STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525543	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquardt Memorial Manor	1020 Hill St Watertown, WI 53098

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on observation, interview and record review, the facility did not provide behavioral health services to ensure a resident received the highest practicable mental and psychosocial well-being. The facility did not create a comprehensive assessment and plan of care to address substance use disorder (SUD) for 3 of 3 residents (R1, R4, and R5) reviewed for SUDs. R1 had cocaine use, regularly drank alcohol while in the facility and had a history of cannabis use. R1 did not have an assessment or comprehensive person-centered care plan for R1's SUD and did not have timely interventions for R1's SUD. R5 regularly drank alcohol while in the facility and did not have a care plan with interventions for SUD. R4 did not have a care plan in place for his diagnosis of alcohol use. This is evidenced by: The facility policy titled Comprehensive Person-Centered Care Plan, dated [DATE], states in full: I. Policy: The Comprehensive Person-Centered Care Plan will reflect the individual's needs and preferences to facilitate care. II. Procedure: A. Within 48 hours after admission: a Baseline Care Plan will be completed and reviewed with Individual and/or Individual Representative. B. Within 21 consecutive days after admission, and in correlation with the Minimum Data Set (MDS), a comprehensive assessment will be completed, and a written care plan will be developed based on the individuals' history, preferences, and assessments from appropriate disciplines and the physician's evaluation and orders. C. Care Plan shall be reviewed and revised quarterly, upon change of condition, and/or as needed. D. Individual and/or Individual Representative and direct care staff will participate in development of the comprehensive person-centered care plan. Example 1 R1 admitted to the facility on [DATE] with diagnoses that include alcohol use, cannabis use, anxiety disorder, major depressive disorder, and falls in the setting of acute alcohol intoxication. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Brief Interview for Mental Status (BIMS) on [DATE] has a score of 15, indicating R1 is cognitively intact. R1's admission comprehensive assessment MDS, dated [DATE], does not include the diagnoses for SUD. R1's quarterly MDS assessment, dated [DATE], includes the diagnoses for cannabis use and alcohol use, unspecified with intoxication. R1's Discharge Summary Instructions, from the hospital to the facility, dated [DATE], states in part: Pt (Patient, R1) endorses plan to follow up on outpatient AODA (Alcohol and Other Drug Abuse)/mental health resources. R1's NP (Nurse Practitioner) progress note, dated [DATE], states in part: Type: SNF (Skilled Nursing Facility) Initial Visit.was hospitalized following fall on ,d+[DATE]. He was intoxicated at time of arrival to ER. He was admitted due to his group home being unwilling to take him back due to inability to meet his needs.he is quite irritable and is very focused on pain medication. He is very persistent that he wants a stronger medication for pain. History of cocaine and marijuana use. No alcohol to be administered in facility. Supportive cares. R1's nurses' progress notes include the following: [DATE] 8:00 PM Resident went back to station 2 in his motorized wheelchair, drunk. [DATE] 9:40 PM Resident is drunk and keeps on cursing to the CNA's (Certified Nursing Assistant) who are helping him. [DATE] 9:47 PM The nurse from AM shifts already talked to him to sign out the resident temporary release if he is going out. Resident is drunk again in the afternoon. Screaming to change his shirt because it always goes up to his belly, which the CNA assisted him . I asked one CNA to go with me to look for the resident. We saw him in [Gas Station] buying alcohol and stuff. He told me that he is an adult, his own self and no one can tell him what to do. He is also cursing me saying the F word. I just told him to at least sign out at the nursing station when going out and left. The incident was reported to the DON (Director of Nursing). {sic} [DATE] 10:28 PM Res (R1) at 2230 had gotten back from [Gas Station] to which res had been drinking beers as well. [DATE] 3:33 AM Resident was sitting in his wheelchair making loud vocalizations and noises for the first 3 hours of the night, as he had been drinking alcoholic beverages. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Psych Initial Evaluation by NP (Nurse Practitioner), dated [DATE], states in part: Pt (Patient, R1) is lying sideways on bed, and has difficulty raising himself up. He is very floppy appearing. He does not have ETOH breath, but staff suspects he may be in a drunkened [sic] state, as this is how he often presents when intoxicated. He states he has been drinking since age of 12yo. (Years Old). He has h/o (History Of) substance use disorder including opiates and cannabis. Behaviors - reckless, poor impulse control, poor judgement. He has been agreeable to be off opioid, he has agreed to be on naltrexone to cut alcohol cravings. Current alcohol abuse. History of cocaine and marijuana use. Discussed alcohol use reduction; discuss Naltrexone for minimizing craving - pt is opened to this. Avoid alcohol in facility. Significant factor in falls and discharge from his current group home. Per staff, has been leaving facility to obtain alcohol and drinking until intoxicated. Large contributor to frequent falling. Was evaluated by psych today. R1's physician orders include the following: Targeted Behavior: ETOH (Alcohol) issues/seeking. Y if occurred. N if no behavior occurred every shift. Frequency: how often behavior occurred. Intensity: how resident responded to redirection. Intensity Code: 0=Did Not Occur; 1=Easily Altered; 2=Difficult to Redirect. Describe interventions in Progress Note. Start date [DATE]. Of note, the facility was aware of R1's alcohol use in the facility in [DATE], and this is the first order placed for monitoring. Naltrexone HCL (Pain) Oral Capsule 4.5 MG give 1 capsule by mouth in the morning for pain, alcohol abuse. Start date [DATE]. Discontinued [DATE]. Naltrexone HCL 50 MG, give 50 mg by mouth in the morning for pain, alcohol abuse. Start date [DATE]. Discontinued [DATE]. Naltrexone HCL 50 MG, give 1 tablet by mouth in the morning for pain, alcohol desire. Start date [DATE]. Of note, R1's physician orders do not include AODA/mental health referrals. R1's Medication Administration Record (MAR) for [DATE] includes the following: Naltrexone HCL 4.5 MG, Give 1 capsule by mouth in the morning for pain, alcohol abuse. Start date [DATE]. Discontinue date [DATE]. For the dates of [DATE] through [DATE], R1's MAR is marked with a 16. 16 indicates the medication was unavailable. Of note, Naltrexone HCL 4.5 MG was not given to R1 during this time. Naltrexone HCL 50 MG, give 50 mg by mouth in the morning for pain, alcohol abuse. Start date [DATE]. For the dates of [DATE] through [DATE], R1's MAR is signed as given. Of note, the first dose of Naltrexone given to R1 was [DATE], 14 days after being ordered by the NP. R1's Nurses' progress notes include the following: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 5:54 PM Resident noted to be drinking found in bathroom between sink and toilet. [DATE] 2:48 PM Note text: PSYCHOACTIVE MEDICATION & BEHAVIOR COMMITTEE: Team reviewed resident's mood, behavior, medication, diagnoses, targeted behavior and PHQ-9 assessment (Screening tool for depression in adults). Diagnoses and targeted behavior clarified. Resident self directs leisure time. Resident's family and careteam [sic] is involved and supportive. His naltrexone was recently increased; team is monitoring his response. [DATE] 3:45 AM At 0110 (1:10 AM), after drinking several alcoholic beverages, and being intoxicated, resident was heard calling for help. [DATE] at 2:32 AM Resident has been drinking alcoholic beverages and has been intoxicated throughout the night. He has been loud, swearing and yelling. Difficult to redirect. [DATE] 11:45 AM Writer reviewed Risk vs Benefits with resident in relation to increase in falls related to intoxication. Resident gave verbal consent for Risk vs Benefits. Writer offered and given resources for AODA, and resident declined. Of note, this is the first documented attempt to give R1 resources for AODA, over four months after R1's admission on [DATE]. [DATE] 3:50 AM Seen resident drunk on his motorized wheelchair outside the facility door. Writer told him it is dangerous to go out in his current state, but the resident said he is his own self and an adult. [DATE] 4:30 AM Saw the resident under the sink of his room lying on his right side. Noted right ear is bleeding (small amount). Helped resident to position properly before calling CNA for help. Cleansed the wound on the right ear, neuro checks done. Help resident back to bed. Resident is drunk. [DATE] 8:52 PM at approx. (approximately) 1900 (7:00 PM) writer was notified by staff: Upon entering resident room med tech (CNA that can administer medications) noted a white powdery substance in a pile with a credit card on his bedside table, which he hastily tried to cover up. Resident also noted to have a white powder all over hisnose [sic] as well. Writer was then notified. Writer then calling on-call (DON B, Director of Nursing). Per instructions called the non-emergent police number to report incident. Officer then came to talk to resident. Resident admitting to police that substance was in-fact cocaine. Police then seized substance and everything that the substance touched. Resident table then wiped down and returned to room. Officer then left building. Approx 2010, resident then left premise again, returning about 2045 (8:45 PM). Resident placed on 15-minute checks. Admin (Nursing Home Administrator NHA A), DON B, & MD (Medical Doctor), all aware of incident. Continue to monitor [DATE] 10:12 AM SW (Social Worker) lm (Left message) for [Supplemental Insurance] CM (Case Manager) and RN (Registered Nurse) that SW needs a return call asap (As Soon As Possible) [DATE] 4:50 PM SW spoke with resident's CM regarding update on incident from 2.4.25 and d/c (Discharge) planning. Call was ended suddenly. Of note, this is the first documented attempt to seek alternate placement for R1. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 12:19 PM SW spoke with with [sic] [Case Manager], regarding incident and placement. [Case Manager] reports that team was working on d/c planning to an apartment .SW and Exec Dir (Executive Director) cont (Continue) conversation with [Case Manager] about d/c. [Case Manager] will contact treatment facility and other d/c placements and return call to SW and/or Exec Dir. [DATE] 4:31 AM Resident has been awake all night and on 15-minute checks. At 3:00 AM, writer heard resident yelling. Writer went to resident's room and found him lying on his side on the floor with a cigarette in his mouth .Resident was intoxicated due to drinking 6 beers tonight .He still continues to self-transfer unless staff anticipate that he may need help to and from the toilet. [DATE] 9:00 AM NP Progress note .per nursing, they have been doing Q15 (Every 15) minute checks to monitor mentation. Do not feel this is necessary at this time, can d/c (discontinue) and resume routing monitoring. [DATE] 9:26 AM IDT (Interdisciplinary Team) reviewed, and 15-minute checks discontinued at this time. Police dept (Department) referred him to APS (Adult Protective Services). R1's Psych Follow Up progress note by NP, dated [DATE], states in part: Patient upset that he recently received a 30-day notice for active cocaine and alcohol use inside the facility. [DATE] 6:30 AM Nurse progress note at 12:55 AM one of the CNAs came to writer due to resident having blue lips. Writer arrived at residents room and observed him on the toilet leaning to his right side, right arm hanging down, eyes were fixed and dilated, no pulse, and not breathing . Resident is a full code . CPR (Cardiopulmonary Resuscitation) was started .Coroner pronounced at 3:23 AM. Coroner and policeman left with body on stretcher at 5:55 AM. R1's comprehensive care plan, printed [DATE], does not include a plan of care for alcohol, cannabis or cocaine use. There are no interventions for R1's SUD. On [DATE] at 10:40 AM, Surveyor interviewed CNA C regarding resident's interventions for SUD. CNA C indicated any interventions would be on the Kardex. CNA C indicated she was unaware of any interventions for SUD. Of note, the Kardex is the CNA's care plan and the interventions on the Kardex would come directly from the resident's care plan, which does not contain interventions for R1's SUD. On [DATE] at 2:00 PM, Surveyor interviewed LPN D (Licensed Practical Nurse) regarding R1's SUD. LPN D indicated R1 sleeps most of the day and goes to the bar or Kwik Trip in the evening and drinks alcohol. LPN D indicated R1 did discuss his history of drug use and told LPN D he could get drugs anytime he wanted. LPN D indicated she did not believe R1. Surveyor asked LPN D what interventions were in place for R1's SUD, and LPN D indicated after R1 was found with cocaine on [DATE], the facility implemented 15-minute checks for a couple of days. LPN D indicated there were no other interventions for R1's SUD. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:16 PM, Surveyor interviewed RN F (Registered Nurse) regarding R1's SUD. RN F indicated he works in the evenings. RN F indicated R1 would start drinking around 7:00 PM and would be drunk by 10:00 PM. RN F indicated he had talked to his supervisors regarding R1's SUD. RN F indicated there was nothing RN F could do about R1's SUD because R1 was his own person. RN F indicated there were no interventions for R1's SUD. Example 2 R5 admitted to the facility on [DATE] with diagnoses that include alcohol use. R5's Brief Interview for Mental Status, dated [DATE], has a score of 15, indicating R5 is cognitively intact. R5's physician orders include an order stating May have alcohol locked in safe and consume independently dated [DATE]. R5's comprehensive care plan does not include a plan of care for R5's alcohol use. On [DATE] at 10:30 AM, Surveyor interviewed R5. Surveyor observed a large [NAME] jar on R5's bedside table. The [NAME] jar was full of clear liquid. Surveyor asked R5 what he was drinking from the [NAME] jar. R5 stated Vodka. R5 indicated he has alcohol delivered to the facility and the alcohol is kept in his locked safe. When surveyor asked how R5 gets the alcohol from his safe, R5 indicated staff will open the safe for him and give him his alcohol. On [DATE] at 10:18 AM, Surveyor interviewed LPN D regarding R5's alcohol use. LPN D indicated R5 drinks 1 liter of vodka daily. LPN D indicated R5 is encouraged to keep his alcohol locked in the safe in his room. LPN D indicated R5 seldom drinks until he passes out, but he has. Surveyor asked LPN D what she would do in a situation where a resident passed out due to drinking too much alcohol, LPN D indicated she would notify the resident's doctor. On [DATE] at 3:30 PM, Surveyor interviewed DLCS E (Director of Life Coach Services) regarding SUD. DLCS E indicated if a resident has SUD, the resident will have a care plan with interventions put in place. DLCS E indicated the interventions would include services offered to the resident and how to care for the resident. DLCS E indicated a care plan would be initiated upon knowledge of SUD. DLCS E indicated R1, R4, and R5 should have had care plans in place for their SUD and did not. On [DATE] at 4:00 PM, NHA A (Nursing Home Administrator) indicated the facility does not have a SUD policy. On [DATE] at 4:00 PM, Surveyor interviewed DON B (Director of Nursing) regarding SUD. DON B indicated if a resident has SUD, a care plan should be in place, and it would be personalized to the resident. Surveyor asked DON B if an assessment should be completed on a resident who is intoxicated or under the influence of drugs or alcohol, DON B indicated there is often a progress note made but not an assessment. DON B indicated R1, R4, and R5 should have had care plans with interventions in place for SUD and did not. 38725 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 3 R4 was a short-term admission to the facility. R4 had the following diagnosis: alcohol use, nicotine dependence, type 2 diabetes mellitus with ketoacidosis (buildup of acids in the blood to levels that can be life threatening) and neuropathy (nerve damage or dysfunction), and epilepsy (seizures). R4 had the diagnosis of alcohol use upon admission to the facility. R4's Discharge Summary dated [DATE]: .# Alcohol use disorder, # Alcohol withdrawal, initially reported last drink was a week ago, but alcohol found in his bag on admission which was thrown away. Became somewhat tremulous (slight shaking) later c/f (concern for) withdrawal. Received symptom-triggered phenobarbital (medication used to treat epilepsy and for alcohol withdrawal) per CIWA (Clinical Institute Withdrawal Assessment) briefly, though CIWA scores quickly down trended prompting discontinuation of protocol. Also received IV thiamine repletion and transitioned to thiamine 100 mg (milligrams) daily on which he was discharged . It is important to note that the facility should have read this document and been aware of R4's alcohol issues. R4's History and Physical dated [DATE]: . alcohol use disorder, T2DM (type 2 diabetes mellitus) on insulin, seizure disorder, HTN (hypertension- high blood pressure), asthma, presenting with recurrent nausea and vomiting. He reports this started around 5 days ago where he started vomiting repeatedly and couldn't keep anything down including water .He has generalized upper abdominal pain that is mild and really worse when vomiting mostly. No diarrhea .Has been drinking less, around a pint of vodka every ,d+[DATE] days but last drink was last Wednesday .# Severe alcohol use disorder, - Initially told me last drink was a week ago, but alcohol found in his bag and thrown away, - Became somewhat tremulous later so will start CIWA protocol with phenobarbital .Alcohol use: comment: Quit just after Christmas. ,d+[DATE] . It is important to note that the facility should have read this document and been aware of R4's alcohol issues. R4's Provider progress notes thoroughly document that R4 went through alcohol withdrawal in the hospital prior to being admitted to the facility. R4's Provider Progress Notes: [DATE] .APNP (Advanced Practice Nurse Practitioner) .hospitalized .from ,d+[DATE] - ,d+[DATE] for nausea, vomiting, diarrhea. Was found to be in DKA (diabetic ketoacidosis) s/p (status post) treatment with insulin gtt (drip) and IVF (intravenous fluids- directly into vein). He did go through alcohol withdrawal during hospitalization which was felt to be contributing to nausea and diarrhea .***Social History*** History of alcoholism Current every day smoker?1 PPD (packs per day) x [AGE] years Denies illicit drug use .* F17.200 - NICOTINE DEPENDENCE, UNSPECIFIED, UNCOMPLICATED *: Encourage cessation. has been smoking at facility, nicotine patch d/c'd (discontinued) ,d+[DATE]; * F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] .MD (Medical Doctor) .alcoholism, nicotine abuse .He did go through alcohol withdrawal during hospitalization which was felt to be contributing to nausea and diarrhea .tobacco abuse .***Social History*** History of alcoholism Current every day smoker?1 PPD x [AGE] years Denies illicit drug use .* F17.200 - NICOTINE DEPENDENCE, UNSPECIFIED, UNCOMPLICATED *: Encourage cessation. has been smoking at facility, nicotine patch d/c'd ,d+[DATE]; * F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .APNP .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .APNP .He does continue to go outside to smoke .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .APNP .We discussed that given his continued smoking particularly in very cold weather, this is not ideal for his asthma .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .APNP .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .APNP .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .APNP .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .APNP .Per staff, he has been smoking every ,d+[DATE] minutes. We did discuss cessation today. He tells me he is working on it and historically was smoked 2 packs/day and has weaned himself down to 1 pack/day. he does not plan to wean any further .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . [DATE] .MD .Continues to smoke but yet is down to about 1 pack a day from 2 packs/day .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility. [DATE]?reports the patient drinking again. He has been hanging out with another resident speck that he is using again. We have seen direct reports of him and taking. Encourage cessation . [DATE] .APNP .* F10.90 - ALCOHOL USE, UNSPECIFIED, UNCOMPLICATED *: Complicated by withdrawal during hospitalization . Continue vitamin supplementation. No alcohol to be administered while at facility . (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 49436 Based on interview and record review, the facility did not ensure the facility wide assessment developed by the facility included all relevant details to ensure the facility provided care and services to residents to meet their individual needs within the facility's identified resources. This has the potential to affect 9 residents (R5, R6, R7, R8, R9, R10, R11, R12, and R13) currently residing in the facility with a substance use disorder (SUD) diagnosis. The facility assessment must reflect the resident population and resources needed to care for this population. Nine residents had a diagnosis of SUD however the facility did not address the resources needed to care for these residents. R5 has a diagnosis of alcohol abuse. R6 has a diagnosis of alochol dependence with alcohol induced persisting dementia. R7 has a diagnosis of alochol abuse. R8 has a diagnosis of alcohol dependence. R9 has a diagnosis of alcohol dependence. R10 has a diagnosis of alcohol dependence. R11 has a diagnosis of alcohol abuse. R12 has a diagnosis of alcohol abuse. R13 has a diagnosis of cannabis use. The facility assessment does not include the following: The evaluation of the SUD resident population. The physical and behavioral health needs within the SUD resident population. The staff competencies, education, training, and skill sets necessary to provide the type of care needed for the SUD resident population. This is evidenced by: According to National Institute of Mental Health (www.nimh.nih.gov), Substance use disorder (SUD) is a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525543	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquardt Memorial Manor	1020 Hill St Watertown, WI 53098

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility document titled Facility Assessment, reviewed 2/28/25, states in part: Resident profile: .our facility has a comprehensive process in place to assess resident needs and determine the care and services required. The interdisciplinary team (IDT) has established Standard Work around the Admissions Capabilities. Any condition listed in the Able to Meet Needs category (Green Light) is one in which staff have the competencies to manage, and the facility has the supplies, equipment, and inventory at hand to meet the resident's needs. Any condition listed in the Review to Meet Needs category (Yellow Light) is one in which the Referral Specialist will consult with the IDT to ensure that the appropriate equipment and supplies are in house and/or the appropriate training has been executed to ensure staff competencies and inventory are at hand to meet the resident's needs. Facility increases in Yellow Light category referrals will trigger the need to drive internal controls to support the identified categories to be safely converted into the [NAME] Light list. Admission capabilities: Able to Meet Needs category does not list SUD as a [NAME] Light. Review to Meet Needs category includes illicit drug user and behaviors as a Yellow Light. Of note, under the facility admission capabilities, SUD is not listed. Resident Population Characteristics: SUD is not listed as being part of the Resident Population Characteristics. Conditions, physical and cognitive disabilities, and other pertinent facts: SUD is not listed as a condition under this category. Staff Education, Training and Competencies: The facility enlists a competency-based approach to determine the knowledge and skill required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. Additional competencies are determined according to the amount of resident interaction required by the job role, job specific knowledge, skill and abilities and those needed to care for the resident population. In instances of a resident admission with care needs not previously offered at the facility, the interdisciplinary team reviews and updates facility staff training, competencies, resources and supplies required to provide care. Policies and Procedures for Provision of Care: Policies and procedures for care are reviewed and updated at least annually and as needed with the introduction of new resident care needs, new technology or equipment or a change in the physical plant or environmental hazards. On 3/6/25 at 4:00 PM, NHA A (Nursing Home Administrator) notified surveyors the facility does not have a SUD policy and procedure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the National Institute on Alcohol Abuse and Alcoholism (www.niaa.nih.gov) combining alcohol with certain medications can increase the risk of adverse events, including falls and fatal overdoses. Alcohol can alter the metabolism and pharmacological effects of many common medications and can alter the absorption and metabolism of alcohol. People aged 65 and older are at particularly high risk for harm. On 3/6/25 at 10:18 AM, Surveyor interviewed LPN D (Licensed Practical Nurse) regarding SUDs. LPN D indicated she had not been given education, training, or completed competencies regarding the care of residents with SUD. Surveyor asked LPN D if there were medications that may interact with alcohol consumption and LPN D could not give any examples. On 3/6/25 at 2:16 PM, Surveyor interviewed RN F (Registered Nurse) regarding SUDs. RN F indicated he had not been given education, training, or completed competencies regarding the care of residents with SUD. RN F indicated he does not have experience with alcohol and medication interactions. On 3/6/25 at 4:00 PM, Surveyor interviewed DON B (Director of Nursing) regarding the facility's ability to care for residents with SUD. DON B indicated the facility would address SUD when the facility is made aware of the substance use. DON B indicated there is no education, training, or competencies for the staff regarding SUD. DON B indicated there is not an assessment for when a resident is under the influence of a substance. DON B indicated staff are not given education regarding medications that may interact with alcohol use. DON B indicated staff have not been provided education or trained on withdrawal symptoms or overdoses. On 3/6/25, NHA A gave surveyors a list of 9 residents who reside in the facility and have a diagnosis of SUD. The facility did not evaluate their SUD resident population. The facility does not have a policy or procedure in place to ensure the proper care for residents with SUD, including their physical and behavioral health needs. The facility assessment does not include education, training, or competencies related to residents with SUD.