STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525528	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Woods	19525 W North Ave Brookfield, WI 53045

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interviews and record review the facility did not document a thorough investigation and did not resolve grievances as outlined in the facility policy for 3 (R4, R12 and R13) of 6 residents reviewed for grievances. *R4 filed a grievance on 1/29/25. The facility did not document a thorough investigation. The grievance was not resolved by issuing a final written grievance decision to R4 as outlined in the facility policy. *R12 filed a grievance regarding a negative interaction with a Certified Nursing Assistant (CNA). The facility did not document a thorough investigation and did not document a resolution. *R13 filed a grievance about a request to be double briefed. The facility did not document a thorough investigation and did not a document a resolution. Findings include: (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Complaints and Grievances with a last reviewed date of 5/2023, documents, in part: This policy sets forth the minimum standards . which must be met at each senior living community with respect to complaints and grievances .It is the policy of [facility] to provide residents and family members . the opportunity to voice complaints and grievances free from restraint, interference, coercion, discrimination or reprisal . Complaints and grievances will be documented and managed in accordance to this policy . The Grievance Official or designee, will be responsible for the complaint and grievance process through their conclusion to include: 1. Review and provide an acknowledgement of receipt of grievances to complainant. 2. Coordinating the investigation . to include but not limited to: Reviewing reports for any reportable issues. Interviewing complainant, staff and/or witnesses. Reviewing the medical records . Acknowledging the grievance within 7 working days from receipt. Issuing a final written grievance decision to the resident and/or family members within a reasonable time frame but not to exceed 30 days . Immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property . Retain evidence, documents, or reports demonstrating the results of all complaints or grievances for a period of no less than 3 years from the issue date of the grievance decision . 3. Documentation of complaints and grievances must be captured and include: Date the grievance or complaint was received orally or in writing. A summary statement of the resident's or resident representative's grievance. The steps actions taken to investigate the grievance. A summary of the pertinent findings or conclusions regarding the resident's . concerns. A statement as to whether the grievance was confirmed or not confirmed .Date the written decision was issued to complainant in response to their grievance. 4. Response timeline for complaints and grievances will be as follows: All complaints and grievances received by associates will be documented and reported by end of shift. Acknowledgment of grievance will be provided to complainant when available within 7 working days from date of receipt. Issuing of a final decision in writing on all grievances will be provided to the complainant when available within a reasonable time frame but not to exceed 30 days from date of receipt . 1.) R4 was admitted to the facility on [DATE] for rehabilitation after a surgical procedure. R4's Admission Minimum Data Set (MDS) assessment dated [DATE], documents R4's cognition is intact. Surveyor reviewed the facility's grievance log. Surveyor noted a grievance filed by R4 on 1/29/25 which documents: Resident stated that staff did not check on her for hours. Nurse manager spoke with staff who answered residents call light multiple times. Resident also received a pain pill at 3 PM. Nurse manager spoke with resident regarding the above. Resident stated staff did check on her, but it felt like they didn't all afternoon. Residents denied questions/concerns. Concern resolved 1/30/25. On 3/19/25, Surveyor asked Nursing Home Administrator (NHA)-A for the investigation into the grievance that R4 filed on 1/29/25. NHA-A informed Surveyor that the facility did not have any further documentation other than what is listed on the grievance log. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 9:32 AM, Surveyor interviewed Unit Manager (UM)-D. Surveyor asked if UM-D was the Nurse Manger listed in R4's grievance. UM-D stated yes. Surveyor asked what UM-D discovered during the investigation of R4's grievance. UM-D stated that R4 returned from a MD appointment on 1/29/25 and R4's bed was not made. This upset R4. R4 did not report being upset until the next day (1/30/25) and that is when UM-D began to investigate. R4 told UM-D about the bed being unmade and that R4 was not checked on for hours. UM-D stated that UM-D spoke to the Certified Nursing Assistant (CNA) and the Nurse who cared for R4 on 1/29/25. UM-D stated that the CNA promptly made R4's bed. The CNA brought R4's lunch to R4 and answered the call light 2 times. UM-D stated the nurse assessed R4's pain and provided pain medication the afternoon of 1/29/25. UM-D stated that UM-D informed R4 of these additional interactions with staff on 1/29/25. UM-D stated that R4 stated that R4 was just upset with the room condition and that is what made R4 upset. Surveyor asked if UM-D had documentation of her investigation and interviews with staff and R4. UM-D stated No. Surveyor asked if UM-D documents the resolution of grievances or provides a final decision in writing. UM-D stated No. Surveyor noted that the facility did not document the steps taken and the interviews completed during the investigation of R4's grievance. On 3/19/25 at 11:49 AM, Surveyor interviewed Social Worker (SW)-G, who is the grievance officer for the facility. Surveyor asked what the process is for filing and investigating a grievance. SW-G indicated that grievances are reported to SW-G at any time and will sometimes be reported to SW-G during morning meeting. SW-G will log the grievance. If it is nursing related, the nurse manager will investigate. If it is dietary, the dietary manager will investigate. SW-G indicated that once the investigation, the department who handled the grievance will follow up with the resident/resident representative. Once all of that is completed, SW-G will close the grievance and will follow up as needed. Surveyor asked for additional documentation for R4's grievance on 1/29/25. SW-G indicated that UM-D took care of that grievance. SW-G stated that the only documentation that SW-G has is the grievance log. Surveyor asked if R4 should have received a written resolution letter as outlined in the facility policy. SW-G stated yes. Surveyor asked if R4 was given a written resolution letter. SW-G stated that SW-G did not think she was given a written resolution letter. Surveyor noted that R4 was not given a written resolution letter as outlined in the facility policy. On 3/19/25 at 3:05 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B of the concern that R4's grievance investigation was not documented as outlined in the facility policy and R4 was not provided a written resolution letter as outlined in the facility policy. NHA-A stated that NHA-A understood. No further information was provided as to why the facility did not document a thorough investigation and did not resolve grievances as outlined in the facility policy. 21855 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 3/18/25 Surveyor obtained, and reviewed, the facility Grievance Log. The Log documents: The date, resident, department assigned, room number, who voiced concern and summary of concern with resolved date. On 1/14/25 (R12) stated they did not like their interactions with on of the Certified Nursing Assistants (CNA). The Nurse Manager spoke with the CNA and that CNA was no longer assigned to the resident. (R12) also stated that they only are receiving 20 minutes of therapy per session. Discussed therapy session durations with therapy and (R12). Social Service (SS) followed up with (R12) regarding therapy and (R12) stated it was getting better and denied further concerns. Concern resolved 1/16/25. On 3/18/25, at 3:00 PM, at the facility exit meeting with Nursing Home Administrator (NHA) - A and Director of Nurses (DON) - B, Surveyor requested the investigation for R12's concerns. On 3/19/25, the facility had placed in the conference room, 10 interview sheets dated 1/15/25. The interview questions were related to interactions with CNA-I. It was discovered that Social Worker (SW) - F provided the forms and these were resident interviews. On 3/19/25, at 8:50 AM, Surveyor interviewed CNA-I. CNA-I stated (R12) was spitting toothpaste at them while talking and pointing their finger in their face. CNA-I stated R12 was not nice and was disrespectful. R12's girlfriend was in the room and told CNA-I to leave R12 alone. CNA-I stated (R12) was telling lies and not being nice. The CNA-I stated they told the Unit Manager (UM) -D and SW-F right away. The CNA-I stated (R12) was not on their assignment after that and moved to a different unit. On 3/19/25, at 9:11 AM, Surveyor interviewed SW-F. SW-F stated they just log the concerns on the Grievance Log. They talk about concerns in the morning meetings as a group. There is not a written document completed for concerns/grievances. SW-F does not conduct the investigations. SW-F completed the resident interviews for CNA-I's assignment from 1/14/25. SW-F thought they were directed to complete the interviews. SW-F stated the UM- D would complete the investigation. SW-F did not have any documentation of the investigation process, and what the actual interactions were between CNA-I and R12. On 3/19/25, at 9:35 AM. Surveyor interviewed UM-D. UM-D provided 6 typed, resident interview sheets, dated 1/15/25. UM-D did not know SW-F provided, and conducted, resident interviews on 1/15/25. UM-D stated R12 brought up the concern with CNA-I during a Care Conference on 1/14/25. UM-D stated R12 did not provide the exact interaction with CNA-I. R12 expressed they just do not get along with CNA-I. UM-D removed R12 from CNA-I assignment. UM-D stated they educated CNA-I to get a nurse if they have a conflict with a resident. The UM-D does not have a written documentation of their investigation process, details of the interaction to determine appropriate corrective action, along with resolution. UM-D did not have written interviews from CNA-I or any other potential witnesses. There is not a written documentation of the investigative process to confirm, or not to confirm, the allegation occurred. On 3/20/25, at 1:44 PM, Surveyor interviewed R12. R12 could not recall the exact details anymore. R12 stated that CNA-I had a bad attitude. R12 stated CNA-I was getting loud and theatrical in the hallway that day. R12 has not had CNA-I help them after that event. R12 did not have any other staff concerns. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25, at 9:49 AM, Surveyor interviewed NHA-A. NHA-A was not the Administrator on 1/14/25. The NHA-A does not have any additional information. The facility did not have evidence of a comprehensive investigation process of R12's care concerns with CNA-I. 3.) On 3/18/25 Surveyor obtained, and reviewed, the facility Grievance Log. The Log documents: The date, resident, department assigned, room number, who voiced concern and summary of concern with resolved date. On 1/21/25 (R13) reported to Social Worker (SW) that a Certified Nursing Assistant (CNA) told them no when (R13) had asked to be double briefed. SW, nurse manager and Administrator all spoke with (R13) in regards to why staff at the facility cannot double brief. R13 understood. Resolved 1/21/25. On 3/18/25, at 3:00 PM, at the facility exit meeting with, Nursing Home Administrator (NHA) - A and Director of Nurses (DON) - B, Surveyor requested the investigation for R13 concerns. On 3/19/25, at 9:11 AM, Surveyor interviewed SW-F. SW-F stated they just log the concerns on the Grievance Log. They talk about concerns in the morning meetings as a group. There is not a written document completed for concerns/grievances. SW-F does not conduct the investigations. SW-F did not have any documentation related to R13's concern on 1/21/25. On 3/19/25, at 9:35 AM. Surveyor interviewed UM-D who oversees R13 care needs. UM-D stated the social worker is in charge of grievances. UM-D did not have any information on R13. On 3/20/24, at 9:35 AM, DON-B spoke with Surveyor. DON-B stated corporate human resources completed the investigation on R13's concerns. DON-B did not have any documentation on the investigation process related to R13's concerns. On 3/20/25, at 9:49 AM, Surveyor interviewed NHA-A. NHA-A was not the Administrator on 1/14/25. The NHA-A does not have any additional information. On 3/20/25, at 11:23 AM, DON-B provided Surveyor an email from corporate human resources. The email did not include any information related to R13's concern. DON-B did not have any information related to R13's concern. R13 was not available for a interview during the survey. The alleged CNA was not known. There was not documentation of the investigative process.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 21855 Based on record reviews and interviews, the facility did not implement their written policies and procedures for investigating, and reporting, allegations of abuse. This was observed with 3 (R11, R10 and R9) of 3 residents reviewed with allegations of abuse. The facility did not implement a documented, comprehensive investigative process for determining abuse which has the potential to effect all 84 residents in the facility. *R11 asked to be changed and Certified Nursing Assistant (CNA) -V stated they just started their shift and would be back, and eventually, came back. CNA-V told R11 to quit looking at the clock to see how long it's been. CNA-V told R11 to turn their light, and television off, and go to bed, however R11 wanted these on. CNA-V told R11 just because their old doesn't mean they can't learn. R11 said ouch during cares provided by CNA-V. CNA-V told R11 they are not going to help them if they keep saying ouch. * Facility Grievance Log documents R10 reported a poor interaction with a CNA on 1/29/25. A facility email by corporate human resources documents: CNA-V went into R10's room to change them, at midnight, and told R10 not to call again. CNA-V threw R10's blankets, and clothing, across the room then left R10 in just a brief, in bed, and did not come back until 5:00 AM (5 hours later). * R9 did not want a male caregiver to assist them with cares. The male caregiver did not relay this information to anyone else. Subsequently, R9 did not receive cares during the male caregivers shift. CROSS REFERENCE F585, F609 and F610. Findings include: 1. The facility's policies and procedures Abuse Investigation and Reporting revised 11/2023. The Policy Statement documents: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging of resident, and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the [Corporation's name] Abuse Prevention Policy.; The Policy Interpretation And Implementation documents: A. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator or designee will assign the investigation to an appropriate individual. B. The Administrator or Designee will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. The Administrator or designee will keep the resident and his/her representative informed of the progress of the investigation. D. The Administrator or designee will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation.: The Role of the Investigator documents: A. The individual conducting the investigation will, at a minimum: 1. Review the completed documentation forms; 2. Review the resident's medical record to determine events leading up to the incident; 3. Interview the person (s) reporting the incident; 4. Interview any witnesses to the incident; 5. Interview the resident; 6. Interview the resident's attending physician as needed; 7. Interview associates members (on all shifts) who have had contact with the resident during the period of the alleged incident; 8. Interview the resident's roommate, family members, and visitors; 9. Interview other residents to whom the accused employee provides care or services; 10. Review events leading up to the alleged incident. B. 3. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have them sign and date it; Reporting documents: A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported to the Administrator or designee and to the following officials or agencies; 1. The State licensing/certification agency responsible for surveying/licensing the community; 2. Other officials in accordance with State Law; . F. If the investigation reveals that the allegation(s) of abuse are founded, appropriate corrective actions will be taken, including but not limited to terminating the involved employee (s) and reporting the employee to applicable licensing agency and governing authorities. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/25, at 3:00 PM, at the facility daily exit meeting with Nursing Home Administrator (NHA) - A and Director of Nurses (DON) - B, Surveyor requested the investigation for R10's concerns with a CNA documented on the facility Grievance Log. On 3/20/25, at 8:00 AM, Surveyor interviewed DON-B regarding R9's care concerns. R9's family expressed care concerns on 2/17/25. The concern was documented on the facility Grievance Log, however there were no details, or documentation, on what care concerns were voiced. DON-B stated Unit Manager (UM)-E has worked closely with R9 and their daughter. DON-B did not have any further documentation related to the concerns. On 3/20/25, at 9:35 AM, DON-B informed Surveyor that an email correspondence regarding R10's concern on 1/29/25, was being sent to them by corporate human resources. On 3/20/25, at 11:23 AM, DON-B provided Surveyor with an email correspondence between corporate human resources and Unit Manager (UM)- E. Surveyor noted DON-B was also included in the email correspondence. The email, dated 1/29/25, documents R10's concern and R11's concern. R10 and R11 voiced concerns regarding CNA-V on 1/29/25. On 3/20/25, at 9:49 AM, Surveyor interviewed NHA-A. NHA-A stated he is in the process of investigating a care concern by R9 from 3/13/25. NHA-A stated he would look into information regarding R9's care concerns from February. NHA-A stated he did not recall any Facility Reported Incidents (FRI) for R10, or R11 related to care concerns with CNA-V. NHA-A did not recall being aware of any concerns expressed by R10 and R11. On 3/20/25, at 11:00 AM, Surveyor interviewed UM-E. UM-E stated nothing happened on 2/17/25, contrary to the date on the Grievance Log. UM-E stated there was a concern with a male agency CNA. UM-E did not know the date, or the CNA's name. UM-E stated R9 did not want cares by a male CNA, and the male CNA assigned to care for her did not tell anyone R9 needed cares. The UM-E stated DON-B was included in the email on 1/29/25 regarding R10 and R11's concerns with CNA-V. UM-E found out about R11's care concern with CNA-V while interviewing other residents due to R10's original concern with CNA-V. UM-E stated CNA-V was a Float Pool (Company owned pool of staff that float where needed.) staff and the corporate human resources would take care of it. UM-E did not have any documentation of a thorough investigation into the concerns expressed by R9's family, and R10 and R11. On 3/20/25, at 11:23 AM, Surveyor interviewed DON-B regarding R10's and R11's care concerns with CNA-V. DON-B stated they talk about resident concerns in morning meetings. DON-B has only submitted 2 FRI's in the last 9 months, the previous Administrator submitted them. DON-B stated she did not know at the time the concerns against CNA-V would be a reportable incident of alleged abuse. On 3/20/25, at 2:33 PM, Surveyor interviewed NHA-A. Surveyor was provided with a Coaching Feedback form for CNA-W. The form documented on 2/18/25 a female resident (R9) declined care from the male caregiver (CNA-W). CNA-W did not report this to anyone else. R9 did not receive any care during CNA-W's 8 hour shift. CNA-W was re-educated on performance expectations. NHA-A felt the concern was related to CNA-W not telling anyone R9 did not want male caregivers. NHA-A stated he did not view this as a neglect of care and services for R9. Surveyor notes this neglect allegation was not thoroughly investigated or reported to the State Survey Agency. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not implement their policies and procedures related to protecting residents from abuse, reporting allegations to the Nursing Home Administrator and State Survey Agency or complete a thorough investigation into allegations of abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 21855 Based on record reviews and interviews, the facility did not ensure allegations of abuse were reported to the Administrator, and the State Survey Agency, as required. This was observed with 3 (R11, R10 and R9) of 3 residents reviewed for alleged abuse. *R11 alleged she asked to be changed and Certified Nursing Assistant (CNA) - V stated they just started their shift and would be back, and eventually, came back. CNA-V told R11 to quit looking at the clock to see how long it's been. CNA-V told R11 to turn their light, and television off, and go to bed, however R11 wanted these on. CNA-V told R11 just because their old doesn't mean they can't learn. R11 said ouch during cares provided by CNA-V. CNA-V told R11 they are not going to help them if they keep saying ouch. There is no evidence these concerns/interactions were reported to the Nursing Home Administrator and the State Survey Agency. *R10 reported a poor interaction with a CNA on 1/29/25. A facility email by corporate human resources documents: CNA-V went into R10's room to change them, at midnight, and told R10 not to call again. CNA-V threw R10's blankets and clothing across the room then left R10 in just a brief in bed and did not come back until 5:00 AM (5 hours later). There is no evidence this was reported to the Nursing Home Administrator and the State Survey Agency. *Surveyor investigated R9's care concerns from 2/17/25 related to not wanting a male caregiver to assist them with cares. The male caregiver did not relay this information to anyone else. R9 did not receive cares during the male caregivers 8 hour shift. There is no evidence this was reported to the State Survey Agency. The facility's policies and procedures Abuse Investigation and Reporting revised 11/2023. The Policy Statement documents: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging of resident, and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the [name of the company] Abuse Prevention Policy.; A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported to the Administrator or designee and to the following officials or agencies; 1. The State licensing/certification agency responsible for surveying/licensing the community; 2. Other officials in accordance with State Law. Findings include: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) On 3/20/25, at 11:23 AM, Director of Nursing (DON)-B provided Surveyor an email correspondence between corporate human resources and Unit Manager (UM)- E. Surveyor notes DON-B was also included in the email correspondence. The email, dated 1/29/25, documents R11's concern regarding Certified Nursing Assistant (CNA)-V. The email is the only documentation of R11's care concerns. R11 alleged she asked to be changed and Certified Nursing Assistant (CNA) - V stated they just started their shift and would be back, and eventually, came back. CNA-V told R11 to quit looking at the clock to see how long it's been. CNA-V told R11 to turn their light, and television off, and go to bed, however R11 wanted these on. CNA-V told R11 just because their old doesn't mean they can't learn. R11 said ouch during cares provided by CNA-V. CNA-V told R11 they are not going to help them if they keep saying ouch. On 3/20/25, at 9:49 AM, Surveyor interviewed Nursing Home Administrator (NHA)- A. NHA-A did not recall any Facility Reported Incidents (FRI) for R11's care concerns with CNA-V. NHA-A did not recall being aware of any concerns with R11. On 3/20/25, at 11:00 AM, Surveyor interviewed UM-E. The UM-E stated DON-B was included in the email on 1/29/25 regarding R11. UM-E became aware of R11's care concern with CNA-V, through interviewing other residents while completing an investigation into R10's concerns. UM-E stated CNA-V was a float pool staff and they (human resources) would take care of it. UM-E did not have any documentation of an investigation into R11's care concerns or notification of NHA-A of the concern. On 3/20/25, at 11:23 AM, Surveyor interviewed the DON-B regarding R11's care concerns with CNA-V. DON-B stated they talk about resident concerns in morning meetings and DON-B had only submitted 2 FRI's in the last 9 months. The previous Administrator submitted them. DON-B stated she did not know at the time the concerns expressed by R11 against CNA-V would be a reportable incident. R11 care concerns with CNA-V were not reported to the Nursing Home Administrator, and the State Survey Agency, as required. 2.) On 3/18/25 Surveyor obtained, and reviewed, the facility Grievance Log. The Log documents the date, resident name, department assigned to address the grievance, room number, who voiced concern, and summary of concern with resolved date. The Grievance Log documents: On 1/29/25 R10 reported they had a poor interaction with a CNA. Nurse Manager followed up with R10 and R10 felt the interaction was poor customer service. The CNA is a float pool and they will follow up. R10 reported CNA-V went into R10's room to change them, at midnight, and told R10 not to call again. CNA-V threw R10's blankets and clothing across the room then left R10 in just a brief in bed and did not come back until 5:00 AM (5 hours later). On 3/18/25, at 3:00 PM, at the facility daily exit meeting with Nursing Home Administrator (NHA) - A and Director of Nurses (DON) - B, Surveyor requested the investigation for R10's concerns. On 3/20/25, at 11:23 AM, DON-B provided Surveyor an email correspondence between corporate human resources and Unit Manager (UM)- E. Surveyor notes DON-B was also included in the email correspondence. The email, dated 1/29/25, documents R10's concerns regarding CNA-V. DON-B stated they did not have any additional documentation. (continued on next page)

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	525528	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Woods	19525 W North Ave Brookfield, WI 53045

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25, at 9:49 AM, Surveyor interviewed NHA-A. NHA-A did not recall any Facility Reported Incidents (FRI) for R10 care concerns with CNA-V. NHA-A did not recall being aware of any concerns with R10. On 3/20/25, at 11:00 AM, Surveyor interviewed UM-E. UM-E stated the DON-B was included in the email on 1/29/25 regarding R10. The UM-E stated CNA-V was a float pool staff and they, (human resources) would take care of it. UM-E did not have any documentation of an investigation of R10's care concerns. On 3/20/25, at 11:23 AM, Surveyor interviewed DON-B regarding R10 care concerns with CNA-V. DON-B stated they talk about resident concerns in morning meetings. DON-B has only submitted 2 FRI's in the last 9 months. The previous Administrator submitted them. DON-B stated they did not know at the time R10's concerns against CNA-V would be a reportable incident. R10's care concerns with CNA-V were not reported to the Nursing Home Administrator, and the State Survey Agency, as required. 3.) On 3/20/25, at 8:00 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R9's care concerns. R9's family expressed care concerns on 2/17/25. Surveyor notes this was documented on the facility Grievance Log, however there was no details, or documentation, on what care concerns were voiced. DON-B stated the Unit Manager (UM)-E has worked closely with R9 and their daughter. DON-B did not have any additional information. On 3/20/25, at 9:49 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated they were in the process of investigating a care concern of R9 from 3/13/25. NHA-A stated they would look into information regarding R9's care concerns from February. NHA-A did not recall any Facility Reported Incidents (FRI) for R9 prior to the current investigation. On 3/20/25, at 11:00 AM, Surveyor interviewed Unit Manager (UM)-E. UM-E stated there was nothing that happened on 2/17/25, contrary to the date on the Grievance Log. UM-E stated there was a concern with a male agency CNA. UM-E did not know the date, or the name of the CNA at this time. UM-E stated R9 did not want cares by a male CNA, and the male CNA-W, did not tell anyone that R9 needed cares. So care was not provided to R9 during CNA-W's shift. On 3/20/25, at 2:33 PM, Surveyor interviewed NHA-A. Surveyor was provided with a Coaching Feedback form for CNA-W. The form documents: On 2/18/25 a female resident (R9) declined care from the male caregiver (CNA-W). CNA-W did not report this to anyone else. R9 did not receive any care for CNA-W's 8 hour shift. CNA-W was re-educated on performance expectations. NHA-A felt this was an issue of the CNA-W not telling anyone and did not originally identify the concern of R9 not receiving care. Surveyor notes R9's care concern was not reported to the State Survey Agency as required.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51014 Based on interview and record review, the Facility did not thoroughly investigate allegations of abuse to prevent further abuse, neglect, exploitation and mistreatment from occurring for 5 (R5, R6, R11, R10 and R9) of 6 residents reviewed for abuse. R5's mistreatment allegation was not thoroughly investigated. R6's Power of Attorney made an allegation of abuse due to an injuries of unknown origin being discovered, no evidence of a thorough investigation can be provided. R11's abuse allegation was not thoroughly investigated R10's abuse allegation was not thoroughly investigated. 9's allegation of neglect was not thoroughly investigated. Findings include: The Facility Policy titled Abuse Investigation and Reporting Policy, revised 11/2023, documents, in part . Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging of residents, and/or injuries of unknown sources (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigation will also be reported as defined by the Facility Abuse Prevention policy. Role of the Investigator: A. The individual conducting the investigation will, at minimum: 1. Review the completed documentation forms; 2. Review the resident's medical record to determine events leading up to the incident; 3. Interview the person(s) reporting the incident; 4. Interview any witnesses to the incident; 5. Interview the resident (as medically appropriate); 6. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25, R5 accused CNA-S of making R5 wait for over an hour to be taken to the bathroom and when CNA-S assisted R5 to bed that evening R5's legs were slammed into the bed frame causing bruising. R5 believed CNA-S didn't want to take care of her. Surveyor reviewed the Facility Reported Incident (FRI) dated 2/10/25, which documented five resident interviews were conducted by Licensed Practical Nurse (LPN)- Unit Manager-D on 1/31/25 when the Facility became aware of the allegation. The residents interviewed resided on the 2W (West) unit and were assigned to Certified Nursing Assistant (CNA)-S on 1/30/25 when the alleged abuse occurred. One resident stating he was given a sponge bath last time but wanted a shower. No other concerns related to the care CNA-S provided were identified. CNA-S's work schedule on the day of alleged abuse and the following day when CNA-S, continued working, includes the following days: 1/30/25, am (day) shift, 3W (West) 1/30/25 pm (evening) shift, 2W 1/31/25 am shift, 2E (East) On 1/30/25, day of alleged abuse, no interviews were conducted for residents on 3W when CNA-S was assigned first shift nor on 1/31/25 on 2E, the following day where CNA-S continued to work. Also, on 1/30/25, during the PM shift, no other residents on the same unit CNA-S was assigned to and whom CNA-S could have assisted were interviewed. On 3/18/25, at 3:20 pm, Surveyor interviewed CNA-I who states, the residents are divided by unit and assigned to a CNA. When Surveyor asked if she would help out other residents not assigned to her, CNA-I states, if she is busy, the other CNA on unit would help out. Yes, these are all of our residents, even the nurse will help out. On 3/19/25, at 8:05 am, Surveyor interviewed LPN-P, who states even when CNA's are assigned to particular unit on the floor, they will absolutely help out the other residents on unit, including the entire floor. On 3/18/25, at 11:45 am, Surveyor interviewed DON-B who states the process for her investigation is to interview all staff involved, interview residents on the unit, interview resident/family of alleged incident, assess resident, potentially suspend caregiver pending investigation and potentially to call to police. On 3/19/25 at 8:33 am, Surveyor interviewed DON-B who indicates she believes the investigation was complete and thorough. Surveyor states to DON-B that the Facility Reported Incident (FRI) had missing components. Surveyor informed DON-B of the concern, residents who were either cared for or may have been cared for by CNA-S on the same day of alleged abuse on 1/30/25 nor the residents who CNA-S cared for on the day after were interviewed. DON-B states, she understood. On 3/19/25, at 3:05 pm, Surveyor notified both NHA-A and DON-B of the above concerns. 49011 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) R6 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes mellitus, cardiomyopathy, heart failure, cognitive communication deficit, mild cognitive impairment, and vascular dementia. On 1/30/25, the following diagnoses were added: unspecified severe protein-calorie malnutrition and encounter for palliative care. R6's Quarterly Minimum Data Set (MDS) with an assessment reference date of 11/16/2024, documents a Brief Interview for Mental Status (BIMS) score of 04, indicating R6 has severe cognitive impairment. The MDS documents R6 was assessed to have no behaviors exhibited during the look back period. R6 is always incontinent of bowel and bladder, no pressure injury was present, but that R6 is at risk of developing pressure injuries. R6 has an activated Power of Attorney (POA). R6's Significant Change MDS with an assessment reference date of 2/6/2025 does not document a BIMS assessment. The MDS documents R6 was assessed to have no behaviors exhibited during the look back period. R6 is always incontinent of bowel and bladder. No swallowing disorders were noted, R6 was coded to have a mechanically altered diet. Weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months was coded as yes, not on a physician prescribed weigh loss regimen. The MDS documents that no pressure injury was present, but that R6 is at risk of developing pressure injuries. Surveyor reviewed the Facility Reported Incident dated 2/18/2025 that documents R6's daughter voicing concerns that R6 was being abused by someone. She stated that R6 has bruised wrists, three skin tears and a UTI (urinary tract infection). She stated that she has found R6 tossed into bed like a rag doll with feet butt up against the footboard or bed and another time found R6 in bed with wet sheets and the room temperature lowered. She further stated she found the air mattress unplugged twice. Surveyor reviewed the Facility investigation documentation provided which included 11 staff interviews and 4 of like residents. None of the staff reported seeing any bruises or skin tears on R6. None of the residents reported any abuse concerns. Surveyor requested the police report involving R6's daughter's allegation of abuse from the police department and reviewed it. The police report documented that daughter reported R6 is possibly being abused by nursing staff due to bruising her wrist within the last 3 weeks. I was unable to speak with R6. Social Worker advised, all incidents are being investigated and have been reported to the state. No elder abuse was suspected. Surveyor noted that 5 dates were used by the Facility to sample nurses and Certified Nursing Assistants (CNAs) who worked with R6 leading up to the discovery of the injures. Surveyor notes on those 5 dates, 2 nurses and 5 CNAs that worked with R6 were not interviewed as part of the investigation. R6's Pressure Ulcers/Skin Prevention care plan documents the following pertinent interventions: -Air mattress with bolsters, check for proper functioning Q (per) shift. Start 4/6/2022 -Tubigrips on from hand to elbow in early am and off at bedtime. Hole cut for thumb. Start 8/9/2023 On 3/18/25, at 10:36 am, Surveyor observed R6 in bed sleeping. The air mattress was plugged in and functioning. R6's left hand was visible and a tubigrip was on with the thumb hole cut out and thumb protruding. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/25, at 10:42 am, Surveyor interviewed Licensed Practical Nurse (LPN)-H who stated R6 wears the tubigrips on their arms due to thin skin, they protect the skin. On 3/18/25, at 1:50 pm, Surveyor interviewed LPN-H again regarding the allegations of skin tears and bruises suffered by R6. LPN-H stated R6 has fragile skin. R6 likes to contract arms up to body and push the tubigrips up and down arms. LPN-H stated this could be how R6's skin was injured leading to the allegation of abuse involving R6. On 3/18/25, at 3:20 pm, Surveyor interviewed LPN-X about R6's wrists and was told R6 has always had bruising and skin tears on and off that is why the tubigrips were started. R6 takes them off and staff put back on. R6 crosses her arms and hands are at opposite wrist, her skin is frail and LPN-X feels R6 can squeeze wrists in this position. On 3/19/25, at 11:02 am, Director of Nursing (DON)-B provided Surveyor documentation titled Safety Event Manager that related to the investigation of this incident. Surveyor reviewed the Safety Event Manager documentation. The document stated the first skin integrity issue that occurred was reported 2/18/25 and is listed as a skin tear/discoloration. The description states contacted by unit manager regarding an email received by family. Discoloration noted to right hand and forearm, skin tear to distal aspect of right wrist, skin tear between thumb and right index finger, and skin tear/scab and discoloration to dorsal aspect of left hand. Arm protectors in place. Resident seen by wound care nurse and social work. Resident unaware of skin changes. Surveyor notes the closure date is listed as 2/19/25, and lists the closure reason as: closed with increased monitoring of similar occurrences. In the additional details section, it lists: no deviation from generally accepted performance standards, there were no preventable known complications, event was not preventable, event was not a safety event. Surveyor noted no additional documentation of the investigation was included within the document. The second skin integrity that is documented occurred on 2/19/25 and was reported 2/20/25. It listed the event type as skin integrity and nature is pressure injury. The description is upon skin assessment a darkened area measuring 1.0 cm (centimeters) x 2.0 cm was noted on residents right heel. On call supervisor updated. [Medical group updated. Skin prep applied. Prevalon boot applied. The closure date is listed as 2/25/25, with the closure reason listed as: closed with increased monitoring of similar occurrences. Surveyor noted no additional documentation of the investigation was included within the document. Surveyor noted the Safety Event Manager documents and the staff and residents' interviews are the only investigation documentation provided. Surveyor noted a root cause was not determined during the investigation to help identify interventions that would prevent further injury or abuse allegations from occurring. Surveyor noted no evidence of monitoring of similar occurrences was provided as stated in the Safety Event Manager documents. On 3/19/25, at 12:23 pm, Surveyor interviewed RN (Registered Nurse) Unit Manager-C regarding the bruises and skin tears on R6's wrists that were alleged as potential abuse on 2/18/25. Surveyor requested documentation of the investigation. RN Unit Manager-C stated they interviewed the CNAs and nurses that had contact with R6. The root cause of the skin tears was determined to be a blood draw, and the rest was chalked up to fragile skin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted no documentation of the root cause of R6's skin tears was provided and no interventions were put into place to prevent injury or abuse allegations from occurring. On 3/19/25, at 3:05 pm, during the daily exit meeting with DON-B and Nursing Home Administrator (NHA)-A, Surveyor informed them of the concern related to the lack of a thorough investigation regarding R6's abuse allegation on 2/18/25. Surveyor informed DON-B and NHA-A of the concern there is no root cause for the skin injuries or identification of interventions to prevent further injury or abuse allegations from occurring. Surveyor informed NHA-A and DON-B that not all staff were interviewed that worked with R6 on the sampled dates of 1/26/25, 2/6/25, 2/9/25, 2/13/25 and 2/16/25 to identify if they had additional information to add to the investigation. No additional information was provided as to why the Facility did not thoroughly investigate R6's POA's allegation of abuse on 2/18/25. 21855 3.) Surveyor reviewed a facility email which documented R11's concern with the care provided by Certified Nursing Assistant (CNA)-V. The email documented R11 asked to be changed and CNA-V stated they just started their shift and would be back, and eventually came back. CNA-V told R11 to quit looking at the clock to see how long it's been. CNA-V told R11 to turn their light and television off, and go to bed, however R11 wanted these on. CNA-V told R11 just because their old doesn't mean they can't learn. R11 said ouch during cares by CNA-V. CNA-V told R11 they are not going to help them if they keep saying ouch. On 3/20/25, at 11:23 AM, Director of Nursing (DON)-B provided Surveyor an email correspondence between corporate human resources and Unit Manager (UM)- E. DON-B was also included in the email correspondence. The email, dated 1/29/25, documents R11's concerns regarding CNA-V. The email is the only documentation of R11's care concerns related to CNA-V. DON-B stated they did not have any additional information. On 3/20/25, at 9:49 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated they did not recall any Facility Reported Incidents (FRI) related to R11's concerns with the care provided by CNA-V. NHA-A stated they did not recall being aware of any concerns expressed by R11. On 3/20/25, at 11:00 AM, Surveyor interviewed UM-E. UM-E stated DON-B was included in the email on 1/29/25 regarding R11. UM-E stated they found out about R11's care concern with CNA-V, through interviewing other residents related to R10's original concern. The UM-E stated CNA-V was a float pool staff (pool of staff that work for the organization but float to different buildings), and they would take care of it. UM-E stated they did not have any documentation of an investigation into R11's care concerns related to CNA-V. On 3/20/25, at 11:23 AM, Surveyor interviewed DON-B regarding R11's care concerns with CNA-V. DON-B stated they talk about resident concerns in the morning meeting. DON-B stated they only submitted 2 FRI's in the last 9 months. DON-B stated the previous Administrator submitted them. DON-B stated they did not know at the time that R11's concerns against CNA-V would be considered a reportable incident. Surveyor notes the Facility did not complete a thorough investigation into R11's concerns about the care provided by CNA-V (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) On 3/18/25 Surveyor obtained and reviewed the Facility Grievance Log. The log documents the date, resident name, department assigned to address the grievance, room number, who voiced concern and summary of concern with resolved date. The log documents: On 1/29/25, R10 reported they had a poor interaction with a CNA (Certified Nursing Assistant). Nurse Manager followed up with R10 and R10 felt the interaction was poor customer service. The CNA is a float pool staff person (pool of staff that work for the organization but float to different buildings), and the Nurse Manager will follow up. On 3/18/25, at 3:00 PM, at the facility exit meeting with Nursing Home Administrator (NHA) - A and Director of Nurses (DON) - B, Surveyor requested the investigation completed related to R10's concerns. On 3/20/25, at 11:23 AM, DON-B provided Surveyor with an email correspondence between corporate human resources and Unit Manager (UM)- E. DON-B was also included in the email correspondence. The email, dated 1/29/25, documents R10's concern about CNA-V. The email documents CNA-V went into R10's room to change them at midnight, and told R10 not to call again. CNA-V threw R10's blankets and clothing across the room. Then left R10 in just a brief in bed and did not come back until 5:00 AM (5 hours later). On 3/20/25, at 9:49 AM, Surveyor interviewed NHA-A. NHA-A stated they did not recall any Facility Reported Incidents (FRI) related to R10's care concerns with CNA-V. NHA-A did not recall being aware of any concerns with R10. On 3/20/25, at 11:00 AM, Surveyor interviewed UM-E. UM-E stated DON-B was included in the email on 1/29/25 regarding R10. UM-E stated CNA-V was a float pool staff, and they, would take care of it. UM-E did not have any further documentation of investigation into R10's care concerns. On 3/20/25, at 11:23 AM, Surveyor interviewed DON-B regarding R10's care concerns with CNA-V. DON-B stated they talk about resident concerns in the morning meetings. DON-B stated they had only submitted 2 FRI's in the last 9 months. The previous Administrator submitted them. DON-B stated she did not know at the time the concerns against CNA-V, would be considered a reportable incident. Surveyor notes the Facility did not complete a thorough investigation into R10's care concerns with CNA-V. 5.) On 3/20/25, at 8:00 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R9's care concerns. DON-B stated R9's family expressed care concerns on 2/17/25. Surveyor noted this was documented on the Facility's Grievance Log, however there were no details or documentation as to what care concerns were voiced. DON-B stated Unit Manager (UM)-E has worked closely with R9 and their daughter and DON-B did not have any additional information. On 3/20/25, at 9:49 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated he is in the process of investigating a care concern by R9 from 3/13/25. NHA-A stated he would look into information regarding R9's care concerns from February. On 3/20/25, at 11:00 AM, Surveyor interviewed UM-E. UM-E stated nothing happened on 2/17/25, contrary to the date on the Grievance Log. UM-E stated she was aware there was a concern with a male agency CNA and R9. UM-E did not know the date she became aware of the concern or the CNA's name. UM-E stated R9 did not want cares provided by a male CNA, and the CNA did not tell anyone R9 needed care assistance. (continued on next page)

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	525528	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Woods	19525 W North Ave Brookfield, WI 53045

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25, at 2:33 PM, Surveyor interviewed NHA-A. Surveyor was provided with a Coaching Feedback form for CNA-W. The form documents: on 2/18/25 a female resident (R9) declined care from the male caregiver CNA-W. CNA-W did not report this concern to anyone else. R9 did not receive any care for the 8 hour shift CNA-W worked. NHA-A stated CNA-W was re-educated on performance expectations. CNA-W signed and acknowledgement of this on 2/25/25. NHA-A felt the concern was CNA-W not telling anyone of R9's concerns and not R9 receiving cares. Surveyor notes the Facility did not conduct a thorough investigation of R9's concerns.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Uncorrected on Revisit Based on observation, interview, 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 3 (R6, R7, R8) of 3 residents reviewed for pressure injuries. *R6 developed a deep tissue injury (DTI) which was discovered on 2/19/25 by a Licensed Practical Nurse (LPN). There is no documentation that the DTI was evaluated by a Registered Nurse until the Wound Nurse Practitioner saw it on 2/27/25. Additionally, R6 did not have nutritional interventions attempted and R6's care plan was delayed in being updated. The DTI declined to a stage 3 pressure injury. *R8 developed a Stage 2 pressure injury to left buttocks on 3/10/25. The wound was not comprehensively assessed until 3/13/25. Treatment for the pressure injury was not obtained until 3/13/25 and R8's care plan was not updated until 3/13/25. *Facility staff documented R7 developed a new wound to R7's mid back on 3/9/25. The wound was not comprehensively assessed until 3/13/25 when the Wound Nurse Practitioner (NP)-M documented that the wound was a stage 2 pressure injury. R7's care plan was not updated with new interventions until 3/13/25, 4 days after the development of the pressure injury. On 3/16/25, R7's wound care was not documented as completed. Findings include: 1.) R6 was admitted to the facility on [DATE]with pertinent diagnoses that include type 2 diabetes mellitus, cardiomyopathy, heart failure, cognitive communication deficit, mild cognitive impairment, and vascular dementia. On 1/30/25, the following diagnoses were added: unspecified severe protein-calorie malnutrition and encounter for palliative care. R6's Quarterly Minimum Data Set (MDS) with an assessment reference date of 11/16/2024, documents a Brief Interview for Mental Status (BIMS) score of 04, indicating that R6 has severe cognitive impairment. The MDS documents that R6 was assessed to have no behaviors exhibited during the look back period. R6 is always incontinent of bowel and bladder. No swallowing disorders were noted, R6 was assessed to have a mechanically altered diet. The MDS assesses no weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The MDS documents that no pressure injury was present, but that R6 is at risk of developing pressure injuries. R6 has an activated Power of Attorney (POA). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R6's Significant Change MDS with an assessment reference date of 2/6/2025 does not document a BIMS assessment. The MDS documents that R6 was assessed to have no behaviors exhibited during the look back period. R6 is always incontinent of bowel and bladder. No swallowing disorders were noted, R6 was assessed to have a mechanically altered diet. The MDS assesses that Weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months occurred and R6 was not on a physician prescribed weight loss regimen. The MDS assesses that no pressure injury was present, but that R6 is at risk of developing pressure injuries. R6 had multiple Braden Scale for Predicting Pressure Score Risk evaluations done. Braden evaluations dated 3/9/24, 8/20/24 and 1/31/25 documented that R6 was assessed to have a score of 10, indicating R6 is at very high risk of developing a pressure injury. R6's Braden evaluation dated 11/10/24 documents R6's risk of developing a pressure injury to be a moderate risk with a score of 16. R6's Pressure Ulcers/Skin Prevention care plan documents the following interventions: Follow community skin care protocol. Start 11/10/2021 Treatments, as indicated, see physician order sheet. Start 11/10/2021 Pressure reducing mattress on bed. Start 11/10/2021 Air mattress with bolsters, check for proper functioning Q (each) shift. Start 4/6/2022 Assist with repositioning when in bed and Broda chair during rounding and cares. Start 4/6/2022 cushion to w/c (wheelchair). Start 12/27/2022 Tubi grips on from hand to elbow in early am and off at bedtime. Hole cut for thumb. Start 8/9/2023 Prevalon Boots while in bed. Start 2/21/2025 (R6) has impaired skin integrity related to right lateral heel DTI (deep tissue injury) noted on 2/19/25 Goal: (R6) will be free from signs and symptoms of infection and will demonstrate optimal healing Interventions: Provide treatment as ordered. Start 3/11/25 Follow with wound APNP (Advanced Practice Nurse Practitioner). Start 3/11/25 Per wound rounds on 3/13/25, with wound APNP, wound is now classified as a stage III (3) pressure injury. Start 3/14/25 (R6) has impaired skin integrity related to right medial heel DTI noted on 3/6/25 Goal: (R6) will be free from signs and symptoms of infection and will demonstrate optimal healing (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interventions: Provide treatment as ordered. Start 3/11/25 Follow with wound APNP. Start 3/11/25 R6's physician order dated 1/28/25 documents severe protein calorie malnutrition: hospice to eval (evaluate) and treat. R6's physician order dated 1/30/25 documents admit to (name of) Hospice Surveyor noted that R6's DTI was found on 2/19/25 and Prevalon boots were added on 2/21/25, which was 2 days after the DTI was identified. Surveyor noted that the rest of R6's care plan was updated 3/11/25 and 3/14/25. Surveyor noted that R6's the right medial heel has progressed to a stage 3 pressure injury, not the right lateral heel as documented in R6's care plan. R6's physician order dated 2/19/25 documents skin prep-topical every shift to be applied to right heel q (each) shift for protection and Heels to be elevated off bed with pillows-topical continuous for protection R6's progress note, written by Licensed Practical Nurse (LPN)-X dated 2/19/2025, at 3:39 pm, documents: bed bath given. A 5.2 cm (centimeter) x 4.5 cm darkened area was noted on right heel. On call RN (Registered Nurse) Supervisor aware and will assess. Heels elevated on pillows. Skin prep to be applied q shift R6's progress note, written by LPN-X dated 2/20/2025, at 2:52 pm, documents: on 2-19-25 a 1. cm x 2.0 cm, darkened area was found on resident's right heel during a bed bath and skin check. On call RN Supervisor was updated, (name of medical group) was updated, and POA (power of attorney) was updated. Skin prep ordered and a Prevalon boot to right foot. No pain to area Surveyor noted there was a discrepancy in R6's right heel measurements listed on 2/19/25 and on 2/20/25 when R6's medical doctor (MD) and POA were informed. On 2/19/25, a Skin Evaluation Form was completed for R6 by LPN-X. Documentation for the heel right is length 5.2 cm, width 4.5 cm, depth 0 cm. and the treatment of skin prep q shift, to be assessed by RN R6's physician order dated 2/20/25 documents Prevalon boot-topical every shift to be worn on right foot for protection On 2/20/25, a Skin Evaluation Form was completed for R6 by wound LPN-E. Documentation for the heel right is length 1.0 cm, width 2.0 cm, depth UTD (unable to determine) cm, cause is identified as pressure, tissue type is 0 = closed/resurfaced, exudate amount is 0 = none and stage is deep tissue injury The treatment section remained the same skin prep q shift, to be assessed by RN On 2/27/25, a Wound Care Assessment was completed by wound Nurse Practitioner (NP)-M, the right heel DTI documentation status is documented as new. Deep tissue pressure injury 0.9 x 2.5 cm. Intact, purple, no drainage. Peri wound is dry, intact. No sign/symptom infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted this is the first documented comprehensive assessment of the wound by an RN. On 3/6/25, a Wound Care Assessment was completed by wound NP-M, the right heel DTI documentation is right lateral heel (DTI), deep tissue pressure injury 1 x 2 cm. Intact, purple, no drainage. Peri wound is dry, intact. No sign/symptom infection. Status- stable. A second pressure injury is discovered. Documentation is right medial heel (DTI), deep tissue pressure injury 0.5 x 1 cm. Intact, purple, no drainage. Peri wound is dry, intact. No sign/symptom infection. Status- new. On 3/13/25, a Wound Care Assessment was completed by wound NP-M, documentation is right lateral heel (DTI), deep tissue pressure injury 1 x 2 cm. Intact, purple, no drainage. Peri wound is dry, intact. No sign/symptom infection. Status- stable. Documentation for right medial heel (stage 3 pressure injury), full thickness wound measuring 1 x 1.5 cm. 100% granular tissue. Scant serosanguinous drainage. Peri wound is dry, intact. No sign/symptom infection. Status- decline. On 3/13/25, wound LPN-E completed the Skin Evaluation Form which documented the right lateral heel size is 1.0 cm x 1.5 cm x 0.1 cm and staged as a stage 3 pressure injury. The right medial heel size is 1.0 cm x 1. 0 cm x UTD, and stage is deep tissue injury. Surveyor noted from 3/6/25 to 3/13/25 the DTI on the right medial heel declined to stage 3 as the measurements went from 0.5 x 1 cm to 1 x 1.5 cm. Surveyor noted wound LPN-E incorrectly documented the right lateral heel as the stage 3 pressure injury. Surveyor noted observing wound care on 3/19/25, at 8:38am, and the stage 3 pressure injury is on the right medial heel, as NP-M documented. Surveyor noted a delay in reporting of DTI to R6's physician and POA. Surveyor noted there was a delay in implementing R6's Prevalon boot as it was not added until 2/20/25, one day after R6's DTI was found. Additionally, Surveyor noted that there is no documentation that an RN assessed R6's heel until 2/27/25, seven days after it was initially discovered, and wound NP-M noted the DTI as new. Surveyor noted that on 3/6/25, a DTI to R6's right medial heel was also discovered. At the time, R6's wound documentation is changed from right heel to right lateral heel for the DTI found 2/19/25. On 3/13/25, the right medial heel DTI progressed to a stage 3 pressure injury per wound NP-M. R6's Interdisciplinary note, written by Registered Dietician (RD)-Y dated 1/29/25, documents: aware of current weight 107 pounds which reflects a significant weight loss of 10% in the past month. Intake appears to have decreased slightly but not significantly. Continues to accept 4oz ensure enlive TID between meals. Family has decided to proceed with hospice care. Will continue to monitor. R6's interdisciplinary note, written by RD-Y dated 3/18/25, documents monitoring wounds to RLE (right lower extremity) (venous ulcer-suspicious for cancerous lesion) and Right lateral heel (DTI). Both are stable. Patient admitted to hospice 1/30/25. Oral intake varies from poor to good although R6 has had an overall decrease as evidence by significant 13.85% weight loss in the past 6 months. R6 does receive 4 oz ensure enlive TID (three times per day) for additional calories/protein. Due to end stage diagnosis weight and wound changes unavoidable. Will continue to offer supplement and food/fluid as patient desires. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted R6's RD note dated 3/18/25 was written a month after R6's right heel DTI was found and did not document that R6's right medial heel had progressed to stage 3. Surveyor noted R6 had a severe weight loss (more than 10%) over 6 months, not significant (less than 10%) as indicated in the 3/18/25 note. On 3/19/25, at 12:35pm, Surveyor interviewed RD-Y and asked about any intervention changes when R6's weight loss was detected, as Surveyor could not locate any in R6's medical record. RD-Y informed Surveyor that R6 was palliative care so RD-Y was not super aggressive in developing interventions for R6. RD-Y stated that in January RD-Y saw R6 and that R6 gets ensure. RD-Y stated that in January R6's family proceeded with hospice care. Surveyor asked if RD-Y updated R6's care plan and was told if a resident is losing weight the goal stays the same, to provide nutritional needs. RD-Y removed the part in the care plan about R6 not having a weight change. RD-Y stated the goal was to provide food and fluids to try to prevent further weight loss, this is for comfort. Surveyor asked about improving R6's nutrition and was told RD-Y did not implement further interventions because hospice was being discussed with the family. RD-Y saw a gradual decrease in R6's appetite, comfort was the goal. Surveyor noted R6 had no interventions that were attempted which could improve protein intake. Surveyor noted R6 had been on hospice previously from 9/30/21 to 9/14/22, 2 years ago. On 3/19/25, at 1:23pm, Surveyor interviewed Hospice RN-AA about weight loss and pressure injuries. Surveyor asked Hospice RN-AA about R6's pressure injury and who monitors it. Hospice RN-AA stated the facility cares for it and that pressure injuries are fairly common at the end of life, especially with R6's diagnosis due to the lack of protein. Surveyor asked if R6 needs a protein supplement or other interventions and was told not necessarily as pressure injuries are part of the decline. On 3/18/25, at 2:20pm, Surveyor interviewed wound LPN-E and was told the wound NP-M stages the wounds, LPN-E just puts in what NP-M says. If a skin issue is found and it is not by the wound rounding day with NP-M, LPN-E grabs a RN to stage and documents what they say. Surveyor asked if anyone was monitoring the right heel between 2/27/25 and 3/6/25 when the new DTI was discovered by wound NP-M. LPN-E stated yes, at the weekly bath skin check and when the skin prep was applied q shift. Surveyor asked if hospice followed the wound and was told no, they are aware and are given updates weekly, but they refer to the wound NP-M for treatments. Surveyor asked why there was no RN assessment on the 19th when the DTI was found and was told there were no managers here at that point, LPN-E believes they have 24 hours for RN to put eyes on it. On 3/18/25, at 3:20pm, Surveyor interviewed LPN-X, who found R6's right heel DTI. LPN-X informed Surveyor that R6's DTI was discovered during R6's skin check, 2/19/25, on bath day. LPN-X let the unit manager know over the phone and was told the wound team would look at it the next day. The wound was not open when it was found. On 3/19/25, at 10:25am, Surveyor interviewed wound LPN-E again after reviewing wound NP-M notes. Surveyor asked why the wound was found on 2/19/25, charted on by LPN-E on 2/20/25, and assessed by NP-M on 2/27/25 as new. LPN-E will look into the documentation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/19/25, at 12:13pm, LPN-E got back to Surveyor that since wound NP-M was coming on the 20th, LPN-E printed wound rounds on the 19th before the DTI was found, so it was not on the sheet. After NP-M left, LPN-E remembered the DTI so took RN Unit Manager-C with to assess. Surveyor asked for documentation of the RN assessing the wound and was told it is noted in treatment section. Surveyor noted it reads to be assessed by RN in the treatment section. Surveyor asked about interventions to keep heels off bed before the DTI was discovered and LPN-E will look into. Surveyor noted no documentation was provided. On 3/19/25, at 12:47pm, Surveyor interviewed RN Unit Manager-C and was told they had been called the night before (2/19/25) about the new wound and took care of the assessment the next day. Surveyor noted no documentation was provided of the RN assessment. On 3/20/25, at 8:08am, Surveyor interviewed wound NP-M who stated the 2nd pressure injury developed because R6 always kicks boots off. Surveyor asked about interventions in place before the DTI was discovered and NP-M cannot speak to that. Surveyor reviewed the CNA Worksheet provided by Facility and R6 is a 2 person assist for transfers, bed mobility, dressing and bathing. It is not documented on the worksheet for R6 to be turned or repositioned on any schedule, float heels or wear Prevalon boots. On 3/20/25, at 10:18am, Surveyor interviewed R6's POA and asked if they had been notified of R6's weight loss. R6's POA responded that R6's weight loss had been mentioned casually. R6's POA stated they bring food in for R6 and R6 has no trouble eating the food. POA felt R6 gets lots of skin tears and feels the bad nutrition would affect skin integrity. On 3/20/25, at 2:06pm, Surveyor spoke with Director of Nursing (DON)-B about the concerns for R6 regarding the lack of RN assessment, lack of care plan interventions or nutrition supplementation that led to a DTI progressing to a stage 3 pressure injury. No further information was provided at the time of write up regarding no documentation that the DTI was evaluated by a Registered Nurse (RN) until the Wound Nurse Practitioner (NP) saw it on 2/27/25, R6 did not have nutritional interventions attempted and R6's care plan was delayed in being updated. Cross-reference F692. 48391 2.) R8 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R8's diagnoses include osteoarthritis, polyneuropathy, basal cell carcinoma, stage 2 left buttocks pressure injury. R8's Quarterly Minimum Data Set (MDS) completed on 2/1/25 documents that R8 is a partial/moderate assist with toileting, showering, dressing, and transferring. R8 is occasionally incontinent of urine and always incontinent of bowels. R8 has one stage 2 unhealed pressure injury. R8 is documented as having a Brief Interview for Mental Status (BIMS) score of 13, indicating R8 is cognitively intact. R8's Care Area Assessment (CAA) for Pressure Ulcer/Injury dated 11/14/24, documents R8 was admitted on [DATE]. R8 was admitted to (name of) Hospital on 10/30/24 for weakness and falls. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R8 has a past medical history for anxiety, depression, chronic pain, Chronic Obstructive Pulmonary Disorder (COPD), Gastroesophageal Reflux Disease (GERD), Hypertension (HTN), and shingles pain. R8 reports over the past few months she has had an increased number of falls. R8 has lived at an Assisted Living Facility (ALF) for the past 3 years. R8 is independent living until 3 weeks ago when she was moved to assisted living. R8 is having issues with falls and needed more help with medications and Activities of Daily Living (ADL)s. R8 has the following impairments: transfers, gait, balance, Range of Motion (ROM), strength, endurance/activity tolerance, safety awareness/judgment, fall risk, and pain in low back. Benefits for R8 at rehab will be additional physical therapy to address deficits. R8's care plan, dated 11/4/24, documents: R8 is at risk for pressure ulcers and other skin related injuries (dated 11/4/24). Interventions include: Braden Scale to be completed (dated 11/4/24). Keep bed linens wrinkle free and do not use excess pads (dated 11/4/24). Observe skin for redness and breakdown during routine care (dated 11/4/24). Use pressure relieving devices, cushion on wheelchair and off of heels, as indicated (dated 11/4/24). Follow community skin care protocol (dated 11/4/24). Treatments, as indicated, see physician order sheet (dated 11/4/24). Pressure reducing mattress on bed (dated 11/4/24). R8 has impaired skin integrity related to cancerous hyperpigmentation on old site from biopsy, present on admission (dated 11/11/24) Interventions include: Follows with wound Advanced Practice Nurse Practitioner (APNP) for monitoring (dated 11/11/24). R8 has stage 2 pressure ulcer buttock (dated 2/4/25) Interventions include: See Electronic Treatment Administration Record (ETAR) (dated 2/4/25). Follows with APNP for monitoring (dated 2/4/25). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2/20/25: left buttock pressure injury resolved: denuded fragile skin due to healed pressure area (dated 3/13/25). 3/13/25: left buttock pressure injury resurfaced, now stage 2 (dated 3/13/25). Provide treatment as ordered (dated 3/13/25). Assist with repositioning during rounding and cares (dated 3/13/25). Surveyor reviewed R8's medical recorder which documents the following: *Order placed on 11/6/24 to apply z-guard to coccyx every shift. *R8 received a bath on 3/10/25. Certified Nursing Assistant (CNA)- T performed the bath on R8 and documents R8 having a new reopened pressure wound to the left buttocks. *R8's Skin Evaluation form dated 3/12/25 documents, denuded fragile skin due to healed pressure area to the left buttocks. Treatment includes z-guard to coccyx every shift. *R8's Skin Evaluation form dated 3/13/25 documents, left buttocks denuded fragile skin due to healed pressure area. Treatment includes z-guard to coccyx every shift. *R8's Skin Evaluation form dated 3/13/25 documents, Stage 2 full thickness wound pressure injury to left buttocks. Resurfaced 100% smooth, red, granulation, serosanguineous drainage, and moderate exudate present. Cause is pressure. Treatment changed to cleanse with Normal Saline (NS), pat dry, followed by Foam Border Dressing (FBD) to be changed daily and as needed (PRN). Surveyor notes this was the second Skin Evaluation performed for R8 on 3/13/25 which was performed by Licensed Practical Nurse (LPN) Unit Manager/Wound Nurse- E who rounds with the wound care Nurse Practitioner (NP) on Thursdays. On 3/18/25, at 10:19 AM, Surveyor interviewed R8 who was sitting in the recliner on top of a pillow. R8 states she prefers to sit on a pillow due to pressure injuries developing on her buttocks. R8 states she spends most of her time in the recliner sitting on pillows and will occasionally go down to the dining room for meals in her wheelchair. Surveyor observed R8's wheelchair in the corner of the room with a cushion on it. Surveyor reviewed R8's medical record which includes a progress note dated 3/12/25, at 3:16 PM, that documents: R8 had a skin check completed on 3/11/25. R8 had a previous skin condition that had since closed on her left buttocks and is now reopened. Measurements were placed in the skin condition. Treatment was not changed and Wound NP- M will assess and change treatment on 3/13/25. Surveyor notes R8's left buttocks wound was identified on 3/10/25 during her bath and facility is documenting the wound was identified on 3/11/25 and documenting treatment be changed on 3/13/25 when Wound NP- M rounds, which is 3 days after R8 developed a left buttocks stage 2 pressure injury. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25, at 1:23 PM, Surveyor interviewed CNA- U who indicates R8 spends all her time in the recliner. CNA- U indicates she has not seen R8 use her bed and staff offer to take R8 to the dining room for meals and sometimes R8 will go but most of her meals are in her room while sitting in the recliner. R8 does not attend facility activities. CNA- U states R8 is continent and will press her call light for assistance to go to the restroom. On 3/18/25, at 1:28 PM, Surveyor interviewed Registered Nurse (RN)- K who states she will complete a comprehensive assessment, notify the unit manager, family, and Medical Director (MD) if she is told by a CNA of a new wound or discovers a new wound on a resident during an assessment. RN- K states she is a Registered Nurse and can perform comprehensive assessments and many nurses on the floor are LPNs who are not able to perform comprehensive assessments. RN- K then stated she doesn't work at the facility very often and relies on the facility CNAs for skin checks and assessments since RN- K does not see resident's skin on a regular basis. RN- K indicates the facility offered R8 a cushion to use for her recliner and R8 declined, indicating R8 prefers to sit on pillows. On 3/18/25, at 1:49 PM, Surveyor interviewed CNA- T who found R8's new pressure injury on 3/10/25, during R8's bath. CNA- T states she notified the nurse on 3/10/25, after identifying a new pressure injury on R8. CNA- T does not recall who that nurse was and then states she always updates the nurse with any new skin finding during cares. On 3/18/25, at 1:49 PM, Surveyor interviewed LPN- P who states she will fill out the facility Skin Injury and Pressure Injury packet if a CNA notifies her of a resident having a new pressure injury. LPN- P states the Skin Injury and Pressure Injury packet has a checklist for nursing staff to complete and fill out. This check list is then placed in the gold basket in the nursing station for the unit manager to pick up and review. LPN- P states the unit managers round daily to pick up the Skin Injury and Pressure Injury packets. LPN- P states measurements and wound descriptions are completed and included in the Skin Injury packets. LPN- P also states measurements and wound descriptions should be obtained immediately and called in to the MD with updates and possible orders. On 3/18/25, at 2:01 PM, Surveyor interviewed LPN Unit Manager- D who states floor nursing staff will notify the unit manager, update family, and contact the MD with any new wounds or pressure injuries. LPN Unit Manager- D then stated Wound NP- M will then evaluate the resident on Thursdays during wound care rounds. LPN Unit Manager- D states the Skin Injury and Pressure Injury packet are completed by nursing staff when a new pressure injury is identified. LPN Unit Manager- D states if the floor nurse is an LPN, the LPN will get the unit manager or an RN to complete a comprehensive assessment to obtain measurements, depth, staging, and wound bed description. LPN Unit Manager- D acknowledged she will get the 1st floor unit manager who is an RN or the DON to complete a comprehensive assessment if she is contacted by nursing staff with a new pressure injury. LPN Unit Manager- D states the comprehensive assessment is completed on the day the pressure injury is identified. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/19/25, at 9:32 AM, Surveyor interviewed LPN Unit Manager- D who states the nurse will complete a comprehensive skin assessment to include measurements, depth, surrounding tissue and if there is any drainage, if a new pressure injury is identified. LPN Unit Manager- D then states the facility staff aim to complete the comprehensive assessment right away, but the facility has 24 hours to complete a full comprehensive assessment. LPN Unit Manager- D states Wound NP- M sees every resident in the facility with a pressure injury. Surveyor notified LPN Unit Manager- D of concerns with R8 having a pressure injury identified on 3/10/25 during her bath and the first comprehensive assessment completed in R8's medical record is documented on 3/13/25. Surveyor notified LPN Unit Manager- D R8 did not receive treatment orders until 3/13/25. LPN Unit Manager- D states she will investigate these concerns. On 3/19/25, at 9:56 AM, Surveyor reviewed R8's medical record and notes wound care was not performed on 3/15/25 and R8 declined wound care treatment on 3/16/25. Surveyor notes R8 went two days without receiving wound care treatment. On 3/19/25, at 10:24 AM, Surveyor interviewed LPN Unit Manager- D and LPN Unit Manager/Wound Nurse- E who state the facility performed a skin sweep on 3/12/25 and R8 was identified as having a new pressure injury to her left buttocks. Surveyor asked LPN Unit Manager- D and LPN Unit Manager/Wound Nurse- E if they were aware of R8 having documentation of a new pressure injury on her left buttocks on 3/10/25. LPN Unit Manager/Wound Nurse- E asked who documented the new wound on 3/10/25. Surveyor notified LPN Unit Manager- D and LPN Unit Manager/Wound Nurse- E of R8 having documentation of a new pressure injury on 3/10/25 during her bath. LPN Unit Manager- D and LPN Unit Manager/Wound Nurse- E then notified Surveyor that R8 had changed her bath day from Monday PMs to Wednesday AMs due to R8 wanting AM baths. LPN Unit Manager- D and LPN Unit Manager/Wound Nurse- E then states R8's wound was identified on 3/12/25 during the facility skin sweep. Surveyor notified LPN Unit Manager- D and LPN Unit Manager/Wound Nurse- E of concerns with R8 having a new pressure injury documented on 3/10/25 and no comprehensive skin assessment, wound care orders, care plan updates, or wound care provider notification until 3/13/25. LPN Unit Manager- D states the facility had orders already going for z-guard. LPN Unit Manager/Wound Nurse- E states FBD dressings were requested by R8 for additional padding. On 3/19/25, at 10:42 AM, LPN Unit Manager- D notified Surveyor skin checks with measurements were performed on 3/11/25 for R8 and is unsure why it is not documented in R8's medical record. On 3/19/25, at 1:06 PM, Surveyor interviewed Director of Nursing (DON)- B. Surveyor asked when an assessment of a new wound should take place. DON-B stated it should be assessed when found and reported to the Medical Director (MD) and Power of Attorney (POA). Treatment orders should be obtained. DON-B stated the facility wound nurse should be updated so the resident can be added to wound rounds which occur every Thursday. DON-B stated the nurse who finds the wound should complete a skin packet and incident report. Surveyor asked what should be included in the initial wound assessment. DON-B stated it should include the location, drainage, color of the wound, and measurement. DON-B stated that this information is documented in the skin packet and in the electronic medical record. Surveyor asked about the facility wide skin sweep. DON-B stated that the sweep was completed on 3/11/25. DON-B stated that it is a different electronic program than the facility's electronic health record. Surveyor asked if staff nurses would be able to see what is documented on the skin sweep. DON-B indicated that staff nurses would not be able to see the information from the skin sweep. Staff nurses need to use the facility's electronic medical record to view any documentation on residents. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/20/25, at 7:38 AM, Surveyor observed R8's wound care with LPN Unit Manager/Wound Nurse- E and Wound NP- M, Surveyor observed a Stage 2 pressure injury to the left buttocks approximately the size of a dime. No drainage was observed, wound bed was red and smooth and surrounding skin was observed to be dry and intact. Surveyor observed white cream on R8's buttocks and surrounding skin. Surveyor observed Wound NP- M notify LPN Unit Manager/Wound Nurse- E of R8's left buttocks pressure injury measuring 0.6 x 0.6 x 0.1. Wound NP- M asked R8 if she would sleep in her bed and R8 declined. Following wound care, Surveyor interviewed Wound NP- M who states she has offered R8 a cushion for her recliner in the past and R8 declines. Wound NP- M states R8 was previously using a donut shaped cushion to sit on and Wound NP- M asked R8 and family not to use the donut shaped cushion due to it putting pressure on R8's buttocks in certain spots. Wound NP- M has not seen the donut shaped cushion for a while and states she is unsure if R8's son took the cushion home. Wound NP- M acknowledged R8's left buttocks pressure injury measuring 0. 6 x 0.6 x 0.1 and being larger than the previous wound care rounding performed on 3/13/25 measuring 0.2 x 0.2 x 0.1. Wound NP- M states the wound looks better but is probably bigger due to noncompliance. On 3/20/25, at 1:07 PM, Surveyor notified DON- B the following concerns for R8: a new stage 2 pressure injury to her left buttocks was identified on 3/10/25 and it was not assessed comprehensively until 3/13/25 when Wound NP- M assessed the area as a stage 2 pressure injury. The skin sweep completed on 3/11/25 was not documented in R8's medical record for all nursing staff to view. R8's care plan was not updated until 3/13/25 which was three days after the wound was found. R8's wound treatment was not completed on 3/15/25, and R8 declined wound care treatment on 3/16/25. Surveyor notes to DON- B that R8 went two days without receiving wound care treatments. DON- B acknowledge these concerns and states that she is familiar with the facility having 24 hours to complete a skin check for residents that are newly admitted . DON- B then stated she is not aware of what is the clock or timeframe for skin checks for newly identified pressure injuries. DON- B indicates her expectation for the nurse would be to contact the MD and complete the skin injury packet the same day. Surveyor asked DON- B if measurements and wound bed description are included in the assessment completed the same day by the nurse. DON- B stated (name of medical group) providers ask what the wound looks like but don't always ask for measurements. DON-B states she doesn't want the [TRUNCATED]

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview, and record review the Facility did not ensure residents maintained acceptable parameters of nutritional status for 1 (R6) of 1 resident reviewed for weight loss. R6 experienced severe weight loss over a period of 6 months, during which time R6 developed pressure injuries. The weight loss was not prescribed, and no new interventions were implemented to prevent R6's weight loss. Surveyor was unable to locate any documentation that the Facility updated the Power of Attorney or R6's physician. Findings include: The facility policy and procedure titled, Nutritional Screening, Assessment, and Monitoring and last revised 11/2022, documents, in part: Policy Statement It is the policy of Ascension Living that a comprehensive nutritional assessment is completed upon admission, annually, or when a significant change occurs for each resident. Policy Interpretation and Implementation A. The RD (Registered Dietician) should complete a comprehensive nutritional assessment on each resident according to the admitted and MDS (Minimum Data Set) schedule, and clinical nutrition need. B. A validated malnutrition screening tool will be utilized to determine malnutrition risk, as per community policy. C. The individualized plan of care will be written and reviewed regularly when changes are noted. The plan of care will be shared with and agreed upon by the resident and/or representative. D. A member of the food and nutrition services team will participate in the IDT (Interdisciplinary Team) care planning process and meetings according to the community's policy . F. The dietitian will monitor regularly to ensure residents maintain acceptable parameters of nutritional status. G. Residents are offered a therapeutic diet when it has been determined that there is a benefit . Procedures C. Interval assessment / Progress note will be completed for the following but are not limited to: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	1. Resident with a confirmed significant change in weight will receive a re-assessment as soon as possible but no longer than 5-days after notification, and the follow-up note will be done a minimum of weekly until weight stabilization occurs or there is a determination in the plan of care to discontinue weekly weights. 2. Resident with insidious weight loss (gradual unintended progressive weight loss over an extended time). 3. Residents with a new pressure injury will receive a re-assessment as soon as possible, but no longer than 5 days after notification, and the follow-up note will be done minimally monthly - until pressure injury is resolved . The Facility Policy and Procedure titled, Procedure: Assistance with Meals and last revised 1/1/2025, documents, in part: Purpose Statement It is the policy of Ascension Living that residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation A. Dining Room Residents 1. All residents are encouraged to eat in the dining room for socialization . 4. Residents who require assistance with eating should be provided with self-help devices and/or provided help as needed. 5. Residents who are unable to feed themselves should be fed with attention to safety, comfort, and dignity . R6 was admitted to the facility on [DATE] with pertinent diagnoses that include type 2 diabetes mellitus, cardiomyopathy, heart failure, cognitive communication deficit, mild cognitive impairment, and vascular dementia. On 1/30/25, the following diagnoses were added: unspecified severe protein-calorie malnutrition and encounter for palliative care. R6's Quarterly Minimum Data Set (MDS) with an assessment reference date of 11/16/2024, documents a Brief Interview for Mental Status (BIMS) score of 04, indicating that R6 has severe cognitive impairment. The MDS documents that R6 was assessed to have no behaviors exhibited during the look back period. R6 is always incontinent of bowel and bladder. No swallowing disorders were noted, R6 was coded to have a mechanically altered diet. The MDS documents no weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The MDS documents that no pressure injury was present, but that R6 is at risk of developing pressure injuries. R6 has an activated Power of Attorney (POA). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R6's Significant Change MDS with an assessment reference date of 2/6/2025 does not document a BIMS assessment. The MDS documents that R6 was assessed to have no behaviors exhibited during the look back period. R6 is always incontinent of bowel and bladder. No swallowing disorders were noted, R6 was coded to have a mechanically altered diet. The MDS documents that Weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months occurred and R6 was not on a physician prescribed weight loss regimen. The MDS documents that no pressure injury was present, but that R6 is at risk of developing pressure injuries. R6's care plan documents Nutritional Status, (R6) is at risk for impaired nutrition related to end stage diagnosis. Goal: (R6) will have nutritional needs met. (R6) is offered diet as prescribed, see physician order sheet. Start 11/10/21 Provide supplement as ordered. Start 11/10/21 Provide assist as needed. Start 12/27/22 Surveyor noted R6 had previously been on hospice from 9/30/21 to 9/14/22. R6 began hospice services again on 1/30/25. R6's care plan documents Dehydration/Fluid Maintenance. (R6) has a potential for fluid volume deficit related to . poor vision, may need staff assist with fluid intake use of diuretic for dx (diagnosis) of CHF (congestive heart failure). Goal: (R6) will be free from signs and symptoms of dehydration and will be well hydrated as evidenced by physical conditions. Keep fresh water, or beverage of preference, in reach. Start 4/4/22 Assess (R6's) preferred fluids and provide. Start 4/4/22 Offer 120 mL fluids with medication pass. Start 4/4/22 Staff to assist with all hot liquids and (R6) to drink hot liquids while sitting at table only. Start 4/4/22 Surveyor noted R6 did not have a diuretic currently prescribed. Surveyor noted there were no updates to R6's care plan when R6 was taken off hospice and when R6's diuretic was discontinued. Surveyor also noted that there were no new interventions when R6's weight loss was discovered. R6's physician order dated 10/21/22 documents Monthly weight - due on the first Wednesday of every new month. Document refusals . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R6's physician orders dated 10/31/23 document diet: consistent carbohydrate, pureed diet . and diet: thin liquids. R6's physician order dated 1/28/25 documents severe protein calorie malnutrition: hospice to eval (evaluate) and treat. R6's physician order dated 1/30/25 documents admit to (name of) Hospice. While investigating a Facility Reported Incident Surveyor reviewed R6's electronic medical record (EMR) and found R6's weights progressively declined from 7/3/2024 to the last weight taken on 1/26/25. Prior to 7/3/24, R6's weight had been stable. On 7/3/24 R6's documented weight was 131.0 pounds. On 8/7/24 R6's documented weight was 124.2 pounds. On 9/4/24 R6's documented weight was 120.8 pounds. On 10/2/24 R6's documented weight was 119.4 pounds. On 11/6/24 R6's documented weight was 118.0 pounds. On 12/10/24 R6's documented weight was 119.0 pounds. On 1/15/25 R6's documented weight was 108.2 pounds. On 1/24/25 R6's documented weight was 105.9 pounds. On 1/26/25 R6's documented weight was 107.0 pounds. Surveyor noted that there is an active physician order for monthly weights. Despite this order, Surveyor noted that 1/26/25 was the last recorded weight for R6. Surveyor noted that R6 experienced a severe weight loss of 18.32% from 7/3/24 to 1/26/25 (6 months), 10. 39% from 10/2/24 to 1/26/25 (3 months), and 10.8% from 12/10/24 to 1/26/25 (1 month). R6's annual Nutrition Risk assessment dated [DATE], completed by Registered Dietician (RD)-Y, documents under the food and nutrition history section 4 oz ensure enlive TID (three times daily). R6's feeding ability is marked as extensive assistance. Surveyor noted per staff interviews (which follow) it was determined that R6 is totally dependent on staff for eating and drinking, RD-Y did not mark R6 as total dependence on assessment. Meal intakes (average) was marked as 51-75%. R6 has chewing difficulty and no swallowing problems per assessment. Surveyor noted R6 is missing many teeth per an interview with staff. At the time of the assessment the current weight was noted as 120.8 pounds (recorded in September by Facility) and the weight trend for last 6 months was marked as stable. Comments/recommendations were Resident seen for annual review . Intake fair at meals. Mostly fed at meals. Weight 120.8 pounds, stable the past 6 months. No new interventions needed at this time. Currently free of pressure injury. Will continue to monitor. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted the 7/3/24 weight was 131.0 pounds, and the weight used for assessment is 120.8 which is a loss, not stable. On 8/20/24, R6 had a compliance visit with R6's internal medicine doctor. The follow-up note reads monitor behaviors, dementia, progressive decline, right lower extremity wound. Continue ongoing plan of management/care with close monitoring. R6's quarterly Nutrition Risk assessment dated [DATE], completed by RD-Y, documents under the food and nutrition history section 4 oz ensure enlive TID remained and encourage fluids with medication pass was added. On 11/11/24 a nursing order was added to R6's physician orders to encourage fluids with medication pass - 3 times per day. Provide resident with 240ml with each medication pass. Surveyor noted in an interview with RD-Y it was indicated that this was added due to a nursing initiative. Feeding ability remained extensive assistance and meal intakes (average) were marked again as 51-75%. Chewing difficulty was indicated and no swallowing problems were noted. R6's current weight is recorded as 118 pounds and the weight trend in the last 6 months was marked as stable. Comments included resident seen for quarterly review . Intake fair at meals. Needs assistance at meals. Weight 118 pounds, stable the past 6 months. No new interventions needed at this time. Currently free of pressure injury. Will continue to monitor. Surveyor noted that R6's 7/3/24 weight was 131.0 pounds, and the weight used for assessment is 118.0 which is a loss, not stable. R6's monthly visit note from (name of NP group), written by the APRN-BC (Advanced Practice Registered Nurse-Board Certified) after a face-to-face visit on 11/20/24, documents (R6) is a [AGE] year-old . being seen today for a follow-up visit. Chart and medications reviewed. Patient and staff interviewed. (R6) is compliant with medication regimen. (R6) is transferred by Hoyer lift and enjoys spending time sitting in Geri chair with the other residents. Weight this month is 118.0 pounds, which is down from 125 pounds in June 2024 and down from 127.2 pounds in November 2023. Staff continue to assist with meals. Discussed weight loss with nurse manager. Voicemail left for daughter/POA. Will discuss potential hospice services with POA given weight loss. Surveyor noted that R6's weight is being recorded as trending down and the information is shared with Facility staff by (name of nurse practitioner (NP) group) APRN-BC. An email, written on 11/26/24, from Register Nurse (RN) Unit Manager-C to R6's POA was provided to Surveyor. The email documents .we did have a care conference last week, (name of NP group) was present as well. I attempted to reach out and contact you during the meeting. I left a message. I'm sorry to hear you didn't receive a notice prior to the meeting . Surveyor noted there is no mention of R6's weight loss. This email was provided when Surveyor requested documentation that R6's POA was updated by the Facility regarding R6's weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R6's follow up visit note from (name of NP group), written by APRN-BC after a face-to-face visit with R6 on 12/9/24, documents (R6) is a [AGE] year old . being seen today for a follow-up visit. Chart and medications reviewed. Patient and staff interviewed. (R6) is compliant with medication regimen. (R6) is transferred by Hoyer lift and enjoys spending time sitting in Geri chair with the other residents. (R6's) most recent weight is 118.0 pounds, which is down from 125 pounds in June and down from 127.2 pounds in November 2023. Staff continue to assist with meals. Voicemail message left for daughter/POA to discuss potential hospice services with POA given weight loss. R6's clinical note written by the (name of NP group) APRN-BC on 12/18/24, which was communicated with POA and Registered Nurse at Facility documents .(R6) most recent weight is 119.0 pounds, which is down from 125 pounds in June 2024 and down from 127.2 pounds in November 2023. Staff continue to assist with meals and R6 drinks ensure. Discussed vascular dementia, weight loss/protein calorie malnutrition with daughter/POA and nurse manager. (R6) has a painful lower extremity venous ulcer full thickness wound and a chronic scab to the right side of nose. Daughter/POA notes that this area on right lower extremity has been an area of concern by dermatologist in the past - likely a skin malignancy. POA also reports she would like comfort goal of care for (R6). Plan for a hospice referral due to vascular dementia, weight loss and protein calorie malnutrition. POA is in agreement. Order given to Nurse Manager. R6's clinical note written by the (name of NP group) APRN-BC on 1/16/25, which was communicated with Nurse Manager at Facility documents Chart review completed. Met with (R6) who is resting comfortably in bed. (R6) states is tired and would like to sleep . Spoke with Nurse Manager and reviewed. Daughter had wanted dermatology consult for chronic wound on right shin and this was being scheduled. Called and spoke with daughter/POA. Discussed chronic wound to right shin and concern for its removal and biopsy which could possibly create an even larger wound area, and if grafting was needed would actually create 2 wounds. Also discussed weight loss, recorded weight show (R6) has lost another 10 pounds in the last month, current weight 108 pounds. POA under impression that biopsy could be completed at SNF (skilled nursing facility). Discussed that was not possible and (R6) would need to be sent for outpatient . POA has decided does not want dermatology referral and would like wound team at SNF to continue treating the wound as they have been. Discussed hospice referral . At the end of the conversation POA did agree to have a hospice evaluation for (R6) and have hospice contact her to discuss and answer all her questions. Called and spoke with 1st Floor Nurse Manager- who will cancel dermatology referral . (R6's) progress note, written by RN Unit Manager-C dated 1/17/2025, documents Writer spoke with (name of NP group), who had followed up with family regarding dermatology consult. POA has decided that is not the route she wants to go. POA stated would prefer to move towards hospice . Surveyor noted no documentation of the Facility discussing weight loss with POA or R6's physician was located. On 1/17/2025, R6 was seen by the APNP (Advanced Practice Nurse Practitioner) for a monthly follow up appointment. The Chief Complaint section documents APNP monthly compliance visit - dementia with decline, anxiety, plans for hospice. Surveyor noted was not able to find documentation of the weight loss being discussed with APNP in the evaluation or nursing concerns. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R6's Interdisciplinary note, written by RD-Y, dated 1/29/25, documents aware of current weight 107 pounds which reflects a significant weight loss of 10% in the past month. Intake appears to have decreased slightly but not significantly. Continues to accept 4oz ensure enlive TID between meals. Family has decided to proceed with hospice care. Will continue to monitor. Upon admission to hospice the hospice provider completed a Hospice Interdisciplinary Group Comprehensive Assessment and Plan of Care Update Report which has the following pertinent orders dated 1/30/25. Skilled nursing to educate patient/family on dietary modification to improve overall nutrition as tolerated including Providing small, frequent meals, offer small amounts of fluids frequently, offer but do not force food/fluids. Skilled nursing to educate caregivers on offering, but not forcing food/fluids. Surveyor noted these hospice orders were not integrated into R6's care plan. On 3/19/25, at 1:23pm, Surveyor interviewed Hospice RN-AA about monthly weights. RN-AA stated that facilities in general do monthly weights, when on hospice, facilities can stop taking weights. Hospice can request for them to take weights though. Surveyor asked RN-AA what interventions were in place for R6 weight loss. Hospice RN-AA told Surveyor weight loss is a normal part of the process with R6's hospice diagnosis of unspecified severe protein calorie malnutrition with prognosis of 6 months or less if the disease runs its normal course. Per RN-AA even if R6 took in more calories R6 would lose weight due to the diagnosis. It is completely normal with R6's diagnosis and being on hospice in general for weight loss to occur. Surveyor asked about the Interdisciplinary Group orders for skilled nursing to educate patient/family on dietary modification to improve overall nutrition as tolerated including Providing small, frequent meals, offer small amounts of fluids frequently, offer but do not force food/fluids. Skilled nursing to educate caregivers on offering, but not forcing food/fluids. Per RN-AA skilled nursing refers to the hospice RN and they should educate staff how to offer food and fluids. This is part of the normal decline, a resident will not eat/drink as much because it is part of the dying process. Surveyor asked if resident is actively dying and was told no declining now. Surveyor asked if small frequent meals should be an order and was told no not necessarily. Staff should offer fluids at regular intervals and feed at mealtime, RN-AA was not sure if R6 gets snacks. RN-AA informed Surveyor it is fairly certain R6 is not eating much as that is part of R6's end of life diagnosis. Surveyor asked RN-AA about R6's pressure injury and who monitors it. RN-AA stated the facility cares for it and that pressure injuries are fairly common at the end of life, especially with R6's diagnosis due to the lack of protein. Surveyor asked if R6 needs a protein supplement or other interventions and was told not necessarily as pressure injuries are part of the decline. R6's significant change Nutrition Risk assessment dated [DATE], completed by RD-Y, documents under the food and nutrition history section 4 oz ensure enlive TID and encourage fluids with medication pass remained. Feeding ability remained extensive assistance and meal intakes (average) were changed to 26-50%. Chewing difficulty was indicated and no swallowing problems were noted. R6's current weight was recorded as 107 pounds and the weight trend in the last 6 months was recorded as significant weight loss. Comments/Recommendations are written as (R6) seen for significant change assessment . Intake fair-poor at meals. Needs assist at meals. Weight 107 pounds, weight loss of 9% times 1 month noted from December to January. Family has opted for hospice care. No new interventions needed at this time. Right shin venous/stasis wound noted. Will continue to monitor. On 3/19/25, at 12:35pm, Surveyor interviewed RD-Y and asked about any intervention changes when R6's weight loss was detected, as Surveyor could not locate any in R6's medical record. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	RD-Y informed Surveyor that R6 was palliative care so RD-Y was not super aggressive in developing interventions for R6. RD-Y stated that in January RD-Y saw R6 and that R6 gets ensure. RD-Y stated that in January R6's family proceeded with hospice care. Surveyor asked if RD-Y updated R6's care plan and was told if a resident is losing weigh the goal stays the same, to provide nutritional needs. RD-Y removed the part about R6 not having a weight change from the care plan. RD-Y stated the goal was to provide food and fluids to try to prevent further weight loss, this is for comfort. Surveyor asked about improving R6's nutrition and was told RD-Y did not implement further interventions because hospice was being discussed with the family. RD-Y saw a gradual decrease in R6's appetite, comfort was the goal. Surveyor noted R6 had no interventions attempted which could provide comfort for R6 and prevent further weight loss. Surveyor noted R6 had been on hospice previously from 9/30/21 to 9/14/22, 2 years ago. R6's progress note written by Licensed Practical Nurse (LPN)-X dated 2/19/2025, at 3:39pm, documents bed bath given. A 5.2cm (centimeter) x 4.5cm darkened area was noted on right heel. On call RN (Register Nurse) Supervisor aware and will assess. Heels elevated on pillows. Skin prep to be applied q shift. R6's progress note, written by LPN-X dated 2/20/2025, at 2:52pm, documents on 2-19-25 a 1.0cm x 2.0cm, darkened area was found on resident's right heel during a bed bath and skin check. On call RN Supervisor was updated, (name of medical group) was updated, and POA was updated. Skin prep ordered and a Prevalon boot to right foot. No pain to area. Surveyor noted there was a discrepancy in R6's right heel measurements listed on 2/19/25 and on 2/20/25 when R6's physician and POA were informed. Surveyor noted that on 3/6/25, a DTI to the right medial heel is also discovered and on 3/13/25, the right medial heel DTI progressed to a stage 3 pressure injury. Surveyor notes no documentation of nutritional interventions are found. R6's interdisciplinary note, written by RD-Y dated 3/18/25, documents monitoring wounds to RLE (venous ulcer-suspicious for cancerous lesion) and Right lateral heel (DTI) (Deep tissue injury). Both are stable. Patient admitted to hospice 1/30/25. Oral intake varies from poor to good although (R6) has had an overall decrease as evidence by significant 13.85% weight loss in the past 6 months. R6 does receive 4 oz ensure enlive TID for additional calories/protein. Due to end stage diagnosis weight and wound changes unavoidable. Will continue to offer supplement and food/fluid as patient desires. Surveyor noted R6's RD note dated 3/18/25 was written a month after R6's right heel DTI was found and did not document the R6's right medial heel had progressed to stage 3. Surveyor noted R6 had a severe weight loss (more than 10%) over 6 months, not significant (less than 10%) as indicated in the 3/18/25 note. Surveyor noted no further assessment completed related to R6 oral intake decreasing, for instance determination of what food R6 likes and may be more likely to consume. Surveyor noted was unable to locate any documentation why, with only a slightly decreased intake, R6 would suffer severe weight loss. Surveyor noted that R6 had no new interventions identified for R6's weight loss other than hospice services. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25, at 1:50pm, Surveyor interviewed LPN-H who confirmed R6 is supposed to get monthly weights. On 3/18/25, at 2:20pm, Surveyor interviewed wound LPN-E who stated R6 has lots of issues. Regarding weight loss, R6 is on hospice so decline is expected. If resident is on hospice facility staff do not do weights unless hospice orders them. Surveyor noted an active physician order for monthly weights dated 10/21/22. On 3/18/24, at 3:20pm, Surveyor interviewed LPN-X regarding weight loss. LPN-X states that the unit nurse manager tracks weights. R6 is on hospice, is fed by staff and accepts food but is not a big eater. Weight loss was happening before R6 was on hospice. R6 has very few teeth so gets a soft diet. Prefers food warm and with coffee. Surveyor noted on 12/10/21 R6's POA elected eye care from the Facility provider, dental was not selected. On 3/19/25, at 1:54pm, Surveyor interviewed RN Unit Manager-C who stated that the RD monitors weights and then staff talk at the daily meetings about this information. On 3/20/25, at 8:08am, Surveyor interviewed Certified Nursing Assistant (CNA)-J about how R6 is set up for meals and was told R6 is a total assist of puree diet. Staff feed R6 every meal. Staff stop and give sips of water during the day. If R6 refuses or will not finish the whole meal it is entered in the charting as the percent eaten. R6 has been a total assist a long time, more than a year. On 3/20/2025, at 9:53 am, Surveyor interviewed RN Unit Manager-C and asked for evidence the Facility informed R6's POA or physician of the weight loss. Surveyor noted only (name of NP group) notes were provided that showed POA being updated by (name of NP group) APRN-BC. Surveyor asked for evidence R6 was being fed all 3 meals and was told the January intake forms were provided to Surveyor, RN Unit Manager-C knows there are holes in the documentation, however, assures Surveyor that they check whenever they work that everyone is being fed appropriately. Surveyor noted while reviewing the intake forms many time slots (holes) were left blank hence not documented if a meal was attempted. In 31 days, 44 meals were not recorded and 49 were documented on. Surveyor asked what happens with the hospice plan of care report and was told staff are to read it for reference. When asked if the small meals and snacks should have been added to the care plan the response was RN Unit Manager-C felt the ensure between meals was the snack and resident could eat as much of meal as wanted. On 3/20/25, at 10:00am, Surveyor interviewed RD-Y again. Surveyor asked why there is a difference in charting. The MDS reads R6 is totally dependent, Kardex reads max assistance, meal ticket has needs assist and RD assessments show extensive assistance. Per RD-Y extensive assistance has no set definition other than the resident needs someone with them the whole time. The meal ticket with needs assist means the resident needs to be fed. Surveyor asked why R6 had a puree diet and was told the altered diet had been in place even before the current order. Per RD-Y, R6 loves puree and has never complained. Surveyor asked why RD-Y referred to weight loss as significant when it is severe and was told it is the verbiage RD-Y uses, RD-Y does not use the severe category like Surveyors. Again, Surveyor clarified that no interventions were attempted in the last 6 months when weight loss occurred and was told none were added. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/20/25, at 10:18am, Surveyor interviewed R6's POA and asked if they had been notified of R6's weight loss. R6's POA responded that R6's weight loss had been mentioned casually. R6's POA stated they bring food in for R6 and R6 has no trouble eating the food. POA felt R6 gets lots of skin tears and feels the bad nutrition would affect skin integrity. On 3/20/25, between 12:40pm and 12:55pm, Surveyor observed R6 being assisted to eat by LPN-H. R6 stated help me multiple times during the observation, LPN-H would ask what can I help you with and R6 would reply food. R6 was assisted to drink coffee between bites of food. Surveyor requested labs from the RN Unit Manager-C and was provided labs done on 2/16/25 and 2/17/25. On 3/20/25, at 1:30pm, Surveyor asked RN Unit Manager-C for labs prior to the 2025 labs provided and was told labs had not been completed in quite a while because R6 was on hospice, off hospice and back on again, labs had not been done in over a year. On 3/20/25, at 2:45pm, Surveyor interviewed MD-Z and asked if there was a significant weight change in a resident should they be notified and was told not directly. MD-Z makes rounds at several facilities, staff should contact the on-site NP who will then contact MD-Z if there are concerns. Surveyor asked if MD-Z was aware R6 had weight loss and was told MD-Z last saw R6 in February and knows R6 lost 10 pounds in one month. Surveyor asked if any interventions should have been started and was told the family was thinking about hospice. With R6 having advanced dementia and the leg wound MD-Z would expect a decline, R6 gets ensure and was eating fair to good, MD-Z felt the RD could handle. On 3/20/25, at 2:06pm, Surveyor spoke with Director of Nursing (DON)-B regarding R6's weight loss. DON-B stated they were not aware of the issue. Surveyor stated no interventions being put in place is a concern and was told during daily clinical report significant changes are brought up, nursing would not be involved with nutrition interventions. Surveyor also stated that the RD charted R6's weight as stable in assessments when weight loss was occurring. Surveyor told DON-B they had requested documentation that R6's POA or MD had been updated about the weight loss by the Facility and none had been provided. Surveyor also discussed the intake forms not being charted on daily so there is no evidence R6 is being fed three meals a day. After the weight loss a pressure injury developed. No further information was provided at the time of write up regarding the severe weight loss R6 experienced that was not prescribed. No new interventions were implemented to prevent R6's weight loss.

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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. 21855 Based on observation, record review and interview, the facility did not comprehensively assess a resident before applying bed mobility devices. This was observed with 1 (R9) of 1 residents observed with bed mobility devices. * R9 was observed with bilateral bed mobility devices. There was not a comprehensive assessment completed. Findings include: The facility's policy and procedure Device Evaluation Form dated 1/2024. The policy documents: Any resident for whom a safety or assistive is being considered will have a Device Evaluation form completed and reviewed by the interdisciplinary team. On 3/19/25, at 12:35 AM, Surveyor observed R9 in their bed. The bed had bilateral mobility devices. R9's medical record documents in the Progress Notes: on 3/13/25 (R9) was readmitted from the hospital and is alert and oriented. (R9's) family requested bed railings on the bed. The bed rails will be installed tomorrow by maintenance. The Maintenance Work Order, dated 3/13/25, documents bed mobility devices were installed on R9's bed. R9's Device Evaluation form, dated 3/16/25, indicates no device needed. R9 signed a consent for Use of Assistive Devices form on 3/13/25. This form is a check box style. It documents, bed rail, for assist device type. R9's comprehensive plans of care were provided. The Activity of Daily Living Functional/ Rehab Potential dated 3/19/25, under, The Bed Mobility, is 1 person staff support and uses a slide sheet. The plan of care does not document bed mobility devices. R9's physician plan of care dated 3/19/25. There is not a physician order for bed mobility devices. On 3/20/25, at 8:00 AM, Surveyor interviewed the Director of Nurses (DON) - B. DON-B did not know why the Device Evaluation form was checked for no. DON-B will look for more information. On 3/20/25, at 11:00 AM, Surveyor interviewed R9's Unit Manager (UM) - E. UM-E stated they can apply bed rails per family requests. The bed rails are not considered a restraint. UM-E did not have a documented comprehensive assessment for the bed mobility devices. UM-E stated R9's daughter wanted them on the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25, at 11:31 AM, DON-B spoke with Surveyor. DON-B provided a signed consent for mobility devices. DON-B did not provide documentation of a comprehensive assessment for the use of the bed mobility devices. On 3/20/25, at 2:30 PM,Surveyor shared the concerns with R9's bed mobility devices with the Nursing Home Administrator-A, and DON-B.

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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 record review and interview, the facility did not have documentation for investigating, and controlling, an outbreak. The facility did not document infection organisms for surveillance prevention. This had the potential to effect all 84 residents in the facility. * The facility had an influenza A outbreak in February 2025. There is no documented investigation summary for identifying, preventing and controlling, the spread of infection. * The facility on-going surveillance does not identify infection organisms. Findings include: The facility's policy and procedures Outbreak of Communicable Diseases dated 1/2024. The policy documents: The outbreaks of communicable diseases within the the community (facility) will be promptly identified and appropriately handled. The facility's policy and procedures Infection Prevention and Control Program dated 8/2024. The policy document includes: The Infection Prevention Control Program (IPCP) is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections; The Policy and Procedures documents: 1. a.) Prevent, detect, investigate, and control infections in the community; 1. d.) Maintain records of incidents and corrective actions related to infections; Surveillance documents: 3. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring associate infections, and detecting unusual pathogens with infection control implications; Facility Outbreak Management documents: 4. a.) Determining the presence of an outbreak; 4. b.) Managing the impacted residents and associates; 4. c.) Preventing the spread to other residents and associates; 4. d.) Documenting information about the outbreak; 4. e.) Reporting the information to appropriate public health authorities; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. f.) Educating associates and visitors; 4. g.) Monitoring for reoccurrences; 4. h.) Reviewing the care after the outbreak has subsided. Surveyor reviewed the facility's Surveillance Logs from the last 3 months, along with any infection outbreaks. The Surveillance Logs from January 2025, February 2025 and March 2025, do not include the organism related to the infection. The February Surveillance Log includes a resident line list for influenza A. There are 14 residents from the 3rd floor on this list. On 3/18/25, at 11:24 AM, Surveyor interviewed the Infection Preventionist (IP) - R. IP-R stated they only have a line list for the influenza A outbreak. IP-R stated they will look for any additional information. On 3/18/25, at 2:00 PM, Surveyor interviewed IP-R. The facility Surveillance Logs were reviewed during the interview. IP-R did not have any more documentation on the influenza A outbreak. IP-R stated there was no staff that got sick. IP-R stated some residents were admitted with the influenza A. All the positive residents were in isolation. IP-R stated they did not document an investigative summary for the influenza A outbreak. IP-R did not provide a reason why they did not document it. IP-R did provide an covid outbreak investigative summary from January 2025. The facility Surveillance Logs were reviewed . IP-R does not track infection organisms unless they are a reportable organism. IP-R stated they have been only documented the MDRO's (multidrug-resistant organisms). IP-R did not provide a reason for not tracking all organisms that caused infection in the facility. On 3/18/25, at 3:00 PM, Surveyor shared the infection control program concerns with Nursing Home Administrator (NHA) - A and Director of Nurses (DON) - B.