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	11/14/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on record review, interview, and policy review, the facility failed to ensure one out of 26 sampled residents' (Resident (R)40) Responsible Party (RP) was notified of changes in condition for R40. Specifically, the RP was not notified when R40 developed a new pressure injury and when he sustained purple marks to his right arm pit. Findings include: Review of the facility's policy titled, Change in a Resident's condition or Status dated 01/2024 and provided by the facility revealed, Our community shall promptly notify the resident, his or her health care provider, and representative of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's health care provider or physician on call when there has been a (an): 1. Accident or incident involving the resident; 2. Discover of injuries of an unknown source; . 4. significant change in the resident's physical/emotional/mental condition . Review of the undated Profile Face Sheet in the Electronic Medical Record (EMR) under the Profile tab revealed R40 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety, and contractures. The Profile Face Sheet revealed a diagnosis of pressure injury of left heel unstageable was added on 06/06/24. Family Member (F)3 was R40's RP. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/24 in the EMR under the MDS tab revealed R40 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of six out of 15. R40 was dependent on staff for all activities of daily living. a. R40 sustained a pressure injury on his left foot on 06/06/24. Review of the Nurse Practitioner's Wound Care assessment dated [DATE] and provided by the facility revealed R40 was identified with a, left heel (unstageable pressure injury).There was no documentation on the Wound Care Assessment of the RP being notified of the new pressure injury. Review of Interdisciplinary Notes for 06/2024 and provided by the facility did not show documentation of R40's RP was notified of the new pressure injury. During an interview on 11/12/24 at 11:54 AM, RP stated she was not notified at the time R40 developed the pressure injury on his left foot. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 3:01 PM, the Director of Nursing (DON) stated R40's pressure injury to his left foot started on 06/06/24 and that the family should have been contacted at the time the pressure injury was first identified. The DON stated there was no documentation to show the RP was notified of the left pressure injury when it developed. b. Review of a Nurse's Interdisciplinary Note dated 08/17/24 and provided by the facility revealed R40 was being monitored for 3 purple marks near R [right] armpit - self-induced . During an interview on 11/14/24 at 1:27 PM, the RP stated she was not notified and was unaware of R40's purple marks to the arm pit.

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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** 15406 Based on interview, record review, and policy review, the facility failed to address a grievance from the Responsible Party (RP) regarding the care for one of 26 sample residents (Resident (R)186). This created the potential for R186's needs to go unmet. Findings include: Review of the facility's policy titled, Complaints and Grievances dated 05/2023 and provided by the facility revealed, It is the policy of Ascension Living to provide residents and family members/legal representative the opportunity to voice complaints and grievances . Such complaints or grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished . Definitions . Grievance - Any moderately complex complaint or service issue received verbally or in writing from residents or resident representative regarding treatment or services that require intervention and a written resolution letter. All written complaints received by residents or resident representatives through any means will be considered a grievance. Review of the undated Profile Face Sheet in the electronic medical record (EMR) under the Profile tab revealed R186 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and muscle weakness. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/15/24 in the EMR under the MDS tab revealed R186 was severely impaired in decision making. R186 required partial/moderate assistance with toileting hygiene and getting on and off the toilet, and substantial/maximal assistance with showers/bathing, dressing, and personal hygiene. R186 was frequently incontinent of urine and always incontinent of bowel. During an interview on 11/11/24 at 4:54 PM, the RP stated that the staff did not change R186's incontinence brief or toilet her regularly and R186 was frequently saturated with urine. The RP stated R186 was soaked on 11/08/24 in the afternoon at around 5:15 PM including her incontinence brief, pants, socks, and her shoes had a puddle of urine in them. The RP stated she had complained about the failure to toilet R186 and changed her incontinence brief to management (Administrator) previously. During a subsequent interview on 11/12/24 at 4:27 PM, the RP stated when R186 was completely saturated with urine on 11/08/24. The RP stated she had sent the unit manager, RN1, an email on 11/09/24 at 9:57 AM regarding her concern of R186 being saturated with urine and she had not heard anything back. The RP stated she considered her email to be a formal complaint/grievance. During an interview on 11/13/24 at 12:41 PM, Registered Nurse (RN)1 stated she was not aware that the RP had emailed her about R186 being saturated with urine. RN1 reviewed the email in the computer and stated it should be handled as a grievance, and she would turn it into a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 2:24 PM, Social Service Director (SSD) stated she maintained the grievance log documentation and worked with the Administrator to get grievances assigned and investigated. SSD stated no one had brought it to her attention of R186's RP concern regarding R186 being found saturated with urine. SSD stated this issue had not been logged and rose to the level of a grievance. During an interview on 11/14/24 at 4:25 PM, the Director of Nursing (DON) stated RN1 mentioned an issue to her about urine in R186's shoes. The DON stated she was not sure if this rose to the level of a grievance. During an interview on 11/14/24 at 6:30 PM, the Administrator stated staff should return phone calls and emails promptly from families/responsible parties. The Administrator stated he worked with the social workers to go over the grievance log and they shared the responsibility for grievances. He confirmed R186's concern expressed to RN1 had not made it into the grievance process and was not currently logged. The Administrator stated the SSD maintained the log and tracked grievances.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 03115 Based on record review, interview and policy review, the facility failed to ensure that a written transfer notice was provided to a resident and the resident's responsible party when one of one resident (R)23) reviewed for hospitalization was transferred to the hospital. This had the potential to affect the resident and the resident's responsible party understanding the reason for the transfer and the resident's right to appeal. Findings include: During an interview on 11/11/24 at 10:37 AM, R23 stated she went to the hospital. She stated she did not remember the date that she was sent to the hospital and that she did not remember receiving a written transfer notice. Review of R23's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/07/24 and located in the MDS tab of the electronic medical record (EMR) revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating she was cognitively intact. Review of R23's progress notes located in the ID notes section of the EMR revealed a nurse's note dated 08/23/24 and at 11:14 PM which indicated R23 was transferred and admitted to the hospital with diagnoses of shock and renal failure. Review of R23's EMR reviewed no documentation that the resident and the resident's responsible party received a written transfer notice. Interview on 11/14/24 at 3:30 PM, the Administrator stated they had not been providing written discharge/transfer notices when residents were sent to the hospital. Review of the facility's policy titled Clinical Protocol: Transfer or Discharge Notice dated 06/2020 indicated the resident and/or resident representative would be informed of a discharge or transfer in writing as soon as practicable.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure two out of four sampled residents (Resident (R)40 and R186) reviewed for activities of daily living (ADLS) were provided with adequate assistance to maintain cleanliness and hygiene. R186 and R40 were not provided with adequate assistance with toileting, incontinence care, and baths/showers. Findings include: Review of the facility's policy titled, Clinical Protocol: Urinary Incontinence dated 01/2024 provided by the facility revealed, As part of the initial assessment, continence status will be identified through interview of resident/resident representative and review of the resident's medical record . As appropriate, based on assessment of the category and causes of incontinence the associate will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status . 1. Review of the undated Profile Face Sheet in the electronic medical record (EMR) under the Profile tab revealed R186 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and muscle weakness. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/15/24 in the EMR under the MDS tab revealed R186 was severely impaired in decision making. The Brief Interview for Mental Status (BIMS) score was not conducted. R186 required partial/moderate assistance with toileting hygiene and getting on and off the toilet, and substantial/maximal assistance with showers/bathing, dressing, and personal hygiene. A voiding trial had not been conducted and the R186 was frequently incontinent of urine and always incontinent of bowel. Review of the Care Plan dated 10/20/24 in the EMR under the Care Plan tab revealed a focus area of, [R186] has altered elimination due to can be incontinent of bowel and bladder, dx [diagnosis] of Alzheimer's dementia with deficits in mobility and self-cares. Interventions include, Assist [R186] with toileting upon arising, before lunch, in mid-afternoon, after supper and at HS [bedtime]. Review of the Care Plan dated 10/20/24 in the EMR under the Care Plan tab revealed a focus area of, [R186] needs assistance with daily ADL care . The goal was for R186 to, have daily care needs met through next review. Interventions included, Toileting: I need extensive assistance with 1 person staff support . I am occasionally incontinent of bladder and incontinent of bowel. I use pull ups . Bathing: I need extensive assistance with 1 person staff support I prefer a shower Friday AM after lunch . Review of the Shower Schedule posted at the second-floor west nursing station revealed R186 was scheduled for a weekly shower on Thursday afternoons. Review of the paper Weekly Bath Check records provided by the facility and Daily Charting for R186 provided by the facility revealed R186 did not always receive one shower per week as follows: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weekly Bath Check for 08/2024 (starting 08/15/24) revealed showers were given on: 08/15/24, 08/22/24, on 08/29/24. Review of the Daily Charting form for 09/05/24 revealed a shower was given on this date. Review of the Weekly Bath Check forms for 09/2024 revealed R186's next shower was on 09/08/24). The remaining showers in 09/2024 were given on 09/12/24, and on 09/19/24. No additional showers were documented for 09/2024. Review of the Weekly Bath Check forms for 10/2024 revealed R186's next shower was on 10/03/24 (a gap of 14 days since the previous shower on 09/19/24). The remaining showers in 10/2024 were given on 10/10/24, and 10/17/24, R186 did not receive a shower due to being in the hospital. R186's last shower in October was documented on 10/24/24. No additional documentation was provided showing showers were given after 10/24/24 in October. Review of the Daily Charting form for 11/2024 (through 11/14/24) revealed R186 received her next shower on 11/07/24 (showing a gap of 14 days since the previous shower on 10/24/24). During an interview on 11/11/24 at 4:54 PM, Family Member (F)1 stated the staff did not change R186's incontinence brief or toilet her regularly and R186 was frequently saturated with urine. F1 stated R186 was soaked on 11/08/24 in the afternoon at around 5:15 PM including her incontinence brief, pants, socks, and her shoes had a puddle of urine in them. F1 took R186 to the toilet during the interview on 11/11/24 at 4:54 PM; R186 used a walker to walk a few steps to the toilet and voided (urine) on the toilet. F1 came out of the bathroom holding R186's pants and they were saturated with urine on one side from the waist band to below the knee. F1 stated the person who came on afternoon shift must think that R186 had been changed or toileted when she had not been. F1 stated she had complained about this to management and there was some improvement but recently it had gotten worse. F1 stated she showered R186 on her shower days (the records reflected F1 as giving R186 some of her showers). F1 stated she toileted R186 and R186 voided on the toilet. F1 stated R186 smelled at times due to being urine soaked. During a subsequent interview on 11/12/24 at 4:27 PM, F1 stated when R186 was completely saturated with urine on 11/08/24, she had shown the nurse and Certified Nurse Aide (CNA) on duty R186's urine-soaked clothing and shoes. Neither of these staff members were regular employees of the facility or available for interview during the survey. There was no documentation of this incident. F1 stated staff applied two briefs, double briefed R186 and she had kept track of this this with the most recent instance occurring on 10/13/24. Observations during the survey showed R186's hair was greasy and flattened against her scalp on 11/12/24 at 10:54 AM and 3:36 PM; and on 11/13/24 at 5:38 AM and 1:05 PM. On 11/13/24 at 1:05 PM, RN1 went with the surveyor and looked at R186's hair and stated R186's hair was greasy, and it might need to be washed more often. RN1 stated R186's shower day was on Thursday (the next day). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/12/24 at 2:25 PM, CNA3 stated she worked day shift and came on duty at 6:30 AM and worked until 2:30 PM. CNA3 stated she had toileted R186 at 7:15 AM, 10:15 AM, and 1:30 PM today and she was finished providing care at this time (2:30 PM). CNA3 stated R186 urinated on the toilet when she had taken her. CNA3 stated R186 was cooperative with care but was unable to speak or use the call light. CNA3 stated R186 was not usually wet when she worked with her because R186 voided on the toilet. CNA3 stated R186 wore pull up incontinence products during the day. R186 stated she assisted R186 with hygiene and dressing and showers were completed once a week in the afternoon and she did not give them. During an interview on 11/12/24 at 3:10 PM Licensed Practical Nurse (LPN)3 stated she worked afternoon/evening shift. LPN3 stated F1 had expressed concerns to her about R186 being wet. LPN3 stated when there was a seasoned aide on the unit versus agency/pool staff, it made all the difference. LPN3 stated the goal during her shift was to make sure R186 was toileted before supper and after going to bed. LPN3 stated R186 raised her hands or said Help if she needed to use the toilet. During an interview on 11/13/24 at 12:41 PM, Registered Nurse (RN)1 stated R186 voided on the toilet but there was no scheduled toileting plan for her. RN1 reviewed an email F1 sent to her on 11/09/24 in the computer and the staff who were working on 11/08/24 (the date F1 reported R186 was saturated with urine). RN1 stated the staff on Friday afternoon (11/08/24) were agency staff and not regular staff. RN1 stated the agency staff might not have known that R186 should be toileted. RN1 stated, when afternoon shift staff came on duty at 2:30 PM they did not toilet residents right away and verified it could be a while before R186 was toileted after last being toileted around 1:30 PM by day staff. The Care Plan dated 10/20/24 in the EMR under the Care Plan tab directed toileting mid-afternoon and then not again until after supper. 2. Review of the undated Profile Face Sheet in the EMR under the Profile tab revealed R40 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety, and contractures. R40 received hospice care. Review of the annual MDS with an ARD of 08/16/24 in the EMR under the MDS tab revealed R40 was severely impaired in cognition with a BIMS score of six out of 15. R40 did not exhibit any behaviors during the assessment period. R40 was dependent on staff for all activities of daily living (toileting/hygiene, shower/baths, dressing, rolling in bed). Attempts were not made to transfer R40 into a tub or shower due to medical condition/safety). R40 was always incontinent of bowel and bladder. Review of the Care Plan dated 12/08/22 in the EMR under the Care Plan tab revealed a focus area of [R40 needs assistance with daily ADL care dx of SAH [subarachnoid hemorrhage, a medical emergency that occurs when blood pools in the space between the brain and the membrane that covers it] , hydrocephalus . expressive & receptive aphasia [a language disorder that makes it difficult to understand, read, write, and speak], hx L [left] hemiparesis [partial paralysis, weakness on one side of the body]. The goal was for R40 to, have daily care needs met through next review period. Interventions in pertinent part included, Wash face daily with soap and water, apply thin layer or Vaseline daily after face is washed to dry flaky areas . I am incontinent of bladder and incontinent of bowel. I use briefs, pull ups .Bathing: I need total assistance with 2 person staff support. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan dated 12/08/22 in the EMR under the Care Plan tab revealed a focus area of, [R40] has altered elimination due to b/b [bowel and bladder] incont [incontinence]. The goal was for R40's, skin to remain clean, dry and free of breakdown related to incontinence. Interventions included, Provide adult incontinent products and monitor for incontinence . Incontinence cares during rounding, cares and PRN [as needed]. Review of the Shower Schedule posted at the second-floor west nursing station revealed R40 was scheduled for a weekly shower by facility staff on Monday afternoons. Bath/shower records from 08/15/24 through 11/14/24 were requested of the DON on 11/14/24. There were no paper Weekly Bath Check records provided by the facility. The Daily Charting for R186 provided by the facility revealed R186 did not receive one shower per week by facility staff as follows: Review of the Daily Charting form for 08/19/24 revealed a shower was given on this date. No other showers were documented after 08/19/24 for the remainder of August 2024. Review of the Daily Charting form for 09/09/24 revealed a shower was given on this date. This shower was provided 21 days after the previous shower on 08/19/24. One additional shower was provided on 09/30/24, 21 days after the previous shower on 09/09/24. Review of the Daily Charting form revealed the next two showers were given on 10/07/24 and 10/14/24. No additional documentation was provided to demonstrate R40 had been provided any showers since 09/30/24. As of 11/14/24, a period more than six weeks (09/30/24 - 11/14/24) had occurred without a shower being documented as being given by the facility. No additional information was provided showing R40 had refused showers. Review of the hospice Visit Note Reports for 08/23/24, 08/30/24, 09/06/24, 09/20/24 and provide by the facility revealed the hospice aide gave a bed bath and washed the R40's hair on these dates. On 09/13/24 the Visit Note Report revealed R40 revealed a bed bath, but his hair was not washed. Neither the facility nor hospice staff had provided a bath or shower since 09/30/24, a period of more than six weeks. During an observation on 11/11/24 at 2:53 PM, R40 was lying in bed, with his long hair unkempt and a long shaggy beard. During an observation on 11/12/24 at 10:48 AM, R40 was lying in bed. The skin on his face was scaly, dry, and flaking. R40's hair and beard were long and unkempt. During observations on 11/13/24 at 05:46 AM and 6:21 AM, R40's hair and beard were long and unkempt. During an interview on 11/12/24 at 7:06 PM, Family Member (F)2 stated she had found R40 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	double diapered on the morning on 09/14/24 when she arrived to feed him breakfast. F2 stated R40 was agitated, and she could tell he was soiled with bowel movement. F2 stated she called an aide into the room and when they pulled back the sheets, the bedding had a dried urine mark in a two-foot diameter from his chest to his calves. F2 stated that when she and the aide went to change him, R40 was noted to be wearing two soiled incontinent briefs. F2 stated she reported the incident to the Administrator. F2 stated R40's hair was frequently not clean, and his face had a scaly dry flakes that were a result of his lack of cleanliness. F2 stated neither she nor F3 had received phone calls that R40 was combative, and the staff could not wash or bathe him. F2 stated R40 smelled terrible last Sunday when she came in. F2 stated R40 was supposed to receive one bath per week. During an interview on 11/12/24 at 11:54 AM, F3 stated R40 was frequently not clean, and his hair was greasy. F3 stated it smelled a lot in R40's room (bowel movement and urine). F3 stated R40 was occasionally shaved. F3 stated R40 was soiled and the staff put another incontinence brief on top of the soiled one. F3 stated this was reported to the Administrator. During a follow up interview on 11/14/24 at 1:36 PM, F2 and F3 stated the facility had not talked to them about R40 refusing showers or the inability to bathe him. During an interview on 11/12/24 at 3:03 PM, LPN3 stated R40 could exhibit behavior of verbal aggression, and he struck out. LPN3 stated R40 was dependent on care for everything, and staff were to check and check his incontinence brief. LPN3 stated he should be checked for incontinence at least every two hours. During an interview on 11/13/24 at 5:24 AM, CNA6 stated she changed R40 around 4:40 AM. At time R40 stated no, but she stated she could get R40 to cooperate. During an interview on 11/14/24 at 7:31 AM, CNA8 stated R40 only received bed baths. CNA8 stated R40 received one bed bath a week in lieu of a shower/tub bath. CNA8 stated she washed R40's hair once, further stating R40 did not always like his face washed. CNA8 stated she was able to provide care based on modifying her approach and explaining what she was doing. During an interview on 11/13/24 1:01 PM, RN1 stated staff should offer R40 showers, but he probably got bed baths. During an interview on 11/14/24 at 10:55 AM, R40's Hospice Nurse (HN) stated the hospice aide went to see R40 weekly and shaved him or trimmed his beard, washed him, and combed his hair. HN stated she had noticed R40's flaky dry skin on his face. HN stated she had concerns about R40's hygiene stating he was unkempt at times. During an interview on 11/13/24 at 10:16 AM , the Director of Nursing (DON) stated if a resident was bedridden, they received bed baths but otherwise, residents received showers. When bed baths and showers were provided, staff were to wash hair, do nails, and shave residents.

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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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure one out of two sampled residents (Resident (R)185) reviewed for tube feeding was provided with tube feeding administration in accordance with physician's orders. The facility failed to administer the prescribed formula and failed to ensure medication (pills) were crushed. R185 was hospitalized on [DATE] with a clogged feeding tube. The facility staff administered R185 medications in a pill form that were not sufficiently crushed which clogged the feeding tube. R185 was hospitalized and a surgical procedure was necessary to unclog the feeding tube due to the pill lodged in the tube. Findings include: Review of the facility's Enteral Nutrition (tube feeding) policy dated 01/2024 and provided by the facility revealed, Adequate nutritional support through enteral feeding should be provided to the resident as ordered . The nurse should confirm that there are appropriate orders for oral (PO) intake or restrictions for nothing by mouth (NPO), as appropriate . Review of the undated Profile Face Sheet in the Electronic Medical Record (EMR) under the Profile tab revealed R185 was admitted to the facility on [DATE] with diagnoses including encounter for surgical aftercare following surgery on the digestive tract, cellulitis (a bacterial infection that affects the deep layers of the skin and underlying tissue) of the abdominal wall, dysphagia (impaired swallowing), and with a gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach). Review of the Physician's Orders from 11/04/24 - 11/12/24 in the EMR under the Orders tab revealed orders for: Nothing by mouth initiated on 11/06/24. Osmolite 1.2 tube feeding formula, 75 milliliters (ml) per hour continuous feeding, check for placement and function every shift dated 11/04/24; and May crush appropriate medications dated 11/04/24. Observations and interview revealed R185 was not administered the tube feeding formula ordered by the Physician, Osmolite 1.2, as follows: During an observation on 11/11/24 at 2:56 PM, R185 was lying in bed and was administered Jevity 1.2 tube feeding solution at 75 ml an hour. During an observation on 11/13/24 at 2:30 PM, there was a supply of Jevity 1.2 and Jevity 1.5 tube feeding formula in the kitchen storeroom. There was no Osmolite tube feeding solution in the storeroom. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Review of the Manufacturer's website ([NAME] Nutrition), https://www.abbottnutrition.com/our-products/jevity-1_2-cal, Jevity 1.2 tube feeding formula provides 285 calories per 8 fluid ounces (237 mL), with 13.2 grams of protein, 9.3 grams of fat, 40.2 grams of carbohydrates, and 4 grams of dietary fiber per serving; it is considered a high-protein, fiber-fortified formula designed for tube feeding, and contains a full spectrum of vitamins and minerals to meet nutritional needs Review of the Manufacturer's website ([NAME] Nutrition), https://www.abbottnutrition.com/our-products/osmolite-1_2-cal, Osmolite 1.2 tube feeding formula provides feeding formula provides 285 calories per 8 fluid ounces (237 mL), with 13.2 grams of protein, 9.3 grams of fat, 37.5 grams of carbohydrates, and no dietary fiber per serving. The primary difference is the absence of fiber in Osmolite 1.2 versus Jevity 1.2. Review of the Medication Administration Record (MAR) dated November 2024 and provided by the facility documented Osmolite 1.2 was administered, when Jevity 1.2 was administered. During an interview on 11/13/24 at 2:20 PM, the Registered Dietitian (RD) stated she started R185's nutritional assessment on 11/05/24 and completed it on 11/08/24. The RD stated Jevity was the facility's house formula, and the facility did not have Osmolite in stock. The RD stated Jevity had fiber and was generally a better formula. The RD stated she assessed R185's tube feeding regimen of 75 ml/hour of Jevity 1.2 when completing her nutritional assessment. The RD stated this was a new feeding tube for R185 and the Jevity 1.2 formula at 75 ml/hour met his nutritional needs. The RD reviewed the EMR and physician's orders and confirmed the physician's order currently read Osmolite 1.2 was prescribed and not Jevity 1.2. The RD stated the order should have been changed. The RD stated nursing had consulted with her about administering Jevity instead of Osmolite and she told nursing Jevity would be okay. During an interview on 11/12/24 at 3:18 PM, Licensed Practical Nurse (LPN)3 stated R185 had been administered Jevity 1.2 since admission. LPN3 stated the current order called for Osmolite 1.2. LPN3 stated she was not sure if the formulas were comparable. During an interview on 11/13/24 at 10:16 AM, the Director of Nursing (DON) stated R185's tube feeding order called for Osmolite 1.2. The DON verified the order should have been corrected to reflect Jevity 1.2 Review of a nursing Interdisciplinary Note dated 11/11/24 at 9:11 PM, Resident's G-tube was occluded. Writer was unable to administer medication or tube feeding. Multiple attempts were made to unclog but were unsuccessful. Paged on-call provider through (name of medical practice) and spoke with NP (Nurse Practitioner) [name]. Writer was advised to flush with Coca-Cola; if it didn't work, then to send patient to [name] ER [emergency room]. Attempts were unsuccessful. Writer contacted charge nurse [name] and on call manager, [name] to advise that patient was being sent out. [Name] ambulance arrived at approximately 1930 [7:30 PM] and patient was transported to [name] ER. Observations on 11/11/24 - 11/14/24 at 7:45 PM revealed R185 did not return to the facility from the hospital. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/12/24 at 3:18 PM, LPN3 stated she was informed in shift change report on this date that R185's G tube was clogged and he had been sent to the ER. LPN3 stated R185 had resided in the facility for a couple weeks and he came with staples down his abdomen for surgery due to a crimped colon. LPN3 confirmed R185 had been getting a continuous tube feeding regimen of Jevity 1.2 administered via a pump at 75 ml/hour. LPN3 stated she checked for placement and residuals on her shift and administered water flushes as ordered. During an interview on 11/13/24 at 10:16 AM, the DON stated R185's feeding tube was clogged, and he was sent to the ER. She stated there was no additional information regarding R185's status. Review of the hospital Gastroenterology Consult dated 11/12/24 at 7:49 AM revealed, Clogged G-tube etiology to clog not clear .Ct scan of the abdomen recommended to assess the G-tube site . This tube was placed surgically less than a month ago so the tract from the stomach to the wall is possible not quite mature for GI to feel comfortable about changing it at the bedside and even endoscopically (plus that puts him at risk for sedation with a procedure). Given that this was a surgically placed G-tube with sutures in place . we would feel more comfort having surgery . attempting to unclog or replace this G-tube given that it was surgically placed . Review of the hospital General Surgery Consult dated 11/12/24 at 2:18 PM and provided by the facility revealed, Chief Complaint: G tube issue . [R185] . was admitted to [name of hospital] from 09/25/24 to 11/04/24 and during his hospital stay he underwent exploratory laparotomy with lysis of adhesions and gastrostomy tube placement on 10/17/24 with [name of physician] for small bowel obstruction who presents today from [nursing home name] due to malfunctioning G tube . I attempted flushing the tube at the bedside and it did not flush. It appeared there was a blockage in the distal tube. The surgeon proceeded with the exchange of the feeding tube at the bedside. The surgeon documented, Ok to resume tube feeds at this time. Surgery will sign off. Please call for any questions or concerns. Please crush pills completely prior to administering as the tube was blocked by pill within the distal tube. During an interview on 11/14/24 at approximately 3:00 PM, the DON was shown the surgeon's report indicating a pill had not been crushed and that it was the source of the clogged feeding tube. The DON, who just obtained the report from the hospital, stated she had not read the report and was not aware of this. During an interview on 11/14/24 at 06:01 PM, the DON stated R185's pills should have been crushed; there was a physician's order to crush them. The DON stated she had not yet interviewed any of the nurses to find out what happened with the administration of his pills. The DON verified the tube became clogged in the facility; nursing staff passed all R185's medications via his feeding tube, and if a pill was not crushed, the facility was responsible.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and document review, the facility failed to ensure there were sufficient staff adequately deployed to meet six out of 26 sampled residents needs (Resident (R)186, R40, R15, R45, R27, and R184). Residents were double briefed, waited too long for call lights to be answered, did not get timely incontinence care/toileting, showers, or the provision of hygiene. Residents remained in bed due to the fear staff would not put them back to bed in time if they got up. Agency staff (internal pool and outside pool) were frequently used. Residents, families, and staff reported agency staff were not well trained/aware of residents' needs. Findings include: 1. Review of the undated Profile Face Sheet in the electronic medical record (EMR) under the Profile tab revealed R186 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and muscle weakness. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/15/24 in the EMR under the MDS tab revealed R186 was severely impaired in decision making. R186 required partial/moderate assistance with toileting hygiene and substantial/maximal assistance with showers/bathing. Review of the paper Weekly Bath Check records provided by the facility and Daily Charting for R186 provided by the facility from 08/15/24 - 11/14/24 revealed R186 did not receive one shower per week as follows: -R186 went 14 days between showers from 09/19/24 - 10/03/24. -R186 went 14 days between showers from 10/24/24 - 11/07/24. Observations during the survey showed R186's hair was greasy and flattened against her scalp on 11/12/24 at 10:54 AM and 3:36 PM; and on 11/13/24 at 5:38 AM and 1:05 PM. On 11/13/24 at 1:05 PM, RN1 observed R186's hair and stated that R186's hair was greasy, and it might need to be washed more often. During an interview on 11/11/24 at 4:54 PM, Family Member (F)1 stated the staff did not change R186's incontinence brief or toilet her regularly and R186 had been saturated with urine. On 11/11/24 at 4:54 PM, F1 came out of the bathroom holding R186's pants and they were saturated with urine on one side from the waist band to below the knee. F1 stated the facility was cutting staff. F1 stated the afternoon shift nurse now covered both sides (east and west) with one CNA on each side and a floater went in between both sides. F1 stated it was hard for the staff to take care of everything due to heavy care needs such as a lot of residents that required transfers with the Hoyer lift (requiring two staff members). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a subsequent interview on 11/12/24 at 4:27 PM, F1 stated when R186 was completely saturated with urine on 11/08/24, she had shown the nurse and CNA on duty R186's urine-soaked clothing and shoes. Neither of these staff members were regular employees of the facility. F1 stated staff applied two incontinence briefs on R186, double briefed R186 with the most recent instance occurring on 10/13/24. During an interview on 11/12/24 at 3:10 PM Licensed Practical Nurse (LPN)3 stated she worked afternoon/evening shift. LPN3 stated when there was a seasoned aide on the unit versus agency/pool staff, it made all the difference. LPN3 indicated R186, who needed to be toileted, was toileted when staff worked. During an interview on 11/13/24 at 12:41 PM, Registered Nurse (RN)1 stated F1's allegation of staff not toileting R186 on 11/08/24 occurred on a day when all the staff on duty were agency staff. RN1 stated the agency staff might not have known that R186 should be toileted. (Cross refer to F677 for Activities of Daily Living (ADLs) citation regarding R186) 2. Review of the admission MDS with an ARD of 08/16/24 in the EMR under the MDS tab revealed R184 was admitted to the facility on [DATE] and was unimpaired in cognition with a BIMS score of 15 out of 15. During an interview on 11/11/24 at 3:16 PM, R184 stated she had waited as long as 45 minutes for her call light to be answered. R184 stated she had to sit in bowel movement (BM) while waiting for staff to come assist her. During observations on 11/13/24 at 6:18 AM, R184 activated her call light. There were no nurses or CNAs on the unit at this time. During an interview at 06:36 AM, R184 stated she turned the call light on so she could be pulled up in bed. R184 slumped in an awkward position. R184 further stated she was soiled and needed her incontinence brief changed. During an observation on 11/13/24 at 6:37 AM, CNA1 (day shift CNA and regular facility employee) went to R184's room to answer the call light. R184 waited 19 minutes for staff to answer her call light; there had been no nurses or CNAs on the unit from the time the call light was activated until 6:37 AM 3. Review of the undated Profile Face Sheet in the Electronic Medical Record (EMR) under the Profile tab revealed R40 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety, and contractures. R40 received hospice care. Review of the annual MDS with an ARD of 08/16/24 in the EMR under the MDS tab revealed R40 was severely impaired in cognition with a BIMS score of six out of 15. R40 was dependent on staff for all activities of daily living. Review of the hospice Visit Note Report and the facility's Daily Charting forms for 08/15/24 - 11/14/24, provided by the facility, revealed a lack of recent bed baths and showers. The most recent shower was provided on 09/30/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 11/11/24 at 2:53 PM, R40 was lying in bed, with his long hair unkempt and a long shaggy beard. During an observation on 11/12/24 at 10:48 AM, R40 was lying in bed. The skin on his face was scaly, dry, and flaking. R40's hair and beard were long and unkempt. During observations on 11/13/24 at 05:46 AM and 6:21 AM, R40's hair and beard were long and unkempt. During an interview on 11/12/24 at 11:54 AM, F3 stated R40 was frequently not clean, and his hair was greasy. F3 stated it smelled a lot in R40's room (bowel movement and urine). F3 stated R40 was soiled and the staff put another incontinence brief on top of the soiled one. F3 stated she had spoken with the Administrator recently, about staffing issues. F3 stated there were some good regular staff, but there were a lot of agency (pool) staff. F3 stated there was low staffing on the weekends and her family members came in on the weekends to monitor R40's care. During an interview on 11/12/24 at 7:06 PM, F2 stated she had found R40 double diapered on the morning on 09/14/24 when she arrived to feed him breakfast. F2 stated she called an aide into the room and when they pulled back the sheets, the bedding had a dried urine mark in a two-foot diameter from his chest to his calves. F2 stated that when she and the aide went to change him, R40 was noted to be wearing two soiled incontinent briefs. F2 stated R40's hair was frequently not clean, and his face had a scaly dry flakes that were a result of his lack of cleanliness. F2 stated R40 smelled terrible last Sunday when she came in. During an interview on 11/14/24 at 1:40 PM F2 stated she came in on a weekend recently and one staff member was sleeping, and the other one was talking on her cell phone. F2 indicated these were the two nursing assistants assigned to R40's unit. During an interview on 11/12/24 at 3:03 PM, LPN3 stated R40 was dependent on care for everything, and staff were to check his incontinence brief at least every two hours. During an interview on 11/14/24 at 7:31 AM, CNA8 stated she had worked with R40 for a couple of years, and he only received bed baths. During an interview on 11/13/24 1:01 PM, RN1 stated staff should offer R40 showers, but he probably got bed baths. During an interview on 11/14/24 at 10:55 AM, R40's Hospice Nurse (HN) stated she had concerns about R40's hygiene stating he was unkempt at times. (Cross refer to F677 for Activities of Daily Living (ADLs) citation regarding R40) 4. Review of the significant change MDS with an ARD of 08/19/24 revealed R15 was admitted to the facility on [DATE]. R15 was unimpaired in cognition with a BIMS score of 15 out of 15, was dependent for toileting, and required substantial to maximum assistance with showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/11/24 at 12:53 PM, F4 (R15's family member) stated there were more agency staff on the weekends and holidays. F4 stated R15 did not get up until 9:00 AM due to short staffing. F4 stated she never knew how many staff were going to show up. F4 stated staffing could be short on all shifts every day, but weekends were the worst. 5. Review of the quarterly 'MDS with an ARD of 09/22/24 revealed R45 was admitted to the facility on [DATE]. R45 was intact in cognition with a BIMS score of 15 out of 15. R45 was dependent on staff for toileting and baths. During an interview on 11/11/24 at 3:55 PM, R45 stated she was unable to move independently in the bed. R45 stated two staff had to use a Hoyer lift to transfer her. R45 stated once she was transferred into her reclining wheelchair, she was dependent on staff to move her, and she had to stay where staff put her. R45 stated staffing on the first floor had been reduced with one CNA on each side and a third person assisting. R45 stated the facility was shorthanded at times. R45 stated that sometimes when she needed help, she did not get help, and she yelled to get assistance. R45 stated she had waited up to an hour for the call light to be answered and it was frustrating. R45 stated short staffing made her apprehensive to get out of bed at times due to her dependence on staff for locomotion and dependence on staff to get back in bed. 6. Review of the annual MDS with an ARD of 09/23/24 in the EMR under the MDS tab revealed R27 was admitted to the facility on [DATE]. R27 was unimpaired in cognition with a BIMS score of 15 out of 15. R27 was impaired to both sides of his upper and lower extremities. R27 was dependent on staff for showers, hygiene, and dressing. During an interview on 11/11/24 at 10:40 AM, R27 stated the staff had not gotten him out of bed in many months, since therapy was discontinued. R27 verified a Hoyer lift was needed with two staff to get him out of bed. R27 stated he needed reliable help after getting out of bed; he needed to lay back down when he became tired and did not have the physical strength to remain up. R27 stated he did not trust the CNAs to get him back to bed on time if he got up. 7. Observations were made on the first floor, primarily one west, on 11/13/24 starting at 5:30 AM. There were two CNAs on the first floor and Licensed Practical Nurse (LPN)1 who floated between both sides. There were 33 residents in total residing on the first floor. The first-floor layout was a long W shaped hallway with east rooms on one end and west rooms on the opposite end. There was a dining room and common area in between (separating) the east and west sides. Observations on one west revealed: During an observation at 5:15 AM, CNA6 was in a room with a resident. CNA6 came out of the room and stated most of the residents on this unit did not use call lights. CNA6 stated she had checked and changed (incontinence briefs) for the residents approximately every two hours and her checks were completed at this time for her shift that ended at 6:30 AM. CNA6 stated she was waiting for the nurse who was on one east to come over and help her with a Hoyer lift transfer for a resident who had to get up early for a medical appointment. No other staff were on the unit. CNA6 stated she was finishing her work because she had to leave early at 6:00 AM instead of 6:30 AM. CNA6 verified she was an agency staff and not a facility employee. When asked who would cover her shift when she left early, CNA6 stated she did not know but had gotten permission to leave early. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/13/24 at 5:31 AM, CNA6 stated she was waiting for the nurse to help her transfer the resident who had a medical appointment. CNA6 stated she had a total of 16 residents she was caring for on the west side. During an observation at 5:50-5:56 AM, CNA6 waited for LPN1 to come and help her transfer the resident with the Hoyer lift. LPN1 was assisting with preparations to send a resident out of the facility. During an observation at 6:16 AM, CNA6 went down the elevator and left the facility. There were no nurses or CNAs on one west from this time until 6:37 AM when CNA1 came on duty. During the period when there were no nurses or CNAs on one west, observation showed that R184's call light was turned on at 6:18 AM. During an interview at 06:36 AM, R184 stated she turned the call light on so she could be pulled up in bed. R184 slumped in an awkward position. R184 further stated she was soiled and needed her incontinence brief changed. During an interview at 6:39 AM, CNA1 stated the night shift CNA should not leave until the day shift CNA came on duty. CNA1 stated there should be two CNAs on day shift for each side; however, a lot of times there was one CNA on each side and a CNA that floated between one east and one west. CNA1 stated she was able to get everything done when three CNAs were working day shift on one west, but she was consistently late completing her work and clocking out. CNA1 stated there were agency staff working on one west every day. During an interview on 11/13/24 at 6:58 AM, LPN1 stated LPN1 stated she was responsible for the 100 floor on night shift and took care of all the residents on 100 [NAME] and 100 East Halls. When she was asked if she was aware there was no nursing staff on 100 [NAME] Hall after CNA6 left this morning, LPN1 stated, I'm aware there was no one on the other side. The CNA on the other side had to go home to get her son. When LPN1 was asked what happened when an emergent situation or someone needing immediate assistance occurred on 100 [NAME] Hall, like she had to address this morning on 100 East Hall, LPN shrugged her shoulders and stated, Well Administration gives the okay to do it. Besides, it was only 15 minutes. The CNA left at 6:15 AM today. 8. Additional staff were interviewed, and their comments were as follows: During an interview on 11/12/24 at 2:30 PM CNA3 stated she worked days primarily (6:30 AM -2:30 PM) and was a regular facility staff. CNA3 stated, when she worked on the weekends, there were less staff scheduled. CNA3 stated there were also less staff on the weekends due to call offs. CNA3 stated there were times when there were not enough staff to get everything done. CNA3 stated a lot of residents on one west were dependent for care and needed Hoyer lift transfers. CNA3 stated two staff were needed for transferring with the lift and it could be challenging getting the second person. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/12/24 at 3:21 PM, LPN3 a regular facility nurse, stated staffing depended on the census, but there should be two aides and one nurse on each side. LPN3 worked on one west on the second (afternoon/evening) shift. LPN3 stated some days she was as one nurse with a medication technician (med tech) instead of the second nurse; this occurred a couple times a week. LPN3 stated that the med tech passed medication, and she did everything for the floor which could be challenging. LPN3 stated there were times when there were three CNAs instead of four. LPN3 stated there were heavy care residents on the first floor and on one west, there were about eight who were transferred with the Hoyer lift and four residents who had to be fed their meals. LPN3 stated things got delayed when staffing was short. During an interview on 11/13/24 at 12:45 PM, RN1 stated the staffing on the first floor was typically two CNAs on east and west and two nurses for first and second shifts. RN1 stated if the census was low CNA staffing would be reduced. RN1 stated the first floor was the heaviest care area and a lot of residents were transferred with Hoyer and required feeding. RN1 stated there should not be periods of time in which the east or west unit had no nursing staff on it, as was the case on this morning when CNA6 left at 6:15 AM. RN1 stated there should always be at least one person on the floor. RN1 stated the CNA on one east should have come over to cover until the day shift CNA arrived since LPN1 was also on east side. During an interview on 11/13/24 at 6:09 AM, CNA9 stated she felt like they were working short staffed all the time. During an interview on 08/11/14/24 at 7:34 AM, CNA8 stated there were not enough staff to get all the work done. CNA8 stated residents waited for call lights to be answered and stated sometimes she was the only aide on the unit. In that case, CNA8 stated baths did not get done. CNA8 stated the weekends were always short staffed and the first shift could be a problem. During an interview on 11/14/24 at 4:25 PM, the Director of Nursing (DON) stated residents were scheduled for one bath a week due to staffing limitations, such as the number of CNAs available to give baths. The DON stated it was unrealistic to provide more than one bath a week based on CNA staffing levels. During an interview on 11/14/24 at 6:04 PM, the DON stated there should be at least one nursing staff on both east and west sides at any given time. The DON stated she had done spot checks and residents waited five to ten minutes for lights to be answered; however, stated it could take longer. The DON stated the staffing was higher on the first floor due to it being heavier care. She stated, typically there were four CNAs on first and second shifts on the first floor. The DON stated if there were only three CNAs, the work would be divided evenly between them. The DON stated double briefs being put on residents was not condoned or allowed. During an interview on 11/14/24 at 6:48 PM, the Administrator stated they staffed four aides and two nurses for days and evening (PM) on the floors. Medication Technicians were only used on PM shift.

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	525528	A. Building B. Wing	11/14/2024

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 03115 Based on observation and staff interviews, the facility failed to ensure the nurse staff information contained the resident census, failed to post it daily, and failed to maintain the nurse staffing data for a minimum of 18 months. This deficient practice had the potential to affect all residents and visitors being uninformed about the facility's staffing status. Findings include: An observation on 11/14/24 at 8:36 AM, the nurse staffing information with the title Ascension Living posted on top of the receptionist desk at the entrance of the facility did not include the resident census number. During an interview on 11/14/24 at 1:36 PM, the Director of Nursing (DON) verified the document did not include the resident census. During the interview, the nurse staff information documents were requested for the past 18 months. She provided the documents for 11/01/24 through 11/13/24. She stated they had not been posting them for a while because they hired a new Staffing Coordinator, and she did not start posting them until October 2024. During an interview on 11/14/24 at 10:00 AM, the Staffing Coordinator was asked to provide the nurse staffing information sheets. The Staffing Coordinator provided the documents for 10/20/24 through 11/13/24. She stated she was not aware she was supposed to be posting the nurse staffing information until 10/20/24. She stated 10/20/24 was the first day she posted it. She stated she was unable to locate any nurse staffing information sheets prior to 10/20/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on interview, record review, and policy review, the facility failed to ensure one out of five residents (Resident (R)40) reviewed for unnecessary medications did not receive an unnecessary medication. R40 was prescribed an anti-anxiety medication on an as needed (PRN) basis without a stop date identified. Findings include: Review of the facility's Psychotropic Medication policy dated 10/2024 and provided by the facility revealed, Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue PRN orders for psychotropic medication beyond 14 days requires that the practitioner document the rationale for the extended order. The specific duration for the PRN order will be indicated in the order. Review of the undated Profile Face Sheet in the Electronic Medical Record (EMR) under the Profile tab revealed R40 was admitted to the facility on [DATE] with diagnoses including dementia and anxiety. R40 was receiving hospice care. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/24 in the EMR under the MDS tab revealed R40 was severely impaired in cognition with a Brief Interview for Mental Status (BIMS) score of six out of 15. R40 did not exhibit any behavior during the assessment period. R40 was taking an antianxiety medication. Review of the current Physician's Orders from 04/08/19 through 11/12/24 in the EMR under the Orders tab revealed R40 was prescribed Ativan (antianxiety medication) .5 milligrams (mg) every two hours for anxiety PRN, initiated on 10/14/24. There was no end date specified on the order. Review of the Medication Administration Record (MAR) for 10/2024 and MAR for 11/2024 provided by the facility revealed R40 was administered the PRN Ativan once on the following days: 10/15/24, 10/16/24, 10/17/24, 10/20/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/30/24, 11/01/24, 11/03/24, and 11/10/24. During an interview on 11/12/24 at 3:03 PM, Licensed Practical Nurse (LPN)3 stated R40 exhibited behavior in the afternoon, and he called help, help, help, which he was heard calling softly at the time of the interview. LPN3 stated R40 did not usually need anything when he called out but liked seeing someone come. LPN3 stated R40 exhibited verbal aggression and had struck at staff occasionally. LPN3 stated the Ativan helped somewhat. During an interview on 11/13/24 at 1:01 PM, Registered Nurse (RN)1 stated the PRN Ativan was ordered on 10/14/24 and typically PRN orders for antianxiety medications were for a duration of 120 days. RN1 reviewed the Physician's Order for Ativan and stated there was no stop date identified, further stating the stop date needed to be included as part of the order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 4:54 PM, the Director of Nursing (DON) stated the Pharmacist typically identified orders for PRN psychotropic medications that lacked stop dates and that was how the facility became aware and corrected the orders. The DON verified there was no Pharmacist's recommendation regarding the PRN Ativan. The DON verified the PRN order for Ativan should include a stop date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 15406 Based on observation, interview, and policy review, the facility failed to ensure dietary staff adhered to proper glove use/hand hygiene when serving meals to 15 residents residing on the west side of the second floor. This created the potential for cross contamination and spread of food borne illness. Findings include: Review of the facility's Disposable Glove Use policy dated 01/2023 and provided by the facility revealed, Disposable gloves must be changed, and hands washed when the gloves are dirty or ripped and when moving from one task to another . Observation on 11/11/24 at 9:02 AM of meal service in the kitchenette on the west side of the second floor. Dietary Aide (DA)1 was serving food from a steam table to residents who resided on the west side of the second floor. DA1 dished up three plates of breakfast which included scrambled eggs and breakfast meat. DA1 scooped the scrambled eggs and meat onto these plates and then repositioned the food on the plate using her gloved hands. In between touching the ready to eat food, she touched the paper tray cards, plates, and utensils. During lunch observations on the west side of the second floor on 11/11/24 11:58 AM to 1:29 PM the following observations were made: On 11/11/24 at 12:31 PM the first plate was served which contained steak, mashed potatoes, broccoli, and a roll. DA1 placed the roll on the plate with her gloved hand and then touched paper tray cards, plates, and serving utensils. On 11/11/24 at 12:32 PM, DA1 served the second plate and touched the broccoli on the plate to position it, then dished up the rest of the foods. She placed the roll on the plate with her gloved hand. DA1 then wiped her face with her gloved hand, touched paper tray cards, and utensils prior to serving the next plate. DA1 did not change her gloves or perform hand hygiene. During an interview on 11/11/24 at 12:38 PM, DA1 stated it was her normal practice to serve the rolls with gloved hands. DA1 stated she did not use tongs for serving bread. DA1 continued this procedure of touching the roll with gloved hand and utensils, tray cards, plates, the counter in between without changing gloves or performing hand hygiene until all residents on the second-floor west side were served. Twelve residents were eating in the dining room and a few in their rooms. During an observation on 11/11/24 at 1:01 PM, DA1 was cutting pieces of cake and serving them to five residents who were sitting in the dining room. DA1 touched each piece of cake with her gloved hand while placing it on a plate and then touched the knife, plate, counter and without changing gloves or performing hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 1:29 PM, the Dietary Manager (DM) stated staff should not touch the food on the tray line with gloved hands. The DM stated DA1 should have used tongs for serving the rolls and should not have touched ready to eat food with gloved hands when using the same gloves to touch other items. The DM stated there was a potential for cross contamination from the gloves to the food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on observation, interviews, record review, policy review, and Centers for Disease Control (CDC) guidance, the facility failed to ensure that staff wore appropriate Personal Protective Equipment (PPE) for two of 18 residents (Resident (R)15, and 40) reviewed for enhanced barrier precautions (EBP) when direct care was provided. The facility staff failed to clean and disinfect patient equipment used for three of eight residents (R24, R48, and R68) reviewed for infection control. These failures could promote the spread of multi-drug-resistant organisms (MDROs) throughout the facility. Findings include: 1. Review of R40's undated Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE] and diagnosis of moderate protein-calorie malnutrition. Review of R40's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/16/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated R40 was severely cognitively impaired. During an observation in R40's room on 11/14/24 at 7:36 AM, Licensed Practical Nurse (LPN) 2 assisted with wound care. LPN2 performed hand hygiene and donned gloves. She held R40's left leg/foot to complete a wound care treatment. LPN2 removed gloves and performed hand hygiene again. LPN2 did not wear a gown throughout patient care. R40 had a pressure ulcer to the left heel requiring the use of EBP. 2. Review of R15's undated Admission Record in the Profile tab of the EMR revealed most recent admitted [DATE] and diagnosis of Alzheimer's disease. Review of R15's significant change in status MDS with an ARD of 08/19/24, located in the EMR MDS tab, revealed a BIMS score of 14 out of 15 which indicated R15 was cognitively intact. During an observation in R15's room on 11/14/24 at 7:43 AM, LPN2 assisted the visiting wound care nurse practitioner (NP) with wound care. LPN2 performed hand hygiene and donned gloves. She removed R15's right foot sock and bandage, and held R15's foot while the NP assessed and completed wound care. LPN2 doffed gloves and performed hand hygiene. LPN2 did not wear a gown throughout direct resident wound treatment. During an interview on 11/14/24 7:53 AM, LPN2 stated, This resident should be on EBP, and we should wear PPE when caring for this resident. LPN2 stated this resident hasn't ever been on EBP during the 4-5 months he's had the wound. During an interview on 11/14/24 at 2:23 PM, the Infection Preventionist (IP) stated, I haven't given any formal in-services yet. I go around and verbally remind all staff about using proper infection control practices. If someone is admitted on EBP or goes on EBP then I let the nurse know and then they are responsible for passing the information on to their nursing staff. Staff should wear PPE for wounds, MDROs, catheters, gastrostomy tubes (G-tube), and colostomy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 2:43 PM, the Director of Nursing (DON) stated, My expectation is that anyone on EBP requires staff to wear PPE. This would include active MDROs or wounds, or any type of indwelling device such as a G-tube, colostomy, or indwelling urinary catheter. It was an oversight that R15 wasn't identified as being on EBP. Review of the facility's policy titled, Enhanced Barrier Precautions in Skilled Nursing Communities, revised 03/2024, indicated, under the section Policy. Each community will fully implement Enhanced Barrier Precautions (EBP) . shall be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring and/or transmitting a multi-drug-resistant organism (MDRO) such as resident with wounds, indwelling medical devices and residents with colonization with an MDRO. Section 5 indicated, Examples of high-contact resident care activities requiring gown and glove use for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care . Review of the CDC website https://www.cdc.gov/long-term-care-facilities/hcp/ prevent-mdro/PPE.html, titled, Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multi-drug resistant Organisms, updated: 04/02/24 revealed, Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization . Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 3. Review of R68's undated Admission Record in the Profile tab of the EMR revealed an admitted [DATE] and diagnosis of diverticulitis of large intestine with perforation and abscess without bleeding. Review of R68's quarterly MDS with an ARD of 11/07/24, located in the EMR MDS tab, revealed a BIMS score of 15 out of 15 which indicated R68 was cognitively intact. During an observation in R68's room on 11/13/24 at 7:39 AM revealed, LPN5 retrieved the portable vital sign machine/equipment on wheels. She applied the blood pressure cuff to R68's upper left arm and obtained the reading. She applied the finger pulse oximeter to R68's left index finger and obtained the reading. LPN5 performed hand hygiene but did not clean patient care equipment after use. 4. Review of R48's undated Admission Record in the Profile tab of the EMR revealed an admitted [DATE] and diagnosis of vascular dementia. Review of R48's admission MDS with an ARD of 10/08/24, located in the EMR MDS tab, revealed a BIMS score of 14 out of 15 which indicated R48 was cognitively intact. During an observation in R48's room on 11/13/24 at 8:15 AM revealed, LPN5 used the same portable vital sign machine/equipment on wheels. She applied the blood pressure cuff to R48. She applied the finger pulse oximeter to R48's right index finger. LPN5 performed hand hygiene but did not clean patient care equipment after use. 5. Review of R24's undated Admission Record in the Profile tab of the EMR revealed an admitted [DATE] and diagnosis of arterial sclerosis heart disease of coronary artery without angina pectoris. Review of R24's quarterly MDS with an ARD of 08/21/24, located in the EMR MDS tab, revealed a BIMS score of nine out of 15 which indicated R24 was moderately cognitively impaired. During an observation in R24's room on 11/13/24 at 8:37 AM, LPN5 used the same portable vital sign machine/equipment on wheels that was used on R48. She applied the blood pressure cuff to upper right arm and obtained the reading. She applied the finger pulse oximeter to right index finger and obtained the reading. LPN5 performed hand hygiene but did not clean patient care equipment after use. During an interview on 11/13/24 1:54 PM, LPN5 stated, We clean the blood pressure cuffs and any patient care equipment when we come on shift or at the beginning of our medication pass and after each resident use with the Sani cleaning clothes on our med carts. I didn't clean them after residents' use. During an interview on 11/14/24 at 2:23 PM, the IP stated, Patient care equipment should be cleaned in between each resident and after use with Cavi disinfectant wipes and then let it air dry for 2 minutes (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 2:43 PM, the DON stated, Staff know and are expected to clean all patient care equipment between each resident and before and after use. I know the nurse said she was nervous about being observed. But we're going to reeducate all staff. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 12/2017, indicated, under the section, Policy Statement. Resident care equipment, including reusable items and durable medical equipment will be and disinfected according to current CDC recommendations for disinfection ., Section Policy Interpretation and Implementation revealed, A.4. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). C. Durable medical equipment (DME) must be cleaned and disinfected before reused by another resident. D. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. Review of the CDC website https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html#toc, titled, Healthcare-Associated Infections (HAIs), Environmental Cleaning Procedures, updated: 03/19/24, indicated, Overview: Current best practices for environmental cleaning procedures in patient care areas Section 4.7 revealed, Noncritical patient care equipment: Portable or stationary noncritical patient care equipment includes IV poles, commode chairs, blood pressure cuffs, and stethoscopes. These high-touch items are: Used by healthcare workers to touch patients (i.e., stethoscopes). Frequently touched by healthcare workers and patients (i.e., IV poles). Often shared between patients. These are the best practices for selection and care of noncritical patient care equipment: All clean these items with the same frequency, Table 27. Recommended Material Cleaning and Disinfectant Compatibility Considerations: Alcohols (60-80%). Could deteriorate glues and cause damage to plastic tubing, silicone, and rubber. Good for disinfecting small equipment or devices that can be immersed (e.g., stethoscopes, thermometers).