STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525532	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - St Croix Falls	750 E Louisiana St St Croix Falls, WI 54024

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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 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. 47807 Based on interview and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status that is a deterioration in heath, mental, or psychosocial status in either life-threatening conditions or clinical complications. Staff did not contact physician when blood sugar levels exceeded the threshold that orders specified a physician to be contacted. This has the ability to effect 1 of 3 residents (R) R2 investigated for insulin use. Findings include: Record review of R2's orders included: HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro), Inject 9 unit subcutaneously three times a day for diabetes AND Inject 5 unit subcutaneously one time only for DM2 for 1 Day starting on 05/07/24. Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine), Inject 50 unit subcutaneously in the morning for Diabetes AND Inject 45 unit subcutaneously one time a day for dm starting on 05/19/24. Blood Glucose monitoring parameter. Hold insulin if BG is less than or equal to 70, give protein carb snack. If BG is greater than 400 administer 12 units of humolog ss insulin and recheck BG in 2 hours. If BG is greater than 400 update provider. Active 06/03/24. Record review of resident's blood sugar levels for the months of June and July after order was active revealed 12 instances where R2's blood sugar levels were above 400 mg/dl: 06/10/24 R2's BS Level at 8:00 PM was 534 mg/dl 06/12/24 R2's BS Level at 8:00 PM was 417 mg/dl 06/16/24 R2's BS Level at 8:00 PM was 557 mg/dl 06/21/24 R2's BS Level at 8:00 PM was 438 mg/dl (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/29/24 R2's BS Level at 4:00 PM was 422 mg/dl 07/06/24 R2's BS Level at 8:00 PM was 408 mg/dl 07/08/24 R2's BS Level at 4:00 PM was 457 mg/dl 07/08/24 R2's BS Level at 8:00 PM was 459 mg/dl 07/09/24 R2's BS Level at 8:00 PM was 494 mg/dl 07/10/24 R2's BS Level at 8:00 PM was 458 mg/dl 07/12/24 R2's BS Level at 8:00 PM was 513 mg/dl 07/15/24 R2's BS Level at 8:00 PM was 438 mg/dl On 07/17/24 at 11:00 AM, Surveyor looked through all available records and could not locate any communications with physician regarding R2's blood sugar levels elevating above 400 mg/dl. On 07/17/24 at 11:51 AM, Surveyor interviewed Registered Nurse (RN) H regarding R2's order to contact the physician if R2's blood sugar levels elevated above 400 mg/dl. RN H did not know of this order and said that typically when any level is outside of the parameters of what is expected the computer system will flag that number for the staff to address it. Surveyor and RN H looked at the orders and did not see this order or parameters attached to the two insulin orders for R2. However, when RN H looked at the complete list of orders they did see the order to contact physician near the bottom of the page. RN H explained the order to contact physician was not being seen in their system when they were performing med pass. On 07/17/24 at 12:32 PM, Surveyor interviewed Director of Nursing (DON) B regarding the lack of physician communication regarding R2's blood sugar levels. DON B said the order was not showing up on the Medical Administration Record (MAR) for the nurses to see when they were performing medication administration. There was an old order that the staff were to contact the physician if there were consistently high numbers three days in a row, but this order was no longer active. The order was changed to contact the physician if R2's blood sugar levels were above 400 mg/dl and this was not done. On 06/24/24, the dietitian and nurse practitioner were contacted to inform them that R2 continued to have raised blood sugar. They did contact the physician on 07/13/24 and let them know that R2 would like a sliding scale and the blood sugars are in the 300s. The facility also contacted a physician on 07/14/24 letting them know that R2's blood sugars continue to be extremely high. There were no other communications with physician or nurse practitioner that blood sugar levels were above the 400 mg/dl threshold for each reading that was not within the ordered parameters.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40590 Based on interview and record review, the facility did not notify the resident/representative in writing of the reason for the transfer/discharge and did not send a copy of the discharge notice to the Office of the State Long Term Care Ombudsman for 4 of 5 residents reviewed who were discharged (R10, R37, R1, R40). This is evidenced by: Example 1 R10 was admitted to the facility on [DATE] and has diagnoses that include post-traumatic stress disorder, Alzheimer's disease, unspecified dementia with behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and major depressive disorder. R10's Minimum Data Set (MDS) assessment, dated 12/13/23, indicated that R10 was transferred to an acute care hospital. Physician's orders reviewed for R10 state, Per Dr. [MD name] at VA Geri psych- if resident demonstrates aggressive behaviors creating a risk for himself or others send him to VA ER for in person psychiatric help. On 12/13/23, R10 was transferred to the hospital due to an increase in inappropriate sexual behavior and refusing to take medications causing staff to continuously monitor R10 due to being a danger to self or others. This was an emergency transfer for a psychological evaluation. R10 returned to the facility on [DATE]. Example 2 R37 was admitted to the facility on [DATE] and has diagnoses that include traumatic subarachnoid hemorrhage with loss of consciousness, nondisplaced fracture of shoulder and congestive heart failure. R37's MDS assessment, dated 12/26/23 and 03/14/24, indicated that R37 was transferred to an acute care hospital. On 12/26/23, R37 was transferred to the hospital due to shortness of breath, adventitious lung sounds and decrease in oxygen saturation. R37 was treated for COVID pneumonia and returned to the facility on [DATE]. On 03/14/24, R37 was transferred to the hospital due to shortness of breath and chest pain. R37 was treated for congestive heart failure exacerbation and pulmonary embolism. R37 returned to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	The facility did not notify the resident/representative in writing of the reason for the transfer/discharge and did not send a copy of the discharge notice to the Office of the State Long Term Care Ombudsman. On 07/16/24, at 11:30 AM, Surveyor requested R10 and R37's bed hold policy and transfer notification sent to the Office of the State Ombudsman. At 11:42 AM, Surveyor received bed hold notifications for R10 and R37. Bed hold does state reason for transfer as admission to the hospital. Bed hold does not state the specific reason for the transfer or discharge, the effective date of the transfer or discharge, the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged , an explanation of the right to appeal the transfer or discharge to the State, the name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests, information on how to obtain an appeal form, Information on obtaining assistance in completing and submitting the appeal hearing request, and the name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. On 07/16/24, at 11:40 AM, Social Worker (SW) G states that she did not know she was supposed to be notifying the Ombudsman of resident transfers. SW G gave Surveyor an E-mail to State Ombudsman dated 06/28/24 that states, It was brought to my attention that we should be submitting monthly discharge reports to you. SW states that no Ombudsman notifications have been done since her date of hire on 12/18/23 until 06/28/24. SW G also did not provide the resident and/or representative in writing of the reason for the transfer/discharge to the hospital. 40181 Example 3 R1 was admitted to the facility on [DATE] with the following diagnoses in part, cerebrovascular disease, hemiparesis and hemiplegia following cerebral infarction affecting left dominant side, Alzheimer's disease with late onset. Record review identified R1 was hospitalized from 04/21/24 to 04/23/24 due to signs and symptoms of a possible stroke. On 07/15/24 at 4:08 PM, Surveyor interviewed R1's Power of Attorney for Health Care, who stated they did not remember if they received a written notice of transfer when R1 was transferred to the hospital. Surveyor was unable to locate a written notice of discharge/transfer form for this hospitalization on R1's medical record. On 07/17/24 at 8:29 AM, Surveyor requested a copy of the written notice of discharge or transfer and documentation of Ombudsman notification for R1's transfer to the hospital on 04/21/24. On 07/17/24 at 11:34 AM, Nursing Home Administrator (NHA) A reported they did not do a written notice of transfer form and did not notify the Ombudsman of this hospital transfer. NHA A stated they are starting a process to fix this non-compliance. 48793 (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Example 4 R40 was admitted to the facility on [DATE] with the following diagnoses in part, necrotizing fasciitis to the right lower limb, and aortic stenosis. Record review identified R40 was hospitalized on [DATE] - 04/29/24 due to septic shock. Surveyor was unable to locate a written notice of discharge/transfer form for this hospitalization on R40's medical record. On 07/17/24 at 8:29 AM, Surveyor requested a copy of the written notice of discharge or transfer and documentation of Ombudsman notification for R40's transfer to the hospital on 04/18/24. On 07/17/24 at 11:34 AM, NHA A reported they did not do a written notice of transfer form and did not notify the Ombudsman of this hospital transfer. NHA A stated they are starting a process to fix this non-compliance.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure resident safety through assessment and that the environment remains as free of accident hazards as is possible for 2 of 2 residents (R301 and R25) reviewed. - R301 was evaluated by the facility to be a fall risk. R301 was observed self-ambulating to R301's car in the parking lot and driving to a neighboring community in R301's personal vehicle. -Facility staff did not follow the plan of care for safety with smoking for 1 of 3 residents (R25) reviewed for smoking. Findings include: R301 was admitted for short term rehabilitation on 07/03/24. R301's diagnoses include status post cerebral cyst removal surgery, schizophrenia, intervertebral disc disorder, bilateral arthritis of the knee, anxiety disorder, and spinal stenosis. R301's Minimum Data Set (MDS) assessment, completed on 07/08/24, confirmed R301 scored 14 during a Brief Interview for Mental Status (BIMS), indicating cognition intact. R301 requires partial to moderate assistance with sitting to standing. R301 requires substantial maximal assistance from staff transferring from chair to bed to chair. R301 was not assessed for car transfer (The ability to transfer in and out of a car or van or on passenger side. Does not include ability to open/close door or fasten seat belt). R301 walking 10 feet was not attempted due to medical condition or safety concerns. R301 walking 10 feet once standing in a room or corridor or similar space was not attempted due to medical condition or safety concerns. R301 walking 50 feet with two turns was not attempted due to medical condition or safety concerns. R301's care plan was initiated on 07/03/24, and included the following interventions: Activities of Daily Living: -Transfer with 1 assist with 2 wheeled walker. -PT/OT evaluation and treatment. Fall risk initial evaluation on 07/03/24 indicates that R301 was at a high risk for falling. Initial assessment note states in part, R301 was just admitted the same hour and fell . R301 is very spontaneous and appears to lack safety awareness. Physical therapy initial evaluation on 07/04/24 indicates that R301 required partial to moderate assist with sitting to standing and walking was not attempted. Physical therapy recommended moderate assist with transfers with front wheel walker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physical therapy evaluation on 07/10/24 indicates that R301 ambulated with assist with front wheel walker 60 feet 5 times but R301 fatigued early due to osteoarthritis in bilateral knees and was unable to ambulate short distances. PT recommends Assist of 1 with transfers with front wheeled walker. Physical therapy notes on 07/16/24 indicates that R301 transfer with assist of 1, gait belt, and front wheeled walker. On 07/16/24 at 7:11 AM, Surveyor observed R301 walking without a walker from the front entrance of the facility across the parking lot to a car. R301 opened the driver's door and got into the car. Surveyor observed R301 drive off in the car and pull out of the parking lot. Surveyor observed an empty wheelchair at the entrance door. On 07/16/24 at 8:42 AM, Surveyor observed R301 enter back into R301's room and transfer self to R301's bed. On 07/16/24 at 8:49 AM, Surveyor interviewed Certified Nurse Assistant (CNA) R and asked if CNA R knew that R301 has his own car parked out front. CNA R indicated that he did not know if R301 had own car. Surveyor asked if CNA R knew R301 had left the building this morning. CNA R indicated that CNA R had heard that R301 left last week by R301's self for an AA meeting. CNA R indicated that CNA R did not realize that R301 had left this morning. CNA R asked Surveyor if CNA R should go ask R301 about R301's car. On 07/16/24 at 8:51 AM, Surveyor entered R301's room with CNA R. Surveyor interviewed R301 and asked if R301 had left the building this morning on 07/16/24 around 7:11 AM. R301 indicated that R301 comes and goes when R301 wants. R301 implied that R301 has had R301's car parked out front for the last week or week and a half. R301 indicated that R301 did not know that leaving was an issue. Surveyor asked R301 where R301 had gone this morning when R301 drove out of the facility parking lot. R301 indicated that R301 always leaves every morning for coffee and drives to the next town over about twenty minutes from the facility. Surveyor had no further questions and thanked R301 for R301's time. On 07/16/24 at 9:07 AM, Surveyor interviewed Registered Nurse (RN) H and asked if RN H was aware of R301 self-transferring R301's self out of the facility and driving R301's car to public places in the next town over. RN H was not aware that R301 self-transfers in and out of car and drives R301's vehicle off the premises. Surveyor asked RN H what is R301's transfer process. RN H indicated that R301 is an assist of 1 with ambulation, to and from wheelchair to surfaces, and that assistance is needed with transfers. RN H indicated that once R301 is in wheelchair then R301 can safely self-propel around the facility. RN H indicated that it is not acceptable that R301 leaves the facility without notifying staff that R301 is leaving and signing the in and out sheet at the front of the entrance of the facility. Surveyor asked RN H if RN H was aware that R301 had a car in the parking lot. RN H indicated that RN H had no knowledge that R301 had a car in the parking lot. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/24 at 9:31 AM, Surveyor interviewed RN I and asked if RN I was aware of R301 leaving the facility and driving R301's car off the premises. RN I indicated that RN I was not aware that R301 drives R301's vehicle off the premises. RN I indicated that RN I knew that R301 had left last week for an AA meeting but that R301 caught a ride from a friend who drove R301's car to pick up R301 from the facility to the AA meeting. Surveyor asked RN I what R301's transfer process is. RN I indicated that R301 is an assist of 1 with ambulation, to and from wheelchair to surfaces, and that assistance is needed with transfers. RN I indicated that facility deemed R301 at risk for falls after R301 had fallen on the first day of admission in R301's room. RN I indicated the facility put fall interventions into place in R301's care plan and that R301 needs assistance with transfers in and out of wheelchair. Surveyor asked RN I if it was acceptable for R301 to leave the building and drive R301's car off the premises. RN I indicated that R301 is R301's own person so facility cannot physically stop R301 from leaving, but R301 should be singing in and out on the intake sheet at the entrance of the building. Surveyor asked RN I if proper assessments were completed for R301 to deem that R301 was safe to operate R301's vehicle and was safe to transfer in and out of R301's car. RN I indicated there were no assessments completed from nursing, Physical Therapy (PT), or Occupational Therapy (OT) in regards to car safety and ambulating out of the building. RN I also indicated that R301 is supposed to check in and out before leaving the building so staff know the whereabouts of R301. Surveyor observed the sign in and out sheet log dated from 06/29/24- 07/16/24 at the front of the facility. Surveyor observed one sign in and out entry that was dated on 07/11/24 that R301 had gone to the bank at 11:00 AM and arrived back to the facility on [DATE] at 1:30 PM. Surveyor did not find a responsible party written down or phone number to reach R301 when R301 left the building. Surveyor did not observe any other entries on the log. Surveyor did not observe an entry from 07/16/24 at 7:11 AM that R301 had left the building or returned. Surveyor requested copy of log, and NHA A provided copy of log to Surveyor. On 07/16/24 at 9:42 AM, Surveyor interviewed Certified Occupational Therapist Assistant (COTA) N and asked COTA N what the process is for when a resident wants to leave the facility and drive their own vehicle. Surveyor asked how staff members allow a resident to leave and operate vehicle safely. COTA N indicated there has to be a proper assessment completed by a Physical Therapist (PT) and this order is originated and coordinated by the facility and physician. Surveyor asked if COTA N has knowledge that R301 leaves the facility and drives R301's car off the premises. COTA N indicated that COTA N was unaware that R301 left the building to drive off the premises. Surveyor asked if COTA N knew if an assessment was completed for R301 to deem R301 had the ability to drive R301's self off the premises safely. COTA N indicated that COTA N was unaware of an assessment and that R301 is a fall risk and therapy is working with R301 to gain strength to ambulate, but at this time R301 is a one assist for transfers to and from R301's wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/24 at 10:07 AM, Surveyor interviewed Director of Nursing (DON) B and asked the expectation of R301 leaving the facility and being deemed safe to do so independently. DON B indicated the recent event of R301 leaving the facility and driving R301's self in R301's car was just brought to the facility's attention. Surveyor asked DON B what expectation would be for R301 to be deemed safe to perform independent transfers in and out of car and off the premises of the facility property. VP of Clinical Operations Q was present and answered for DON B. VP of Clinical Operations Q indicated that R301 leaving independently and driving R301's vehicle was not appropriate without proper measures in place that included: physician order for complete assessment from PT for safety in and out of a car and off the premises, a complete assessment completed by PT, care plan update, education to R301 of risks when leaving the premises on safety emphasis, and mandatory singing in and out of facility on facility sign in sheet located at the front door of the facility. VP of Clinical Operations Q also indicated that there will be a risk management implementation going forward and the facility will be working on this right away. On 07/16/24 at 10:46 AM, Surveyor interviewed Physical Therapist Assistant (PTA) O and asked if a complete assessment was completed for the safety of R301 to transfer in and out of R301's car and drive off the premises. PTA O indicated the complete assessment is not done by the PTA and that the PT is supposed to complete this assessment on R301. PTA O indicated that PTA O was unaware if R301 had the proper assessment completed. PTA O indicated the process is supposed to be orchestrated with the facility staff and requesting the assessment be completed by a physician order. On 07/16/24 at 11:07 AM, Surveyor observed PTA O and Assistant Director of Nursing (ADON) C speaking to one another in the hallway. ADON C asked PTA O if PTA O could go perform a complete assessment of R301 transferring in and out of R301's car right now. PTA O indicated to ADON C that this assessment needs to be completed by a PT after a physician order is obtained. PTA O indicated that the PT is not available at this time. On 07/16/24 at 12:03 PM, Surveyor entered R301's room and observed PTA P working with R301 on physical therapy exercises. Surveyor interviewed PTA P and asked if an assessment was completed with R301 to assess safety with transferring to R301's car and driving off the premises. PTA P indicated the physical therapy company that PTA P works for does not assess behind the wheel for safety. PTA P indicated that safety of driving is recommended to be assessed after discharge from the facility. PTA P indicate that R301 should not be driving until after discharge. Surveyor reviewed care plan dated 07/03/24 that did not indicate any interventions of the safety of transferring in and out of car and leaving the premises. Surveyor reviewed electronic Health Record (EHR) and could not find any documents of education, assessments, or orders that pertained to R301 being able to transfer to and from R301's car or the safety of leaving the premises. No further documentation was given regarding the safety of R301 using personal vehicle, transferring to and from R301's car and leaving the premises. 40181 Example 2 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: Facility policy and procedure entitled, Resident Smoking/Tobacco Policy and Procedure last reviewed 07/03/24, stated in part, .7. Tobacco products will be kept in the nurse's medication cart. Residents are not allowed to keep their tobacco products on their person or in their room. Upon request, staff will provide these materials .9. If Resident fails to follow this policy, the use of the designated area could be denied . R25 was admitted to the facility on [DATE] with the following diagnoses, in part, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, and major depressive disorder. R25's most recent Brief Interview for Mental Status score was 12, which indicated R25 had moderate cognitive impairment. On 07/16/24 at 7:26 AM, Surveyor observed R25 remove the oxygen nasal cannula and place it on the bed in R25's room. R25 propelled self in wheelchair outside through double doors into the courtyard. R25 propelled self to smoking area at center of courtyard, took a cigarette and lighter out of a black pouch clipped on the front of R25's shirt and lit the cigarette. Surveyor interviewed R25, who stated they keep their cigarettes and lighter in the black pouch so they can go out and smoke whenever they want. R25 stated if they run out of cigarettes, they have to go to the nurse and get more. R25 stated sometimes, depending on which nurse is working, they will only give him 2 cigarettes instead of a whole pack. R25 stated they always keep the lighter in the pouch. Record review identified the most recent Smoking Safety Screen, dated 06/21/24, stated R25 had a score of 2, which meant R25 was safe to smoke with supervision. The Smoking Safety Screen stated in part, . Resident is able to wheel self outside, light and hold cigarette, and bring self back in with some difficulty. Resident requires staff assistance with maintaining cigarettes and lighter for safety due to resident not maintaining safety. Resident requires staff to ensure oxygen is not on [R25's] w/c[wheel chair]. Resident is able to smoke independently with need for supervision of smoking materials. Resident is required to ask for materials after oxygen has been removed from [R25's] person . Nursing progress note, dated 07/1/24, stated in part, Met with [R25] this afternoon to discuss smoking interventions. According to staff [R25] continues to be non compliant with smoking. Writer informed [R25] that we have to keep [R25] and others safe and how would [R25] feel about having the nurse trade [R25's] oxygen tank for two cigarettes when [R25] wants to smoke. [R25] said that [R25] usually gets the whole pack and smokes several at a time. I explained to [R25] that by only getting two at a time could smoke them, then come in and get [R25's] oxygen on for a while then go back out and have two more if [R25] still desired more. This way [R25] would be alternating cigarettes and oxygen. [R25] seemed somewhat receptive to this. We also discussed the non flame tobacco and [R25] said [R25] would think about this too. Reiterated to [R25] that [R25] cannot smoke next to the building because this could pose a risk to others and could result in no cigarettes being allowed. [R25] expressed understanding . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's care plan stated in part, .Focus: I am a smoker. Goal: I will not smoke without supervision of materials and safe independent smoking through the review date. Interventions: .Staff to ensure resident is not wearing oxygen and portable is not on [R25's] chair before giving smoking materials over. Staff to ensure after smoking [R25] returns all provided materials back to nurse for storage in med room Date Initiated: 06/21/2024. The resident requires SUPERVISION of materials and oxygen while smoking. Date Initiated: 05/31/2024 Revision on: 07/01/2024. The resident's smoking supplies are stored at nursing station (cigarettes, lighter, cigarette rolling machine. Date Initiated: 05/31/2024 Revision on: 07/11/2024 . On 07/16/24 at 11:21 AM, Surveyor interviewed CNA F, and asked if R25 was allowed to keep smoking materials and go out to smoke independently. CNA F stated R25 always went out to smoke independently during the day shift. CNA F thought R25 was allowed to keep their smoking materials in the black pouch during the day and then had to return them to the nurse at night. On 07/16/24 at 11:42 PM, Surveyor observed R25 assisted outside to smoking area in courtyard by hospice nurse. Surveyor observed R25 take a cigarette and lighter from the black pouch clipped to R25's shirt. Surveyor interviewed R25 and asked if they just got the smoking materials from the nurse. R25 stated they kept a pack of cigarettes and lighter in the black pouch so they can go out to smoke whenever they want during the day. On 07/16/24 at 1:01 PM, Surveyor interviewed RN E and asked if R25 was allowed to keep cigarettes and lighter on R25's person. RN E stated they were supposed to keep R25's cigarettes and lighter in the medication cart. R25 was supposed to come and get them from us, or the CNA was supposed to get them for R25, so that the nurse or the aide could verify that R25's oxygen tank was off the wheelchair and R25 moved away from the building to smoke. Surveyor asked if that happened today. RN E stated no, R25 was supposed to bring the cigarettes and lighter back to us after smoking, but that did not always happen. RN E stated R25 already had the cigarettes and lighter when RN E started work, and R25 often had the smoking materials in the pouch on R25's shirt during the day. On 07/16/24 at 2:46 PM, Surveyor interviewed DON B and RN C and informed them of two observations of R25 going out to smoke today. Surveyor informed them R25 had a full pack of cigarettes and lighter in the black pouch clipped to R25's shirt. Surveyor also informed them R25 stated they kept the cigarettes and lighter in the pouch during the day so they could go out whenever they wanted to smoke. Surveyor asked if that was what was care planned for R25's smoking safety. DON B and RN C stated R25 was not supposed to keep smoking materials during the day due to previous non-compliance with the smoking plan. RN C stated R25 would go out to smoke with oxygen on and would smoke right beside the building instead of in the designated smoking area. DON B stated nursing staff were to keep lighter and cigarettes in the medication cart and only give out two cigarettes at a time and the lighter, so they could verify R25's oxygen was off. DON B stated the smoking materials were to be returned to the nurse after R25 was done smoking.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure that parenteral medications were administered consistent with professional standards of nursing practice for 1 of 1 (R24) resident reviewed. R24 was admitted to the facility on [DATE], with a Peripherally Inserted Central Catheter (PICC) line, which is a soft, thin, flexible tube in a vein used to administer IV medications and fluids. Staff did not complete appropriate assessment before administration of IV antibiotics. Staff were observed not applying alcohol-based connector locks after the administration of IV antibiotics. Findings include: The Association for Professionals in Infection Control and Epidemiology (APIC) guidelines, entitled Guide to Preventing Central Line-Associated Blood stream Infections, last reviewed 2015, states in part: Focus has shifted to use of disinfection caps that can be placed on the access port and maintain a level of disinfection. Various disinfection combinations are currently available, including alcohol and alcohol/chlorhexidine combinations. These plastic caps are placed on the access point in between intermittent infusions, thus minimizing contamination opportunities of the access point . R24 was admitted on the short-term rehabilitation unit on 06/26/24. R24's diagnoses include status post infection due to internal right knee prothesis. R24's care plan was initiated on 06/26/24, and included the following interventions: Infection of the bone/joint infection right lower extremity: -Administer antibiotic as per MD orders. -Measure length of PICC line daily prior to administering antibiotic. Physician orders state in part, -indicate use Daptomycin 500 mg intravenous one time a day for bone or joint infection for 24 days. -Notify provider/practitioner if external catheter length has changed from last measurement- see supplementary documentation. -PICC order for routine nursing care for IV medication administration. PICC 4 fr. Double lumen PICC, right arm basilic vessel, total catheter length is 37cm with 2cm external catheter. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Iv site observation every shift before and after each administration of intermittent medications. Every shift document abnormal condition, site observation, (i.e. redness, swelling, pain, drainage, arm to touch, etc). Surveyor reviewed progress notes and did not find documentation of PICC line measurements completed since the initial placement of the PICC line. On 07/16/24 at 9:23 AM, Surveyor observed Registered Nurse (RN) H enter R24's room. RN H donned gown and gloves. RN H began wiping down red hub connector with alcohol pad. RN H took 10ml saline flush and flushed the red hub. RN H wiped the other purple hub connector with a different alcohol pad and began flushing the purple hub with another 10ml saline flush. RN H connected the antibiotic Daptomycin and began infusing the antibiotic. Surveyor did not observe RN H measure the length of the catheter before administering antibiotic as R24's care plan indicates. On 07/16/24 at 9:31 AM, Surveyor interviewed RN H and asked if RN H was supposed to measure length of catheter before administering antibiotic. RN H stated, Yes I should have done that, and I did not. On 07/16/24 at 9:37 AM, Surveyor interviewed RN I and asked what expectations were for PICC line care in regard to measuring length of the PICC line before administering antibiotics. RN I indicated that RN I's expectation would be that RN H follow the care plan for PICC care and measure the length of the PICC before administering antibiotic. Surveyor asked RN I what expectation is for using the alcohol-based caps on the end of the PICC hubs to mitigate infections. RN I indicated the supply company does not send the alcohol based connector caps with the PICC line dressing kit, and the facility needs to call to have these ordered in. RN I indicated that RN I has not done this yet. Surveyor asked RN I what standards of practice is utilized during PICC cares. RN I indicated the facility follows the national standards of practices. On 07/16/24 at 11:01 AM, Surveyor interviewed Director of Nursing (DON) B and asked what expectation is for using the alcohol-based caps on the end of the PICC hubs to mitigate infections. DON B indicated the facility is between utilizing the corporation's polices and the pharmacy's polices, but at this time, DON B would expect that we use alcohol-based connectors to prevent spread of infection. Surveyor asked DON B what DON B's expectation was for measuring the length of the PICC line before administering antibiotics. DONB indicated that if it is ordered or care planned it should be being completed before administering medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43352 Based on observations and interviews, the facility did not distribute and serve food with professional standards for food service safety. This has the potential to affect all 43 residents in the facility. Observations of handling ready to eat foods with contaminated gloves. Observed dirty air conditioner blowing on clean dishes. Dirty, unsanitary condition in dish room. Findings include: On 07/16/24 at 11:05 AM, Surveyor observed the dish room; there was a window air conditioner blowing on the clean dishes. Surveyor observed the blades of the air conditioner and there was a light gray colored dust on them. Surveyor also observed the exhaust fan above the dishwasher; there was a black colored fuzzy substance on the fan. Surveyor also observed a fan attached to the wall across from the dish machine with fuzzy, black in color substance on it. Also on the wall all around the fan were black fuzzy spots. On 07/16/24 at about 3:28 PM, Surveyor toured the dish room with Nutritional Services Director (NSD) K and asked NSD K if they thought the air conditioner was clean. NSD K indicated nope. Surveyor pointed out the fan and the wall around it and asked if it was clean. NSD K indicated it looks yucky. Surveyor then pointed out the exhaust fan above the dish machine, and NSD K indicated it looks like it needs cleaning. On 07/16/24 at 12:08 PM, Surveyor observed [NAME] J wearing gloves and grabbed 2 spatulas to put sandwiches on the plates. With same gloves [NAME] J went into the cooler and brought out a tray of deviled eggs. With the same contaminated gloves on [NAME] J's hands, [NAME] J put 2 halves of sandwiches on a plate then removed half of the sandwich using the same contaminated gloved hand and a spatula. [NAME] J continued serving lunch then used their same contaminated gloved hand to help with dishing up a sandwich with a spatula on the plate. On 07/16/24 at about 3:28 PM, Surveyor interviewed NSD K sharing the observations of [NAME] J serving the sandwiches during lunch. Surveyor asked what the process should be. NSD K indicated that [NAME] J should have used tongs instead.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility did not establish an Infection Control Program under which it investigates, controls, and prevents infections in the facility, and a system for recording incidents identified under the facility's Infection Control Program, including corrective action in a timely manner, for both residents and staff. This has the potential to affect all 43 residents in the facility. -The facility did not a have a clear water management process or plan in effect to prevent transmission of Legionella infection. This has the potential to effect 43 of 43 residents reviewed. -The facility did not have a tracking program in place for the early detection of infected and exposed residents (R) and staff for COVID-19 during an outbreak. -Observations were made of the facility not implementing Enhanced Barrier Precautions (EBP) for 2 of 5 sampled residents on EBP. This is evidenced by: Example 1: The facility policy entitled, Water Management Program, which is not dated, states in part: Infection Control - . #3. Risk Assessment - will be conducted by water management team annually to identify where legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. #5. Based on risk assessment, control points will be identified and kept in the water management program binder: . #6. The measures shall be specified in the water management program action plan. #7. Testing protocols and control limits will be established, and adequate records of infection control measures documented then corrective actions be taken and documented . #9. Effectiveness of the water management program shall be evaluated with routine infection surveillance data, water quality data, and rounding data to validate effectiveness. The Center for Disease Control and Prevention (CDC) guidelines entitled, Controlling Legionella in potable water systems, last reviewed March 15, 2024, states in part: Flush low-flow piping runs and dead legs at least weekly and flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as-needed to maintain water quality parameters within control limits. On 07/17/24 at 9:15 AM, Surveyor reviewed the facility's Water Management Plan (WMP) and did not find a record of maintenance, inspections, or flushing of areas of concerns that required flushing. Surveyor did not observe the updated version of water management plan being utilized. Surveyor did not observe the flow diagram or WMP updated with locations of hot spots/stagnation areas deemed high risk areas of Legionella growth. Surveyor observed an annual risk assessment was completed on 07/07/23 and brief review of plan was conducted on 06/19/24 with no documented revisions or documentation on audit logs, surveillance data, or effectiveness of the last year's plan in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/17/24 at 10:11 AM, Surveyor interviewed Nursing Home Administrator (NHA) A who indicated that NHA A and Environmental Service (EVS) Director M are responsible for the water management plan in the facility. Surveyor interviewed NHA A and asked to walk Surveyor through the WMP. NHA A admitted to following the WMP tool kit from the CDC that was not updated from 2017. NHA A indicated the current WMP that the facility is using does not show distinct quality measures on the flow diagram or where stagnation/hot spots are located throughout the facility. NHA A indicated that nothing has specified locations and the flow diagram shows just description such as water heater, fountain, etc. but not where these items are located through the building and what is being assessed. NHA A indicated that there were no audit logs being completed by the facility until 06/27/24. Example 2: The facility policy entitled, Infection Surveillance, which is dated 08/2022, states in part: #6: The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: a. Data to be collected, including how often and the type of data to be documented, including: i. The infection site, pathogen, signs and symptoms, and residents' location, including summary and analysis of the number of residents and staff who developed infections . Surveyor reviewed Infection Control (IC) surveillance logs and found the facility identified the facility had an outbreak of COVID-19 starting in December of 2023 and ending in February 2024, which affected 19 of 43 residents. Surveyor observed data logs to be inconsistent and missing residents' last names, identifiers, and room numbers. Surveillance logs were observed missing information identifying onset of symptoms, when precautions were implemented, any testing, last well date, when symptoms ended, when precautions ended, and if provider was notified. Surveyor reviewed IC 2023 data line lists for residents and staff. Surveyor noted that all line lists from January 2023-December 2023 were inconsistent and missing data. Surveyor reviewed and noted line lists were missing the infection site, pathogen, signs and symptoms, residents' or staff's location, last well date, any summary and analysis of the number of residents and staff who developed infections. Line lists had incomplete data. On 07/16/24 at 9:33 AM, Surveyor interviewed Registered Nurse (RN) D who was the Infection Preventionist (IP) until 06/08/24 when the Director of Nursing (DON) B took over as IP. Surveyor asked RN D about the process for tracking surveillance of resident infections and sicknesses. RN D indicated that line lists were incomplete throughout the whole year last year in 2023 and into June of 2024. RND D indicated that RN D was doing the best that RN D could but that RN D was not fully trained in IP and had lots going on in RN D's role as DON and IP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor asked RN D about the process for tracking surveillance of resident infections during the identified COVID-19 outbreak that started on unknown day in December 2023. RN D indicated that RN D was supposed to track the date of onset of symptoms, testing parameters, when precautions such as quarantine start, and end based on the CDC recommendations for the COVID-19 virus. RN D indicated that RN D did the best that RN D could but that there was no other information documented pertaining to the COVID-19 outbreak. RN D indicated that RN D did not have a surveillance log tracking the 19 residents who became infected with COVID-19 sometime in December of 2023 and ending sometime in February 2024. Surveyor asked RN D if any staff members were identified as positive with COVID-19 virus in the COVID-19 outbreak. RN D indicated there were several staff members who became sick with COVID-19, but that RN D did not keep any records of the sick staff members and what actions were taken. Surveyor asked RN D if there was any other information that RN D could provide Surveyor with pertaining to the documentation of the COVID-19 outbreak. RN D indicated that RN D had no other information as the COVID-19 outbreak was not surveilled as it should have been. On 07/16/24 at 9:41 AM, Surveyor interviewed Director of Nursing (DON) B and asked about expectations for surveillance of infections throughout the building and what criteria is being utilized to determine antibiotic usage compliance. DON B indicated that DON B started as DON/IP on 06/10/24. DON B indicated the process for tracking infections and mitigating the spread of infections has not been in effect, and DON B is currently working on a correct process going forward. DON B indicated that last night on 07/15/24, DON B started formulating a nice spreadsheet line list to implement going forward. On 07/17/24 at 10:02 AM, DON B indicated that until today on 07/17/24 DON B has been pulling all residents who are on antibiotics and running a report at the end of the month and filling out the McGeers criteria sheet individually for them. DON B indicated that DON B started back tracking and reviewing antibiotic use from January 2024 to present and is gathering data to make into spreadsheets. DON B indicated then DON B places it in the correct set month and using the tracking list to verify what antibiotic residents were on and calculating the infection rate off that data. DON B indicated that DON B would start the McGeer's criteria right away once resident is deemed to have an infection to make sure that resident meets the criteria to be on antibiotic, but DON B indicated this was not being implemented with current residents who have infections and are on antibiotics. Surveyor asked DON B if DON B or RN D had any staff infection control line lists for January 2024 to present. DON B and RN D indicated that no staff line lists for January 2024 to present could be found. 40181 Example 3: According to CDC guidance entitled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), last updated 07/12/22, .EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. Infection or colonization with an MDRO .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 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/15/24 at 10:40 AM, Surveyor noted the Resident Matrix (CMS-802) identified R30 was on Transmission-Based Precautions (TBP). Surveyor observed there was no sign on R30's door identifying TBP, and there were no PPE supplies by R30's door or in the room. Surveyor asked Certified Nursing Assistant (CNA) L if R30 was on TBP and if Surveyor needed to put on PPE to enter R30's room. CNA L did not know if R30 was supposed to be on TBP. CNA L stated usually there should be a sign indicating what type of TBP on the resident's door, and a PPE cart outside the door for residents on TBP. On 07/15/24 at 10:45 AM, Registered Nurse (RN) C stated R30 should be on EBP due to an open wound on the foot. RN C stated there should be a sign on the door and PPE cart set up, and they would get that set up. At 11:05 AM, RN C came back and informed Surveyor R30 was no longer on EBP because their corporate consultant told them it was no longer required. On 07/16/24 at 8:14 AM, Surveyor observed RN D and CNA F provide incontinence cares for R30. RN D and CNA F were not wearing gowns during this high-contact care. On 07/16/24 at 1:31 PM, Surveyor observed RN D perform wound care on R30's left lateral ankle pressure injury. RN D did not wear a gown during this high-contact care. RN D stated the left ankle wound had been present for several months. On 07/17/24 at 8:38 AM, Surveyor interviewed Director of Nursing (DON) B and asked what criteria the facility used for putting residents on EBP. DON B stated they follow CDC guidance for EBP. Surveyor asked why R30 was taken off EBP since R30 still has a chronic wound open on the left outer ankle and CDC guidance recommends EBP for residents with chronic wounds. DON B stated their corporate nurse told them the corporation has a different policy and procedure related to criteria for EBP and R30 did not need to be on EBP, so they removed it. DON will get the policy and procedure for Surveyor to review. On 07/17/24 at 10:13 AM, DON B provided facility policy and procedure entitled Enhanced Barrier Precautions, last reviewed 4/2024. The policy and procedure stated in part, .EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Enhanced Barrier Precautions may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Infection or colonization with a targeted MDRO. Infection or colonization with other epidemiologically important MDROs, or Chronic wounds or indwelling medical devices, regardless of their MDRO colonization status . Surveyor asked DON B if R30's left ankle wound, which had been present since February of 2024, would be considered a chronic wound. DON B stated yes, it would be considered a chronic wound. Surveyor asked DON B if R30 should be on EBP due to having a chronic wound which was still open and getting daily wound care. DON B stated R30 should be on EBP and they would implement that today. 43352 Example 4: R21 was listed on the roster matrix as being on transmission based precautions (TBP) and was not observed to be on TBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled Enhanced Barrier Precautions with an effective date of March 2023 read in part, Additional MDROS that can be considered for enhanced barrier precautions may include, ESBL - producing Enterobacterales may be considered per Director of Nursing directions. R21 was admitted to the facility on [DATE] and has diagnoses that include acute pain of right knee, neuropathy, osteoarthritis of right knee, kidney disease stage 3, ESBL producing bacteria infection in urine, and an open wound on vagina area. R21 also receives daily wound care on right and left ankles. On 07/17/24 at about 8:45 AM, Surveyor interviewed RN I, who is also the case manager and asked if R21 was supposed to be on any type of precautions. RN I looked at their bulletin board and indicated yes. Surveyor asked how someone would know if a resident is on any sort of precautions. RN I indicated there is supposed to be a bin inside the resident's room and a sign on the door. Surveyor told RN I that neither of those items were present. RN I said, Let's go check. When we got to R21's door, RN I indicated there should be a sign on the door and there is not. RN I knocked on the door and when R21 said come in, RN I and Surveyor entered the room. RN I asked R21 if there was ever a bin in R21's room. R21 indicated they never had one. On 07/17/24 at 9:00 AM, Surveyor interviewed DON B and asked if R21 should be on precautions with a history of ESBL. DON B indicated if ESBL they should be on EBP.

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	525532	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - St Croix Falls	750 E Louisiana St St Croix Falls, WI 54024

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48793 Based on interview, the facility failed to ensure the Infection Preventionist (IP) is trained in special education and training in infection prevention and control. This has the potential to affect all 43 residents. This is evidenced by: Registered Nurse (RN) D was the facility's Infection Preventionist (IP) until 06/08/24. On 07/17/24 at 9:30 AM, Surveyor asked RN D if RN D had specialized training in Infection Control (IC) and prevention. RN D stated, No, I never did finish the infection control instructional class to become certified but that there was a corporation person for IC who oversaw the infection control program sometimes. Surveyor asked what that role consisted of for the corporation IC and RN indicated that corporation IC would come into facility sometimes and oversee some of the significant IC data but that it was inconsistent, and RN D would conduct surveillance as best as RN D could. Surveyor asked RN D how long has RN D been the IP at the facility. RN D stated, I started this role sometime in April/May of 2023 and continued in the IC/Director of Nursing (DON) role until the interim DON B took over in June of 2024, but I was not proficient in IC surveillance and implementing the IC program. I did my best with the little experience and resources I had but IC was not being completed as IC needed to be. Surveyor reviewed documentation and only found that there was a corporation person overseeing the infection control program from Jan-July 2023 and then RN D was on RN D's own thereafter from July 2023-June 2024. Surveyor found significant errors and lack of documentation during infection surveillance from January 2023 - 07/17/24. Last known documentation that was signed from a trained infection preventionsit was a line list dated 07/2023 that had been reviewed and signed. DON B began the IC role around March of 2024. The facility has an inadequate water management program to prevent the spread of infection. Deficiencies were noted in Covid immunizations and influenza and pneumococcal vaccinations not being offered or given to prevent the spread of infection. See F880, F883, F887. The facility failed to ensure the IP has specialized training in infection prevention and control.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview, medical record review and facility document review, the facility did not have a comprehensive system for ensuring residents received influenza and/or pneumococcal immunizations, for 9 of 13 sampled residents, (R). (R40, R24, R11, R1, R2, R21, R42, R37, and R31) This is evidenced by: The CDC Influenza Vaccine Timing for Adults reads, in part: One dose of Influenza vaccine is recommended for adults each flu season . The CDC Pneumococcal Vaccine Timing for Adults reads, in part: Administer 1 dose of PCV13 at least 1 year after the most recent pneumococcal vaccine dose. Administer a second dose of PPSV23 at least 8 weeks after PCV13 and at least 5 years after the previous dose of PPSV23 . Surveyor requested a list of current residents and their influenza and pneumococcal immunization dates. R40 was admitted on [DATE]. R40's immunization record stated that influenza and pneumococcal vaccinations were recommended. Facility did not have documentation that the facility offered or educated R40 of the influenza and pneumococcal vaccinations recommended. The facility did not have a declination form in R40's record of the influenza and pneumococcal being declined. R24 was readmitted on [DATE]. R24's immunization record stated influenza immunization recommended. Facility did not have documentation that the facility offered or educated R24 of the influenza vaccination. The facility did not have a declination form in R24's record of the influenza vaccination being declined. R11 was admitted on [DATE]. R11's immunization record stated that influenza and pneumococcal were recommended. Facility did not have documentation that the facility offered or educated R24 of the influenza vaccination or pneumococcal immunization. The facility did not have a declination form in R24's record of the influenza vaccination or pneumococcal being declined. R1 was admitted on [DATE]. R1's immunization record stated influenza immunization and pneumococcal recommended. Facility did not have documentation that the facility offered or educated R1 of the influenza vaccination. Surveyor reviewed a consent form signed on 11/23/23 titled, Influenza vaccine consent form, signed by R1's Power of Attorney (POA) which indicated the consent to receive the influenza vaccination from the facility. The consent form does not specify that education was given, and the form does not have the screening questions answered to receive the vaccination appropriately. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor also reviewed a consent form signed on 11/23/23 titled, Pneumococcal Vaccine consent form, signed by R1's Power of Attorney (POA) which indicated the consent to receive the pneumococcal vaccination from the facility. The consent form does not specify that education was given, and the form does not have the screening questions answered to receive the vaccination appropriately. R2 was admitted on [DATE]. R2's immunization record stated influenza vaccination was recommended. Facility did not have documentation that the facility offered or educated R2 of the influenza vaccination. Surveyor reviewed a consent form signed on 11/14/23 titled, Influenza vaccine consent form, signed by R2 which indicated the declination of the influenza vaccination from the facility. The declination form does not specify that education was given. Surveyor reviewed R21, R42, R37, and R31's immunization record which indicated influenza and pneumococcal vaccinations were not offered and/or kept up to date, and/or education was not given to residents or POAs regarding the vaccinations. On 07/17/24 at 11:17 AM, Surveyor interviewed R40 and asked if R40 was offered or educated on influenza, pneumococcal, and COVID-19 vaccinations. R40 indicated that no one has spoken to R40 about vaccinations. R40 indicated that R40 was not offered an influenza vaccination or anything else while being admitted to the facility. On 07/17/24 at 11:45 AM, Surveyor interviewed Director of Nursing (DON) B, Registered Nurse (RN) D, and VP of Clinical Operations Q and asked about the process for admission and up to date on current immunizations. DON B and RN D indicated the process for following up with vaccinations after residents are admitted is a working process at this time. RN D indicated the facility has recognized the process for updating immunizations, offering, and educating on vaccinations was not being completed throughout the whole facility. RN D indicated this task had fallen through the cracks. RN D indicated the staff did not administer or educate on influenza and/or pneumococcal vaccinations appropriately to R40, R24, R11, R1, R2, R21, R42, R37, and R31.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on staff interview and record review, the facility did not ensure 8 residents (R) of 13 sampled were offered a COVID-19 vaccine as indicated. (R40, R24, R1, R2, R21, R42, R37, and R31) This is evidenced by: The CDC COVID-19 vaccine Timing for Adults reads, in part: One dose of COVID-19 vaccination booster is recommended for adults every 6 months unless immunocompromised . Surveyor requested a list of current residents and their COVID-19 immunization dates. R40 was admitted on [DATE]. R40's immunization record stated that COVID-19 vaccinations were recommended. Facility did not have documentation that the facility offered or educated R40 of the COVID-19 vaccination recommendation. The facility did not have a declination form in R40's record of the COVID-19 vaccination being declined. R24 was readmitted on [DATE]. R24's immunization record stated COVID-19 vaccination recommended. Facility did not have documentation that the facility offered or educated R24 of the COVID-19 vaccination. The facility did not have a declination form in R24's record of the COVID-19 vaccination being declined. R1 was admitted on [DATE]. R1's immunization record stated COVID-19 vaccination recommended. Facility did not have documentation that the facility offered or educated R1 of the COVID-19 vaccination. Surveyor reviewed a consent form signed on 11/23/23 titled, COVID-19 vaccine consent form, signed by R1's Power of Attorney (POA) which indicated the consent to receive the COVID-19 vaccine from the facility. The consent form does not specify that education was given, and the form does not have the screening questions answered to receive the vaccination appropriately. The immunization record does not indicate that R1 received the COVID-19 vaccination as requested. R2 was admitted on [DATE]. R2's immunization record stated that COVID-19 vaccination was recommended. Facility did not have documentation that the facility offered or educated R2 of the COVID-19 vaccination. Surveyor reviewed a consent form signed on 11/14/23 titled, COVID-19 vaccine consent form, signed by R2 which indicated the declination of the COVID-19 vaccination from the facility. The declination form does not specify that education was given. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R21, R42, R37, and R31's immunization record which indicated COVID-19 vaccinations were not offered and/or kept up to date, and/or education was not given to residents or POAs regarding the vaccinations. On 07/17/24 at 11:17 AM, Surveyor interviewed R40 and asked if R40 was offered or educated on COVID-19 vaccinations. R40 indicated that no one has spoken to R40 about vaccinations. R40 indicated that R40 was not offered an COVID-19 vaccination while being admitted to the facility. On 07/17/24 at 11:45 AM, Surveyor interviewed Director of Nursing (DON) B, Registered Nurse (RN) D, and VP of Clinical Operations Q and asked about the process for admission and up to date on current immunizations. DON B and RN D indicated the process for following up with vaccinations after residents are admitted is a working process at this time. RN D indicated the facility has recognized the process for updating immunizations, offering, and educating on vaccinations was not being completed throughout the whole facility. RN D indicated this task had fallen through the cracks. RN D indicated the staff did not administer or educate on COVID-19 vaccinations appropriately to R40, R24, R1, R2, R21, R42, R37, and R31.