthly safety audits of side rails completed by the maintenance department. Findings include: On 11/12/24 at 2:20 PM, Nursing Home Administrator (NHA)-A informed surveyor that the facility does not have a siderail policy. R5 was admitted to the facility on [DATE] with diagnosis that include Chronic Kidney disease, Type 2 Diabetes, Dementia, Stroke history, Encephalopathy and Adult Failure to Thrive. R5's Significant Change Minimum Data Set assessment dated [DATE] documents R5 has a severe cognitive impairment. R5 is dependent for bed mobility, hygiene cares and transfers. R5 is always incontinent of bowel and bladder. On 11/11/24 at 10:13 AM, Surveyor observed R5 in bed. Surveyor noted a half siderail/grab bar placed on the right side of the bed. On 11/11/24 at 3:27 PM, Surveyor observed R5 sitting in a Broda chair next to R5's bed. Surveyor noted a half siderail/grab bar placed on the right side of R5's bed. R5's Activities of Daily Living (ADL) care plan initiated on 10/10/22 documents the following intervention: Bed Mobility: the resident needs assist of 1 for bed positioning. Uses bed rail for assistance. R5's Side Rail Assessment and Risk Screen dated 9/18/23 documents, part: . Does the Resident use the half siderail or bed bar for positioning, turning or support? Yes. Based on this assessment, is the use of half side rail or bed bar indicated? Yes. Which type would be beneficial? Half side rail . If rails are to be used, do rails fit against mattress with no more than a 2-inch gap? Yes. Summary of evaluation: Resident uses mobility bar to turn and reposition in bed. Able to use bar for assistance with bed mobility. What kind of adaptive equipment? Siderail. Informed Consent obtained 9/18/23. Describe On-Going monitoring and Supervision. Routine assessment, reassess and continued monitoring. R5's MD order with a start date of 9/11/23 documents: Ensure proper use of bed rail every day shift. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 8:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-X. Surveyor asked how often R5 used the half side rail on the right of R5's bed. CNA-X stated that R5 did not use a siderail. CNA-X stated that R5 was dependent and was not able to use the siderail. On 11/12/24 at 8:04 AM, Surveyor interviewed Registered Nurse (RN)-H. Surveyor asked about R5's mobility and half siderails. RN-H indicated that R5 was dependent for all cares and mobility. R5 had to be assisted to eat. R5 needed assistance from staff to move in bed. R5 did not use the half siderails. Surveyor noted at the time of the survey, R5 was completely dependent and was not capable of using the siderail. Surveyor reviewed R5's Electronic Medical Record for evidence that a side rail assessment and risk screen had been completed since 9/18/24. Surveyor located a Side Rail Assessment and Risk Screen dated 10/22/24 but the document was not filled out. On 11/12/24 at 10:41 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-E. Surveyor asked what the process is for the use of half side rails. ADON-E stated that a physical therapist will assess the need for side rails. An order will be place for maintenance to put the siderails on the bed. A siderail assessment and risk screen will be completed. Surveyor asked how often the side rail assessment and risk screen needs to be completed. ADON-E stated ADON-E was not sure but was guessing quarterly. On 11/13/24 at 1:12 PM, Surveyor interviewed Physical Therapist (PT)-K. Surveyor asked what the process is for a resident who needs a siderail. PT-K stated that the therapy department will do the siderail assessment, and alert maintenance of the need of a siderail. Surveyor asked how often the siderail assessment and risk screen should be completed. PT-K stated that they should be done quarterly or with a change in condition. Surveyor asked if R5 had a side rail assessment and risk screen completed after 9/18/23. PT-K indicated that the assessments must have been missed. Surveyor noted that R5 had a change of condition that made R5 dependent on staff for mobility. R5's side rail risk assessment was not completed after R5 became dependent. On 11/12/24 at 1:52 PM, Surveyor interviewed Facility Services Manager (FSM)-I. Surveyor asked about how side rails are placed on resident's bed. FSM-I stated that maintenance will be notified by therapy if side rails are needed. Once the siderails are placed, FSM-I will complete monthly audits to ensure proper function and safety. Surveyor asked to review the monthly siderail audits since September of 2023. FSM-I returned with the audits. Surveyor noted that R5 was not included in the monthly side rail audit review. On 11/13/24 at 8:18 AM, Surveyor interviewed Director of Nursing (DON)-B and Clinical Nurse Coordinator (CNC)-C. Surveyor asked about R5's siderail use. DON-B indicated that the side rail was used to assist R5 with turning in bed. Currently, R5 is dependent but R5 was not dependent when the side rail was placed. Surveyor asked when a siderail assessment and risk screen should be completed. DON-B indicated that the assessment and risk screen should be completed quarterly or with a change in condition. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 10:38 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor informed NHA-A of the concerns that R5 did not have a side rail assessment and risk screen completed since 9/18/23. R5 had a change in condition that made R5 dependent, and the side rail was not removed. The maintenance department was not completing monthly audits on R5's half siderail. Surveyor asked if NHA-A would expect a side rail assessment to be completed quarterly. NHA-A stated yes. No further information was provided as to why the facility did not regularly assess the risk of entrapment and review the risk & benefits for R5 bedrail use.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42037 Based on observation, interview, and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Surveyors made observations of residents waiting for assistance with delayed call light wait responses. Residents were interviewed and expressed concerns to surveyors that the facility does not have sufficient staff, resulting in delayed call light responses. Surveyor reviewed last 30 days of facility nursing schedules and nurse staff postings. Surveyor noted that the facility did not designate a charge nurse for each tour of duty on each daily nursing schedule. This deficient practice has the potential to affect a pattern of all 43 residents residing in the facility. Findings include: Delayed call light response On 11/11/24 at 11:12 AM, during initial interview, R2 reported they still have trouble getting to the bathroom either before or after meals. R2 reported that no staff is left on the floor to take anyone to the bathroom and call lights don't get answered. On 11/11/24 at 11:25 AM, Surveyor observed R2's call light on the illuminated call light board. Surveyor confirmed with R2 that their call light is on because they need to go to the bathroom. On 11/11/24 at 11:53 AM, Surveyor noted the illuminated call light board. Surveyor noted R2's call light was on for over 28 minutes. On 11/11/24 at 12:00 PM, Surveyor observed a staff member in R2's room assisting with putting on her sweater. The staff member left the room with the sit to stand lift. R2 reported they had been taken to the bathroom. R2 stated they felt like she waited 45 minutes and that they had to go to the bathroom very badly and was barely able to hold it until staff came to help them. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/11/24 at 1:41 PM, Surveyor observed R1's call light on in their room. On 11/11/24 at 1:59 PM, Surveyor conducted interview with R1 about their call light. R1 stated they wanted to go back into bed and that's why they have their call light on. Surveyor asked how long they have been waiting for help. R1 stated that they have been waiting for quite a while and asked Surveyor to inform staff. On 11/11/24 at 2:00 PM, Surveyor exited R1's room. Surveyor noted at this time that R1's call light was no longer on. R1 told Surveyor that staff had turned off call light without speaking to R1. At this time, Surveyor informed 2 staff members at the nurses' station that R1 wanted to get back into bed. Staff left nurses' station and went to assist R1. On 11/12/24 at 11:15 AM, Surveyor conducted the Resident Council meeting. The residents informed Surveyor of the following staffing concerns: Residents stated that they did not feel like the facility had enough staff to help with their needs. Residents stated that call light wait times can be long. Surveyor asked how long they will need to wait for their call lights to be answered. Residents stated that it varies. Sometimes can be less than 5 minutes. Sometimes it can be much longer. R20 stated that R20 has asked CNAs (Certified Nursing Assistants) for help and has been told by CNAs the following: That is not my job or I am not your aide. R20 stated that any CNA should be able to help R20 if they need help. R27 stated that in the past R27 has had a CNA that is a floater, meaning that the CNA will work on both the first and second floor throughout their shift and does not have a designated unit that they are assigned to. R27 stated that it is frustrating when R27 has a floater because it takes even longer to get help. R27 stated that when their electric wheelchair is charged, R27 will go to the nurses' station, wait there for staff and continually ask staff for help until R27 gets the assistance that they need. R27 stated that it is the fastest way to get help because the call lights are not answered as timely as R27 would like. R27 stated that staff will tell R27 that they can start R27's cares but will not be able to finish the cares before the end of the shift. R27 stated their frustration with this, feeling like they should tell staff that they might as well not start the cares for them if they will not be able to finish them in a timely fashion. R27 stated, The CNAs here make me feel like I am just a job to them . R27 completed reporting their staffing concerns by stating, I'm really just an afterthought to these workers .please don't treat me like I am not a human being. Scheduler Interview On 11/12/24, Surveyor reviewed the last 30 days of facility nursing schedules and nurse staff postings from 10/14/24-11/11/24. Surveyor reviewed the Facility Assessment. Surveyor did not note any documentation in the Facility Assessment related to staffing levels or staff/resident ratios. Surveyor noted that the facility did not designate a charge nurse for each daily nursing schedule on the following dates: 10/19/24, 10/20/24, 10/26/24, 10/27/24, 11/2/24, 11/3/24, 11/9/24, and 11/10/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anne's Salvatorian Campus	3800 N 92nd St Milwaukee, WI 53222

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 1:35 PM, Surveyor conducted an interview with Scheduler-Y. Scheduler-Y told Surveyor that they utilize a staffing grid to determine staffing levels based off the facility's census. Scheduler-Y reported to Surveyor that the facility may assign one CNA downstairs on the first floor (rehabilitation unit) at times as the census on the second floor (long term care unit) is typically higher. Surveyor asked Scheduler-Y if they have had concerns brought forward to them about the current staffing levels at the facility. Scheduler-Y told Surveyor that the facility has recently hired a new medication technician to help with passing medications as well as resident cares to improve staffing situations. Surveyor asked Scheduler-Y if they are aware of the Facility Assessment document and whether or not it contains guidance for staffing ratios. Scheduler-Y told Surveyor that they have never heard of a Facility Assessment document and using it for guidance for staffing. Surveyor asked Scheduler-Y if they were aware that there was not a charge nurse designated on the facility's nursing schedules on 10/19/24, 10/20/24, 10/26/24, 10/27/24, 11/2/24, 11/3/24, 11/9/24, and 11/10/24. Scheduler-Y told Surveyor that they have, done this job for four years and that they have never in their life heard about having to denote who the facility's charge nurse is on a schedule. On 11/14/24 at 11:20 AM, Surveyor conducted an interview with NHA (Nursing Home Administrator)-A. Surveyor informed NHA-A of the concerns mentioned by the resident council group, including Surveyor's interviews with R1, R2, and R20 and about insufficient staffing levels and observations of prolonged call light wait times by surveyors. NHA-A stated that the facility has just hired a Medication Technician and has 3 new Medication Technician positions posted to help with staffing needs. Surveyor shared concern related to the Facility Assessment document which did not include any staffing information including staff to resident ratios. Surveyor shared concern related to facility's schedules not designating who the facility charge nurse would be on 10/19/24, 10/20/24, 10/26/24, 10/27/24, 11/2/24, 11/3/24, 11/9/24, and 11/10/24 as confirmed by interview with Scheduler-Y. The facility did not share any additional information at this time related to above concerns.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51014 Based on observation, interview, and record review the facility did not ensure 1 (R10) of 3 residents reviewed, received medically related social services to attain their highest practicable mental and psychosocial well-being resulting in R10's increased level of depression, anxiety and uncertainty regarding transfer/discharge. Findings include: R10's facility Social Services did not communicate timely with family and R10, nor follow through with R10's expressed desire to leave the facility and transfer/discharge to another facility until Surveyor brought it to the attention of staff. R10 was admitted to the facility on [DATE] with a diagnosis to include depression and anxiety disorder. R10's quarterly MDS (Minimum Date Set) dated 9/11/24, Section C (Cognition) documents a BIMS (Brief Interview for Mental Status) score of 12, on a scale of 0 to 15, indicating that R10 has moderate cognitive impairment. Section E (Behavior) document that R10 does not experience hallucinations or delusions. Section GG (Functional Abilities) documents that R10 is independent with requiring assistance with daily living. R10's medications include Mirtazapine oral tablet 30 mg at bedtime related to depression, Depakote Sprinkles oral capsule 125 mg by mouth two times a day for depression and Buspirone HCl 10 mg tablet three times a day for anxiety. R10's care plan dated 9/5/24 documents, [NAME] has a mood problem r/t (related to) history of Depression and Anxiety. Receives medications. Interventions include, [NAME] will have no s/sx (signs and symptoms) of depression or anxiety through the review date. Administer medications as ordered. Monitor/document for side effects and effectiveness. Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these. R10's Social Services Quarterly assessment, completed on 4/19/23 documents no change is status when asking, Has the resident experienced any changes regarding his/her feelings about placement and/or discharge potential? No additional Social Services Quarterly assessments were located before and after the entry on 4/19/23. Life Coach-Q documents in handwritten notebook, entry date on 10/21/2024, [NAME], Care Age of [NAME], [PHONE NUMBER], 1755 N [NAME] Rd, need to move stuff out, [NAME] (left message 10/21/24.) (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Life Coach-Q documents in handwritten notebook, entry date on 10/22/2024, [NAME], need to see me, Care Age of [NAME], [PHONE NUMBER], waiting for response. Life Coach-Q did not have any additional progress notes documented following 10/22/2024 regarding transfer/discharge with R10 until Surveyor brought it to her attention on 11/12/2024. R10's Progress Note dated 11/12/2024 at 10:00 AM by Life Coach-Q, Writer left message for [NAME] from Care age. Writer asked for a return call. R10's Progress Note dated 11/12/2024 at 10:35 AM by Life Coach-Q, [NAME] from Care Age stated they are not accepting resident with Medicaid at this time. R10's Progress Note dated 11/12/2024 at 10:36 AM by Life Coach-Q, Writer followed up with resident regarding her transferring. Writer stated resident wasn't accepted due to the facility not accepting Medicaid/ T-19 at this time. Resident stated okay. Writer asked resident do she have any other places she would like referral send to. Resident stated she have to talk to her daughter. R10's Progress Note dated 11/14/2024 at 10:16 AM by Life Coach-Q, Writer spoke with resident daughter [NAME] regarding items in [NAME] Hall. [NAME] stated she don't have a date when she's coming. Writer asked if she can come by the end of the month. [NAME] stated she will try. Writer stated Care Age denied resident due to them having to many Medicaid residents. [NAME] stated she been looking for placement for her mom but it's been hard due to her having Medicaid. At this time, Surveyor was unable to locate any additional documentation in R10's medical record that documents R10's desire to transfer/discharge to another facility nor the emotional impact it was having on her. On 11/11/2024, at 10:48 AM, Surveyor observed R10 dressed wearing tennis shoes and sitting on edge of bed with two feet on the floor. R10 had head down with TV on low volume. On 11/11/2024 at 10:49 AM, Surveyor interviewed R10 who states she doesn't feel like she is involved in her care planning, especially with the Life Coach-Q and R10's desire to transfer/discharge to a different facility. R10 states, Life Coach-Q never shows up for scheduled appointments and is very difficult to work with. She has called Life Coach-Q many times but she never calls her back. R10 states, This place is going downhill fast and wants to get to another facility. R10 states, Life Coach-Q did get back to her once regarding transfer to Care Age of [NAME] but hasn't worked on it in a couple of weeks and she is very upset and anxious about the situation. Surveyor questioned R10 regarding why she wants to transfer and R10 states the staff are always rushed and do not take the time to get to know her or meet her needs and she has been very anxious. R10 states she does not trust anyone to follow through at this place, especially Life Coach-Q. R10 states, she is on medication for depression and anxiety but does not feel the medication is working because her depression is completely because she is here and no pill can help her for being here. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/2024 at 08:29 AM, Surveyor interviewed, Life Coach-Q regarding R10's request to transfer to Care Age of [NAME]. Life Coach-Q reports that R10 does not want to be in the Skilled Nursing Home but rather go back to the Assisted Living she came from but R10 has a significant debt and cannot afford to go back there. Life Coach-Q states she had been working with R10 on applying for Medicaid and now it is approved but Medicaid won't cover the entire cost of the Assisted Living. Life Coach-Q states, R10 asked to see her on 10/21/2024 and they had a meeting. During this meeting, R10 asked Life Coach-Q to call the Care Age of [NAME] to see if she could transfer there. Life Coach-Q states she did call Care Age of [NAME] on 10/21/2024 and they said they had already spoken to daughter and R10 but was concerned about financial coverage of cancer medication, however, Life Coach-Q still made a referral. Life Coach-Q called Care Age of [NAME] to do follow up on 10/22/2024 and they were working on paperwork. Life Coach states she first provided an update to R10 on 10/30/2024 that the transfer/discharge to Care Age of [NAME] is still pending as there were medication concerns and where the medications were coming from and who would be paying for it. At this time, there is no documentation in the medical record nor in Life Coach-Q handwritten notebook to support the communication with R10 on 10/30/2024. Life Coach-Q states she has not provided any additional update to R10 since her undocumented last interaction on 10/30/2024. Life Coach-Q states, Care Age of [NAME] then called DON (Director of Nursing)-B. Surveyor asked if Life Coach-Q knew the result of the conversation and Life Coach-Q states, I do not know, you will have to ask DON.-B Surveyor inquired as to what is the status of transfer and Life Coach-Q states, the transfer is unknown at this time. On 11/12/2024 at 09:55 AM, Surveyor interviewed both Life Coach-Q and DON.-B together. DON-B states, she did speak with Care Age of [NAME], about a month ago and they were asking questions regarding her medications. DON-B states the conversation was brief, and they asked to go over R10's medication list. DON-B states, I assumed they were not going to take her. Surveyor asked what the status of the transfer is and DON-B states, I believe the transfer was denied. Life Coach-Q also states, I thought it was denied as well because of medication costs and I have not heard back from them since 10/22/2024. Life Coach-Q states Care Age of [NAME] has made no follow up attempts and typically approval for transfer happens promptly, therefore she thought transfer was denied. DON-B states, she did not even know an official request was made to transfer to Care Age of [NAME] and that the family of R10 was just looking around for another placement. Surveyor asked, who is responsible for coordinating and communicating transfers/discharges and Life Coach-Q states, I am. Life Coach-Q states there was no additional communication with Care Age of [NAME] since 10/22/2024 which prompted Life Coach-Q to follow up after this interview. On 11/12/2024 at 11:04 AM, Life Coach-Q informed Surveyor that Care Age of [NAME] had returned her call today and said they have denied transfer as they are not accepted Medicaid residents at this time. Life Coach-Q stated she updated R10 as well. On 11/13/2024 at 8:50 AM, Surveyor informed NHA (Nursing Home Administrator)- A of the above findings. No additional information was provided as to why the facility failed to provide medically related social services to attain their highest practicable mental and psychosocial well-being resulting in R10's increased level of depression, anxiety and uncertainty regarding transfer/discharge.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38146 Based on observations, interviews and record review the facility did not ensure it's medication error rates are not 5 percent or greater. The facility had a medication error rate of 8%. Findings include: The facility Policy and Procedure titled Medication Administration General Guidelines dated May 2018 documents (in part) . .Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures: 4). Five rights - right resident, right drug, right dose, right route and right time are applied for each medication being administered. B. Administration 2) Medications are administered in accordance with written orders of the prescriber. On 11/12/24 at 7:36 AM, Surveyor observed RN (Registered Nurse)-O prepare medications for R38. The following medications were prepared and placed in a plastic medication cup: Vitamin B1 100 mg (milligrams) 1 tablet Acetaminophen 500 mg 1 tablet Atorvastatin 20 mg 1 tablet Potassium Chloride 10 meq (milliequivalents) ER (extended release) 1 tablet (label read - take 1 with 20 meq tablet to = 30 meq). Vitamin B12 500 mcg 2 tablets Aspirin EC (enteric coated) 81 mg 1 tablet Furosemide 40 mg 1 tablet Metformin 1000 mg 1 tablet Fluticasone spray 50 mcg 1 spray each nostril once daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN-O then stated aloud, I'm missing Potassium Chloride 20 meq and Atorvastatin, I have to go to contingency. RN left the cart to go to contingency, and returned at 7:58 AM. RN-O proceeded to punch out and place in the plastic medication cup: Potassium Chloride ER 20 meq 1 tablet and Atorvastatin 10 mg 2 tablets. Surveyor verified the number of tablets. RN-O administered the medications to R38 followed by water. Surveyor reconciled R38's medications. R38's current November, 2024 MAR (Medication Administration Record) documented an order for Lasix Oral Tablet 40 mg (Furosemide) - Give 0.5 tablet by mouth in the morning for Fluid Overload and an order for Atorvastatin Calcium oral tablet 20 mg give 1 tablet by mouth one time a day for Hyperlipidemia. Surveyor noted Furosemide 40 mg was administered versus the 0.5 tablet (20 mg) ordered and an additional dose of Atorvastatin 20 mg was administered during medication pass observation. On 11/13/24, NHA (Nursing Home Administrator)-A was notified of the above observations and medication error rate. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38146 Based on observations and interview, the facility did not ensure that drugs and biological's used in the facility were labeled in accordance with currently accepted professional principles, and include the and the expiration date when applicable for 3 of 3 (R9, R41 and R44) residents reviewed. Insulin pens and vials in the medication cart and medication room refrigerator were open and used, but not dated when opened. Findings include: The facility Policy and Procedure titled Vials and Ampules of Injectable Medications dated May 2018 documents (in part) . .Policy: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, uses, and disposal. Procedures: B. Expiration dates: Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this shortened expiration date are both important to be recorded on multidose vials (on the vial label or an accessory label affixed for that purpose). At a minimum, the date opened must be recorded. The shortened expiration date for multidose vials that have been opened or accessed is 28 days unless manufacturer specifies a shorter or longer interval for the shortened expiration date. On 11/12/24, Surveyor observed the 1st floor medication cart cart. In the top drawer of the cart, Surveyor located the following: Glargine insulin vial belonging to R9 which was opened and used, but not dated when opened. Lispro insulin vial belonging to R41 which was opened and used, but not dated when opened. 2 (two) Novolog mix 70/30 insulin pens belonging to R44 which were opened and used, but not dated when opened. On 11/12/24 at 8:10 AM, Surveyor showed RN (Registered Nurse)-O the above insulin's, none of which were dated when opened. RN-O acknowledged and placed the insulin's in the top drawer of the medication cart. On 11/13/24 at 8:50 AM, Surveyor observed the refrigerator in the 1st floor medication room. Surveyor located the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Glargine insulin vial belonging to R9 which was opened and used, but not dated when opened. A plastic bag labeled with R44's name containing 2 (two) Novolog mix 70/30 insulin pens which were opened and used, but not dated when opened. On 11/13/24 at 9:50 AM, DON (Director of Nursing)-B was advised of the above concerns regarding insulin's that are opened and used, but not dated when opened. No additional information was provided.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not conduct and document a facility-wide assessment. The assessment did not include the hours allocated for the (Infection Preventionist) IP, the Water Management Committee, infectious diseases, and staffing ratios. This had the potential to affect all 43 residents currently in the facility. Findings include: Surveyor reviewed the Facility assessment dated [DATE]. The staffing in the facility is not documented for shift ratios breakdown. This would assess the resident care levels and the staff needed to implement the care. Director of Nurses (DON)-B is also the facility IP and the time allocated to each role is not assessed. The facility's Water Management Committee is not documented in the assessment. The potential infection organisms such as Covid, influenza, Legionella, etc. are not assessed. CROSS REFERENCE F880 and F725. On 11/13/24 at 12:24 PM, Surveyor interviewed the Nursing Home Administrator (NHA)-A and reviewed the Facility Assessment. NHA-A stated, the DON role is combined with the IP role as one. The water management and infections are reviewed with QAPI. NHA-A stated, They are focusing on other things in the facility right now and not the Facility Assessment. On 11/14/24 at 08:02 AM, NHA-A provided Surveyor with a revised facility assessment dated [DATE]. The revised highlighted section included, The Director of Nursing currently serves as the Infection Preventionist above and beyond her role and DON. She dedicates time needed for (Infection Preventionist Control Program) IPCP as needed. We follow the Water management plan outlined in the Emergency Preparedness Plan for compliance. As a part of the IPCP we monitor for all types of potential infections including COVID, Influenza, respiratory syncytial virus (RSV), methicillin-resistant staphylococcus aureus (MRSA,) and Legionella to name a few.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observation, interviews, and record review, the facility failed to ensure Hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 of 2 residents (R5) reviewed for hospice care. R5 was being treated for an unstageable coccyx pressure injury and a Deep Tissue Injury (DTI) to R5's right heel. R5 was hospitalized from [DATE] through [DATE] with sepsis related to bilateral parotitis (inflammation and infection of both parotid glands [salivary glands located in front of the ears]). While hospitalized , R5's pressure injuries were both staged as unstageable. R5 was readmitted to the facility on [DATE] on hospice. Facility staff determined that hospice staff would be responsible for assessing and treating R5's pressure injuries. Communication between the facility and hospice staff was not clear. Hospice Nurse, Registered Nurse (RN)-J told Surveyor that RN-J was not aware that RN-J was the only staff member caring for R5's pressure injuries. From [DATE] through [DATE], R5's coccyx pressure injury was not measured, and a comprehensive assessment was not documented by the facility staff or hospice staff. From [DATE] through [DATE], hospice staff measured R5's heel wound 3 out of the 6 weeks, but a comprehensive assessment of the pressure injury was not completed. On [DATE], R5 developed a new wound to R5's right lateral leg. The facility staff or hospice staff did not complete a comprehensive assessment of R5's wound with measurements or a description of the wound bed. RN-J measured the new wound for the first time on [DATE] and determined the wound was a laceration. Facility staff and Hospice staff did not determine the root cause of the new wound to R5's right lateral leg and did not update R5's care plan with new interventions. On [DATE], R5 died while in hospice at the facility. Findings include: The facility policy titled, Pressure injury prevention and managing skin integrity with a review date of [DATE], documents in part: Policy: Prevention measures are put in place to reduce the occurrence of pressure injuries . Risk Assessment: . Based on the individual's Braden Scale Score, pressure reduction interventions will be implemented by nursing and documented in the individual's medical record . Identify Interventions: The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown . Identification of risk factors present or acquired that compromise skin integrity will be considered. Weekly Wound Rounds: Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds. Registered Nurse (RN) or designee will: Conduct weekly skin evaluation. Update the [Primary Care Provider] with any decline in wound appearance, or as necessary. Update the Care plan with any new interventions as applicable . On [DATE] at 12:16 PM, Nursing Home Administrator (NHA)-A informed Surveyor that the facility does not have a hospice policy. R5 was admitted to the facility on [DATE] with diagnosis that include Chronic Kidney disease, Type 2 Diabetes, Dementia, Stroke history, Encephalopathy, and Adult Failure to Thrive. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Significant Change Minimum Data Set assessment dated [DATE], documents: R5 has a severe cognitive impairment. R5 is dependent for bed mobility, hygiene cares, and transfers. R5 is always incontinent of bowel and bladder. R5 is at risk of developing pressure ulcers. R5 has 2 unstageable pressure ulcers. R5's Care Area Assessment for pressure injuries dated [DATE], documents: [R5] has had a decline in overall health and is now signed on to hospice. Will continue current care plan. R5's Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE] documents a score of 8 making R5 a very high risk for developing a pressure injury. R5's potential for pressure ulcer development facility care plan, with an initiation date of [DATE], documents the following interventions: The resident will have intact skin, free of redness, blisters, or discoloration by/through review date. Educate the resident/family/caregivers as to causes of skin breakdown including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. The resident requires pressure reducing mattress on bed and pressure reducing cushion in [wheelchair]. R5's potential impairment to skin integrity facility care plan, with an initiation date of [DATE], documents the following interventions: Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. Use a draw sheet or lifting device to move resident. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. R5 developed a stage 2 coccyx pressure injury on [DATE]. The facility wound Nurse Practitioner (NP)-G oversaw caring for this pressure injury from [DATE] through [DATE]. R5 developed a DTI to R5's right heel on [DATE]. NP-G oversaw caring for this pressure injury from [DATE] through [DATE]. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer evolved to unstageable). Full thickness wound with 100% soft light brown necrotic tissue at the base. Wound measuring 7 x 4.0 x UTD cm . Continue offloading measures. Right lateral heel (DTI). 100% eschar measuring 4 x 6 x UTD cm. Eschar is intact/adherent with slight lifting at the margins, without fluctuance . Prevalon boot to be worn whenever in bed or use of heels up cushion. Avoid use of shoes. R5's progress note dated [DATE] at 12:02 PM documents, in part: [By mouth] intake has decreased to ~25%. At the time of last nutrition assessment 3 months ago, PO intake was 38% on average. R5's progress note dated [DATE] at 3:33 PM documents: Resident was transferred to [name of local hospital] today via ambulance accompanied by EMT due to lethargy, poor appetite, and critical labs. The ADON and family updated. R5 was admitted to the hospital from [DATE] through [DATE] with Severe sepsis in setting of bilateral parotitis. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	While hospitalized , R5 had an x-ray completed of R5's right lower extremity and Vascular Surgery visited R5. R5's X-ray results dated [DATE] document a final result of: suspicious for osteomyelitis given overlying wound. R5's Vascular Surgery Consult dated [DATE] documents, in part: [R5] with functional decline and poor [by mouth] intake in the past 4 months who is bed/wheelchair bound at this point . The heel wound appears to be a pressure wound . The eschar is hard and well adhered to the heel. Given these findings of the heel wound, no surgical debridement is recommended . Suggestion of osteomyelitis on [x-ray]- it is highly unlikely that this is contributing to [R5's] [altered mental status] and overall deconditioning . Given the patient's age, multiple co-morbidities and her current altered status with sepsis that is being treated, no surgical intervention is recommended . Recommend heel off-loading shoe. Surveyor noted Vascular Surgery signed off on R5's care and noted that R5 should have a heel off-loading shoe. R5 was readmitted to the facility on [DATE] with hospice care. R5's progress note dated [DATE] 2:34 PM documents, Hospice will take over wound care for resident [related to] hospice services. On [DATE], R5's potential impairment to skin integrity facility care plan focus was updated with, Hospice will do all wound care on admission to hospice. Surveyor noted that a heel off-loading shoe was not placed as an intervention as recommended by the Vascular Surgery MD. R5's Hospice Certification and Plan of Care dated [DATE], documents in part: .This patient is being admitted for hospice services. Primary Diagnosis: Senile degeneration of brain . R5's Hospice interdisciplinary care plan included an Impaired skin integrity problem with a start date of [DATE]. Goals: Patient/caregiver can verbalize/demonstrate techniques to promote stasis ulcer healing appropriate for stage of disease. Interventions: Assess skin integrity and overall condition of skin including - [signs and symptoms] of breakdown, friction, shearing, or pressure areas. Skilled nursing facility to perform wound care/dressing change-coccyx and right heel. Surveyor noted the hospice care plan intervention states that the facility staff will perform wound care for R5. Surveyor noted that R5 did not have any offloading interventions, like turning and repositioning on the hospice care plan. Surveyor noted that R5 did not have an intervention for offloading or floating of R5's heels on the hospice care plan. Surveyor noted that a heel offloading shoe was not placed as an intervention as recommended by the Vascular Surgery MD. Surveyor reviewed R5's electronic medical record and did not locate any measurements or assessments of R5's wounds from [DATE] until [DATE]. R5's progress note dated [DATE] 10:15 PM documents in part: An open area noted to resident [right] lateral leg. No bleeding noted. Dressing applied. No [signs and symptoms] of infection noted. ADON and hospice updated. Message left for family to call facility for update. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R5's electronic medical record and did not locate any further documentation of the new right lateral leg wound including measurements and a comprehensive wound bed assessment. R5's facility care plan and R5's hospice care plan were not updated with this new wound and a new intervention was not placed. Surveyor noted a wound treatment with a start date of [DATE] was put in place for the right lateral leg wound and staff were completing treatments for this new wound. On [DATE] at 10:41 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-E. Surveyor asked what the plan was for R5's wound care after R5 returned to the facility on [DATE]. ADON-E stated that the hospice nurse, RN-J, told ADON-E that RN-J would complete all R5's wound care needs. ADON-E stated that RN-J would do all the dressing changes and assessments. If needed, the facility staff would fill in the gaps when RN-J was not in the facility on the weekends. Surveyor asked ADON-E if hospice was completing the assessments of R5's wounds. ADON-E stated that no assessments or measurements were in the electronic health record, but ADON-E reached out to the hospice company on [DATE] to get the documentation of the assessments. ADON-E stated that hospice did not have the documentation and stated that they did not document on the wounds. On [DATE] at 8:50 AM, Surveyor interviewed a hospice Certified Nursing Assistant (CNA)-X. Surveyor asked if CNA-X was familiar with R5. CNA-X stated CNA-X had a total of about 6 visits with R5 so indicated that CNA-X was familiar with R5's care. Surveyor asked if CNA-X was involved in caring for any of R5's pressure injuries or wounds. CNA-X stated that CNA-X wasn't quite sure but did not think hospice was involved in R5's wound cares. CNA-X stated that CNA-X did not do any cares on wounds but was aware that R5 had a wound on R5's ankle. CNA-X stated that CNA-X was not sure if hospice nurse or facility nurse was taking care of R5's wound cares. Surveyor asked what interventions were in place for R5's skin integrity. CNA-X stated that CNA-X would complete skin care including bed bath and moisturizing. CNA-X stated that R5 may have had boots on some of the time. CNA-X stated that R5 would sometimes have R5's heels floated on pillows and a pillow between R5's knees. On [DATE] at 12:27 PM, Surveyor interviewed RN-J, the hospice nurse, regarding R5's wound care. RN-J stated that RN-J remembered having a conversation about completing R5's wound care with the Director of Nursing (DON)-B. RN-J stated that RN-J remembers saying that RN-J would complete the wound care treatments and take care of any MD orders associated with R5's wound care. RN-J stated that RN-J was not aware that RN-J was the only staff member who would be getting measurements of the wounds or assessing the wounds. RN-J stated that in other facilities, RN-J will work with the Wound Doctor or Nurse Practitioner. RN-J stated that during the conversation, RN-J recommended that DON-B follow up about having the facility Wound Nurse Practitioner (NP)-G continue to follow R5's wounds. Surveyor asked about the wound that developed on [DATE]. RN-J stated that the wound was not a pressure injury, but it was a laceration. Surveyor asked if it was a laceration, how the laceration occurred. RN-J stated that it could have happened from a transfer or from a pillow. RN-J was not sure how the injury happened but stated again that it was a laceration/skin tear not a pressure injury. RN-J stated that RN-J did get measurements of the laceration when she did an assessment on [DATE], but that was the first-time measurements were completed. Surveyor asked if hospice or the facility determined the cause of the new wound. RN-J was not sure if a cause was identified. Surveyor asked if any measurements or assessments were completed on R5's pressure injuries/wounds from [DATE] through [DATE]. RN-J gave the following assessment information from RN-J's notes: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] - Coccyx unstageable pressure injury was not measured or assessed. Right heel pressure injury was unstageable and measured 7 x 5.5 cm. Wound had eschar and was moist with red, pink, and black areas. Small amount of drainage. Right lateral leg laceration measured 7 x 1.5. Wound had a small amount bloody drainage and was moist with red and pink wound bed. [DATE] - Coccyx unstageable pressure injury was not measured. Facility RN was doing wound care, so RN-J looked at the wound and documented the coccyx wound to be moist with red, pink, and yellow areas. Small amount serosanguineous drainage. Right heel unstageable pressure injury measured 7.5 x 4.5 cm. Moist, black with no drainage. Right lateral leg laceration measured 8 x 3.5. Wound was pink and yellow with a small amount of tan drainage. [DATE] - Coccyx unstageable pressure injury was not measured or assessed. Right heel unstageable pressure injury measured 7.5 x 4.5 cm. Dry. Black. No drainage. Right lateral leg laceration measured 8 x 3. 5 Clean. Wound was scabbed and edges were attached. No drainage was noted. Surveyor asked if there were any changes that were made to R5's MD orders regarding treatment of the pressure injuries. RN-J stated that R5 already had previous treatment orders in place before R5's hospitalization and those treatment orders continued the entire time RN-J cared for R5's wounds. RN-J stated that RN-J was more focused on R5's comfort. RN-J stated that R5 was not eating or drinking so the pressure injuries were not going to heal but RN-J wanted to make sure that R5 was comfortable. Surveyor asked what interventions were in place for R5's skin integrity. RN-J stated R5 had the following interventions on the hospice care plan: Air mattress. Incontinent care. Assess skin and pressure areas. SNF (skilled nursing facility) to perform wound care. Surveyor asked if RN-J's hospice care plan included any offloading measures for R5. RN-J stated that RN-J remembers R5 having a pillow offloading her coccyx area. RN-J stated that RN-J was not sure if R5 was turned every 2 hours because that would be the facility staff responsibility. Surveyor noted that the facility communication of the wound care plan was not communicated clearly to RN-J. Surveyor noted that none of the wound measurements given to Surveyor in the interview with RN-J were located anywhere within R5's electronic medical record. Surveyor noted that without facility and hospice staff knowing the status of R5's wounds, staff would not be able to tell if the wounds were deteriorating or not. Surveyor noted that the new wound on R5's Right lateral leg was designated a laceration by RN-J. Surveyor noted that a treatment was put in place but there was not a root cause analysis completed for the [DATE] wound. Surveyor noted that the right lateral leg wound was not thoroughly assessed or measured until 5 days after its development and was not thoroughly assessed or measured weekly. R5's facility care plan or hospice care plan were not updated with a new intervention after the development of this new wound. Surveyor noted that R5's coccyx pressure injury was not thoroughly assessed or measured after R5 was placed on hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted that R5's right heel pressure injury was not assessed on admission to the facility. The right heel was not assessed or measured from [DATE] through [DATE]. The [DATE] assessment completed by RN-J did not include a thorough wound bed assessment including the percentage of eschar, slough, or granulation tissue present. The right heel was not assessed or measured from [DATE] through [DATE]. The [DATE] and the [DATE] assessment completed by RN-J did not include a thorough wound bed assessment including the percentage of eschar, slough, or granulation tissue present. On [DATE] at 9:12 AM, Surveyor interviewed NP-G, who is the facility's Wound Nurse Practitioner. NP-G stated that NP-G initially saw R5 after R5 developed a coccyx/sacral pressure injury and cared for R5 until R5 went on hospice. NP-G stated that R5's overall condition was declining and R5 was refusing oral intake. NP-G stated that NP-G talked to R5's family about Arterial studies and more aggressive care after R5 developed the right heel pressure injury, but the family was not agreeable to an aggressive plan. NP-G stated that the goal was limit the risk of infection and continue with treatments on the pressure injury areas. NP-G stated on [DATE] when R5 was transferred to the hospital, R5 had taken a fast downward spiral. NP-G stated R5 was not acting like herself. NP-G stated when R5 returned to the facility, NP-G was no longer involved in R5's care. Surveyor asked if R5's wound care and assessments schedule would need to change since R5 was on hospice. NP-G stated that taking care of R5's wound would be no different if R5 was on hospice or not. NP-G stated that you still need to do assessments and change treatments as needed while a resident is on hospice. NP-G stated that at other facilities, NP-G continues to care for resident's wounds even when the resident is put on hospice. NP-G did not know why the decision was made for hospice to care for R5's pressure injuries. On [DATE] at 10:13 AM, Surveyor observed R5 on R5's back sleeping in bed. R5's head of the bed was elevated 35 degrees. R5's air mattress was on and functioning. Surveyor did not observe a Prevalon boot on R5's right lower extremity. On [DATE] at 11:36 AM, Surveyor observed R5 sitting up in a cushioned Broda chair. R5 appeared comfortable and was sleeping. R5 had socks on without shoes. R5's progress note dated [DATE] at 10:00 PM documents, Writer called to resident room by [staff member] the [Certified Nursing Assistant] that the resident was not breathing, at around [9 PM]. Writer went to resident's room assessed resident and confirmed that resident was not breathing. Writer updated hospice; writer also left a message for the [Power of Attorney] and emergency contact to call the facility for update. The [Director of Nursing] updated by text. Hospice nurse is here at the moment, she stated she updated resident's son. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:08 AM, Surveyor interviewed DON-B. Surveyor asked about R5's pressure injuries and the plan for hospice involvement for R5's wound care. DON-B stated that R5 did not have a good potential for healing R5's wounds because R5's health was declining and R5 was not eating enough. DON-B stated that the facility had tried to get R5 into hospice sooner but R5's family was not agreeable. Surveyor asked what was expected of hospice staff for R5's wound care after R5 returned to the facility on [DATE]. DON-B stated that RN-J was to take over all aspects of R5's wound care after R5 was admitted to hospice. DON-B stated the facility wound NP no longer visited R5 anymore. Surveyor asked how this plan was communicated to the hospice staff. DON-B indicated that it was a conversation. Surveyor informed DON-B of the concerns that R5's coccyx pressure injury was not thoroughly assessed or measured by the facility or hospice from [DATE] through [DATE]. When R5 returned to the facility on hospice, communication was not clear, assessments and measurements of R5's heel pressure injury were not completed weekly. In addition, documentation of the measurements completed by hospice staff were not anywhere in R5's electronic medical record. R5 developed a new wound on [DATE]. The wound was not measured by facility or hospice staff until [DATE]. A root cause analysis of the wound was not completed. DON-B stated ok. Surveyor asked what the process is when a nurse finds a new wound on a resident. DON-B stated the nurse should do an assessment, notify the doctor, power of attorney, and wound care nurse (ADON-E). Surveyor asked what the initial assessment should include. DON-B indicated the wound should be measured and have a description of the wound bed including the surrounding skin, drainage, and odor. DON-B stated that an intervention should be placed to address the area of concerns. On [DATE] at 11:08 AM, Surveyor interviewed Nursing Home Administrator about R5's wounds after R5 was placed on hospice. NHA-A indicated that NHA-A did not like that R5's wound care assessments and measurements were missed. NHA-A stated that NHA-A was not happy with the hospice care team. NHA-A indicated that NHA-A had spoken to the director of the hospice company and informed the director that the facility would be taking back the responsibility of doing resident's wound care even while on hospice. NHA-A stated that NHA-A can only correct the problem and then focus on improvement going forward. No further information was provided as to why the facility failed to ensure Hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for R5.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 21855 Based on observation, record review and interview, the facility did not implement infection control measures. This was observed with 2 (R41 and R38) of 2 residents with glucometer's. The facility did not conduct an infection control program to prevent, and track, potential infections. This had the potential to effect all 43 residents in the facility. * R41 and R38 received blood sugar through a unsanitized glucometer machine. * The facility did not transport linens under sanitary conditions. * The facility did not implement and document Legionella control measures. * The facility did not track staff who can utilize a N95 mask during an outbreak. * The facility did not calculate infections to determine trends for preventative interventions. * The facility did not document surveillance of infections to identify concerns. Findings include: The facility's policy and procedure Infection Control, dated 9/20/2023. The procedure under surveillance states: Properly store, handle, process, and transport linens to minimize contamination.; Perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection.; Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions. LAUNDRY 1.) On 11/13/24, at 9:21 AM, Surveyor observed Laundry Staff (LS)-S delivering clothes to residents on the 2nd floor. Surveyor observed there was no cover over the clothes rack in the hallway. The clothes were delivered by LS-S to rooms as the clothes rack was stationary in the hallway uncovered. Surveyor interviewed LS-S about clothing delivery. LS-S stated they have been working in Laundry for a year and has never seen a cover for the cart. On 11/13/24, at 9:49 AM, Surveyor interviewed Laundry Supervisor (LS)-T, along with observing the facility Laundry areas. LS-T did not have any covers for the clothing racks and was not aware of using them. WATER MANAGEMENT During review of the Facility Assessment, dated 7/31/24, Surveyors noted the facility assessment does not identify who makes up the Water Management Committee for the facility and how the facility addresses the possibility of Legionella. (Cross-reference F838). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the Facility's Water Management Plan. The facility identifies the following control measures to prevent Legionella: - ice machine cleaning every 3 months. - circulation pumps checked for functioning weekly. - water heaters monitor weekly. - unoccupied resident rooms - run faucet. Surveyor requested documentation to review how these control measures were being carried out. On 11/13/24, at 1:50 PM. Maintenance Director (MD)-I provided an invoice for cleaning the ice machine. Review of the provided ice machine invoice does not indicate what was completed during the cleaning. MD-I does not have documentation of water boiler temperatures. Surveyor reviewed the documentation for control measures from the facility plan with MD-I. MD-I only has the ice machine contractor service report. MD-I showed Surveyor a blank form for unoccupied resident room checks. MD-I was able to show documentation for the circulating pumps. However, the documentation is for oiling the circulation pumps every 2 months versus showing they are checked weekly for functioning. On 11/13/24, at 2:27 PM, MD-I provided Surveyor 1 form for running the faucet in an unoccupied resident room. The last entry was from 1/2/2024. MD-I did not have any additional documentation. There is no water heater temperature documentation. It was noted there is no documentation indicating the control measures per the facility water management plan, are being carried out as planned. On 11/13/24, at 2:40 PM, MD-I spoke with Surveyor. MD-I stated the Ice Machine company does the checklist attached to the invoice. However, the checklist is blank. The ice machine invoice just indicates preventative maintenance. There is no documentation of what was performed with the facility ice machines to prevent Legionella. OUTBREAK N95 MASK On 11/13/24, at 1:14 PM, Surveyor interviewed the (Infection Preventionist) IP-B and (Nurse Consultant) NC-C. IP-B has been in this role since August 2024. NC-C stated the Nurse Educator for the facilities comes in annually to do staff fit-testing. NC-C provided a binder with staff names and types of mask. There are no dates documented, nor does the list identify if these are current staff or not. NC-C stated they will look for more information regarding how they complete/maintain staff being fit tested in preparation of an outbreak. On 11/13/24, at 2:46 PM, NC-C spoke with Surveyor. NC-C was unable to provide a current list of staff that are N95 fit tested . NC-C could only locate a staff list from 2021. SURVEILLANCE/TRACKING/TRENDS (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/13/24, at 1:14 PM, Surveyor interviewed, IP-B and NC-C, and reviewed the facility's Infection Control program. The surveillance tracking documentation does not have consistent data, nor current infections in the facility. The surveillance/tracking forms are not documented per infection to help identify trends in infections/infection activity in the facility. It was identified the facility utilizes McGeer's criteria for their definitions of infections. IP-B indicated they do utilize this criteria if a resident is admitted from the hospital on an antibiotic. IP-B shared they do not document when isolation is required, or the type of organism of the infection to identify training and preventative measures. IP-B shared the facility floor nurses will call IP-B with any newly ordered antibiotic or symptoms. IP-B also reviews the Electronic Record Monitoring daily as part of infection prevention and control. IP-B stated they also review the infection details monthly with Quality Assurance and Improvement Plan (QAPI) meetings. On 11/14/24, at 8:41 AM, IP-B spoke with spoke with Surveyor. IP-B queried the process to calculate baseline infection rates. IP-B showed Surveyor the formula to calculate baseline infection rates. Surveyor noted IP-B is calculating by the group of all infections in a month and that IP-B is not calculating infections individually and by census days to determine trends. The IP-B stated moving forward, they will calculate infection rates per infection and census days. 38146 Glucometer Sanitization On 11/12/24 at 7:36 AM, Surveyor observed RN (Registered Nurse)-O prepare to do blood sugar testing for R38. RN-O removed a glucometer, alcohol wipes, bottle of strips and a lancet from the left pocket of her scrub uniform. RN-O applied gloves, wiped R38's finger with an alcohol wipe, poked her finger and obtained a blood sample using the glucometer. RN-O wiped R38's finger with a tissue and discarded the lancet in the garbage can. RN-O walked back to the medication cart, placed the glucometer on top of the cart (without a barrier), removed her gloves, sanitized her hands and proceeded to prepare R38's medications. After administering R38's medications, RN-O walked back to the medication cart, picked up the glucometer and placed it in her left scrub pocket. Surveyor noted the glucometer was not cleaned after obtaining R38's blood sugar. Surveyor continued to observed RN-O during medication pass. On 11/12/24 at 8:07 AM, Surveyor observed RN-O prepare to do blood sugar testing for R41. RN-O removed the glucometer and supplies from her left scrub pocket, entered R41's room, sanitized her hands and applied gloves. RN-O wiped R41's finger with an alcohol wipe, poked his finger and obtained a blood sample using the glucometer. After obtaining R41's blood sugar, RN-O placed the glucometer in the left pocket of her scrubs, removed her gloves and sanitized her hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525524	A. Building B. Wing	11/14/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/12/24 at 8:18 AM, Surveyor asked RN-O if residents have their own glucometer's or if they are shared between residents. RN-O stated, They share, we have two. RN-O opened the drawer of the medication cart revealing an empty black pouch. RN-O stated, The other one must be on the treatment cart. Surveyor confirmed RN-O used the observed glucometer to test blood sugars for both R38 and R41. Surveyor asked what is used to clean the glucometer. RN-O stated, Either alcohol wipes or a sanitizing wipe, we have a container. RN-O looked on, and in the medication cart, but did not locate a container of sanitizing wipes. RN-O stated, It must be on the treatment cart. On 11/12/24 at 9:07 AM, Surveyor advised DON (Director of Nursing)-B of observation the shared glucometer used on the first floor was not cleaned between residents' use. Surveyor asked for a list of residents on the first floor that require blood sugar testing and the policy and procedure on glucometer cleaning. Surveyor reviewed diagnoses of residents that utilize the shared glucometer on the first floor. There were no residents (including R38 and R41) with communicable disease. On 11/12/24 at 11:04 AM, Clinical Development Coordinator-D advised Surveyor the facility does not have a policy and procedure on glucometer cleaning. Surveyor asked what is the expectation for cleaning of the glucometer. Clinical Development Coordinator-D reported the expectation is staff would use the Sani cloth wipes (with the purple top), adding Alcohol wipes are not effective for cleaning glucometer's. Education has been provided to all staff. No additional information was provided. 50700

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 50700 Based upon interview and record review, the facility did not ensure it maintained an antibiotic stewardship program for 1 (R7) of 1 residents reviewed receiving an antibiotic prophylactically for clostridium difficile (c-diff). R7 started receiving vancomycin prophylactically for c-diff in April of 2023. The facility infection preventionist (IP)/Director of Nursing (DON)-B was not aware R7 received an antibiotic prophylactically. R7's antibiotic use was not monitored or reviewed during infection prevention and control surveillance and reporting to the facility quality improvement team (QAPI). Findings include: The facility's Policy & Procedure titled: Infection Control, with review date of 09/20/2023 documents: Subject: Antibiotic Stewardship. II. Procedure Leadership-The infection Preventionist (IP) will be identified to support the facility's safe and appropriate use of antibiotics. Accountability: 1. Review infections and monitor antibiotic usage patterns through Quality Assurance Performance Improvement (QAPI) process. 3. Monitor antibiotic resistance patterns and infections. On 11/12/2024, Surveyor reviewed R7's medical record and noted R7 has an order to receive the antibiotic (ABT) Vancomycin Hydrochloride Oral Capsule, 125 milligrams 1 capsule twice a day, Surveyor noted the order started in April 2023. Surveyor also noted the documentation in R7's medical record indicating Gastrointestinal (GI) recommended possible fecal transplant in 2021, patient declines. On 11/13/2024, at 09:10 AM, Surveyor interviewed the IP/Director of Nursing (DON)-B regarding R7's order to receive an antibiotic going back to April of 2023 as a prophylactic medication. IP/DON-B shared with Surveyor she didn't know that R7 was currently taking an antibiotic and started to look in the computer at R7's record. IP/DON-B stated R7 is currently on this antibiotic but, IP/DON-B is not tracking the medication as part of infection control because it is being used prophylactically and not due to an active infection. Surveyor reviewed the facility's policy along with IP/DON-B and noted the policy didn't specify tracking for antibiotics would only consist of antibiotics used for current infections. DON-B said she would have to look some more and get back to surveyor later. On 11/13/2024, at 02:37 PM, surveyor interviewed Nursing Home Administrator (NHA)-A and Surveyor explained that IP/DON-B is aware of a prophylactic antibiotic concern regarding R7. Surveyor reviewed the facility policy with NHA-A with no additional information received. NHA-A stated they don't know who is on antibiotics in the facility but acknowledged IP/DON-B is aware of the concern.