STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525545	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home	7500 W North Ave Wauwatosa, WI 53213

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 3.) On 2/11/25, the nurses note indicates R54 was experiencing a change in condition and was sent to the hospital. The nurses note on 2/11/25 indicates R54 was being admitted to the facility due to influenza and needing dialysis. On 6/9/25 at 3:10 p.m., during the daily exit meeting with NHA(Nursing Home Administrator)-A and DON (Director of Nursing)-B, Surveyor asked for a copy of the transfer and bedhold notice given to R54 for the 2/11/25 hospitalization. On 6/10/25 Surveyor received the transfer and bedhold notice dated 2/12/25 for R54. The transfer and bedhold notice does not include email address for state agency and facility and does not include information regarding the Ombudsman and how to contact the ombudsman. On 6/10/25 at 10:45 a.m. Surveyor interviewed NHA-A. NHA-A stated she understood the concern and had no additional information. Based on record review and interview, the facility did not provide the required documentation with resident transfers to the hospital. This was observed with 4 (R22, R86, R54, and R77) of 5 resident hospitalization reviews. * R22, R86, R54, and R77 were transferred from the facility to a hospital. The facility Transfer Notice did not include contact information of the Office of the State Long-Term Care Ombudsman. The Appeals contacts did not include emails of the contacts and resident transfers were not sent to a representative of the Office of the State Long-Term Care Ombudsman. Findings include: The facility does not have a specific Transfer Notice Requirements policy and procedure On 6/09/25 at 9:40 AM, Surveyor interviewed the Social Worker (SW)- D, who is responsible for notifying the Ombudsman with resident transfers. SW-D stated they will look for a notification of when a resident transfers. SW-D stated the facility will call the Emergency Contact with a Bed Hold Notice and mail the notice to the emergency contact. SW-D did not create the Bed Hold and Transfer documentation that is provided. (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

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed the facility's transfer notices and noted that there is no contact information for the Office of the State Long-Term Care Ombudsman, and no email contacts for the Appeals Agencies. On 6/09/25, at 12:01 PM, Nursing Home Administrator (NHA)-A, Director of Nurses (DON)-B spoke with Surveyor. NHA-A informed Surveyor that NHA-A did not realize the Ombudsman was not being identified on the Transfer Notice. NHA-A stated The Social Worker thought the Ombudsman is notified with discharges and not transfers. 1.) R22's medical record was reviewed by Surveyor. R22 was transferred to the hospital on 2/11/25 and returned to the facility on 2/17/25. R22's Transfer Notice did not have documentation including: The email of the State entity which receives such appeal hearing requests; The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. Surveyor noted that the transfer notice was not sent to a representative of the Office of the State Long-Term Care Ombudsman. R22 was transferred to the hospital on 3/6/25 and returned to the facility on 3/11/25. R22 Transfer Notice did not have documentation including: The email of the State entity which receives such appeal hearing requests; The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. Surveyor noted that the transfer was not sent to a representative of the Office of the State Long-Term Care Ombudsman. 2.) R86 was transferred to the hospital on 2/19/25 and returned to the facility on 3/3/25. R86 Transfer Notice did not have documentation including: The email of the State entity which receives such appeal hearing requests; The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. Surveoyr noted that the transfer notice was not sent to a representative of the Office of the State Long-Term Care Ombudsman. R86 was transferred to the hospital on 3/24/25 and returned to the facility on 3/26/25. R86 Transfer Notice did not have documentation including: The email of the State entity which receives such appeal hearing requests; The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. Surveoyr noted that the transfer notice was not sent to a representative of the Office of the State Long-Term Care Ombudsman. R86 was transferred to the hospital on 3/18/25 and returned to the facility on 3/21/25. R86 Transfer Notice did not have documentation including: The email of the State entity which receives such appeal hearing requests; The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. Surveoyr noted that the transfer notice was not sent to a representative of the Office of the State Long-Term Care Ombudsman. No additional information was provided. 4.) On 6/10/2025, Surveyor reviewed R77's nursing progress note dated 4/17/25 indicating x-ray results positive for displaced fractur of distal femur. Surveyor observed orders to send out to the hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/2025 Surveyor reviewed the transfer and bed hold notice dated 4/17/2025 for R77. surveyor noted that the transfer and bed hold notuce did not include an email address for state agency and facility and does not include information regarding the Ombudsman and how to contact the ombudsman. On 6/10/2025, at 12:16 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern with R77's bed hold document. NHA-A stated she understood the concern and had no additional information.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4.) R14 was admitted to the facility on [DATE] with diagnoses of CHF(congestive heart failure), Parkinson's disease, dementia, schizophrenia, bipolar and anxiety. R14's significant change MDS (minimum data set) dated 9/16/24 documents under Section A1500 that R14 does not have a serious mental illness. The PASRR (preadmission screeen and resident review) level 1 screen dated 9/28/18 indicates R14 has a serious mental illness. The PASRR level 2 screen was completed 10/22/18 and indicates R14 is not in need of specialized services or specialized psychiatric rehabilitation services at this time. On 6/10/25 at 10:55 a.m. Surveyor interviewed DON-B and NHA-A. Surveyor explained the concern with the incorrect assessment on the significant change MDS dated [DATE]. Surveyor explained on the MDS, R14 was assessed as not having a serious mental illness. Surveyor explained R14 has diagnoses of mental illness and a PASRR level 1 and 2 was completed which reveals R14 has a serious mental illness. DON-B stated R14 does have a mental illness and understood the MDS was incorrectly assessed. No additional information was provided. 3.) R52 was admitted to the facility on [DATE] with a diagnoses of Bipolar, Anxiety and Depression. R52 had a Preadmission Screening and Resident Review (PASSR) level one and level two completed due to mental illness. Per R77's PASSR level 2 screening, does not require specialized services for their mental illness. R77's 4/1/25 Minimum Data Set (MDS) assessment, completed 4/1/25, does not document that R77 had a PASSR screening completed. Section A that contains this information was completed by Social Worker (SW) -D. On 6/09/25, at 9:46 AM, Surveyor interviewed SW-D. The SW-D stated They made a mistake on the MDS assessment. On 6/9/25, at 3:10 PM, at the facility exit meeting with Nursing Home Administrator (NHA)-A and the Director of Nursing (DON)-B, Surveyor informed the concerns with R52's MDS assessment. No additional information was provided. Based on record review and interview, the facility did not ensure assessments accurately reflected residents' status for 4 (R55, R59, R52, and R14) of 4 reviewed for Preadmission Screening and Resident Review (PASRR) with serious mental illness diagnosis. *R55, R59, R52, and R514 had PASRR Level I and Level II completed, and had diagnosis of serious mental illnesses, but this was not documented into the Minimum Data Set (MDS) comprehensive assessment at section A1500. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Findings include: 1.) R55 was admitted to the facility on [DATE] with diagnoses of major depression, auditory and visual hallucinations, and anxiety. On 6/9/25, R55's Annual Minimum Data Set (MDS) dated 11/6//24 section A1500 documented R55 does not have a serious mental illness. Section I labeled active diagnosis documented R59 has diagnosis of anxiety, depression, and psychotic disorder. This MDS was completed by Social Worker-T. On 6/9/25, R55's preadmission screen and resident review (PASRR) level 1 screen dated 8/25/20 indicates R55 has a serious mental illness. The PASRR level 2 screen was completed 9/30/20 and indicates R55 is not in need of specialized services or specialized psychiatric rehabilitation services at this time. On 6/10/25 at 10:30 AM, Social Worker-T was interviewed and indicated R55's Annual MDS dated [DATE] was coded wrong and R55 did have a serious mental illness at the time of the assessment. The above findings were shared with Nursing Home Adminstrator (NHA)-A and Director of Nursing (DON)-B on 6/10/25 at 3:00 PM. Additional information was requested, if available as to why R55's MDS was coded incorrectly. None was provided. 2.) R59 was admitted to the facility on [DATE] with diagnosis of anxiety, major depression, post traumatic stress disorder, and psychotic disorder with hallucinations. On 6/9/25, R59's Annual Minimum Data Set (MDS) dated [DATE] section A1500 documents R59 does not have a serious mental illness. Section I labeled active diagnosis documents R59 has diagnosis of anxiety, depression, psychotic disorder and post traumatic stress disorder. This MDS was completed by a Social Worker-U who is no longer employed by the facility. On 6/9/25, R59's preadmission screen and resident review (PASRR) level 1 screen dated 8/3/23 documents R59 has a serious mental illness. The PASRR level 2 screen was completed 9/5/23 and indicates R59 is not in need of specialized services or specialized psychiatric rehabilitation services at this time. On 6/10/25 at 10:30 AM, MDS Coordinator-V was interviewed and indicated R59's Annual MDS dated [DATE] was coded wrong and R55 did have a serious mental illness at the time of the assessment. The above findings were shared with Administrator-A and Director of Nurses-B on 6/10/25 at 3:00 PM. Additional information was requested, if available as to why R59's MDS was coded incorrectly. None was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide a comprehensive care plan for 1 (R96) of 5 residents reviewed for bowel and bladder incontinence. R96 is incontinent of bowel and bladder and did not have a comprehensive care plan for incontinence. Findings include: 1.) R96 was admitted to the facility on [DATE] with diagnoses that included Chronic Kidney Disease Stage 3, and Dysuria (pain with urination) On 6/5/25, R96's Annual Minimum Date Set (MDS) dated [DATE] was reviewed and indicated R96 was frequently incontinent of bladder. R96's brief interview for mental status on this assessment documented a score of 13 (cognitively intact). R96's MDS triggered for urinary incontinence and was selected to continue to care plan. R96's Care Area Assessment (CAA) for urinary incontinence dated 3/24/25 triggered and documented resident needing assistance with toileting including transfers, clothing adjustment and toileting hygiene. Resident is frequently incontinent of bladder. Staff provides substantial/max (maximum) assist for toileting hygiene and partial moderate assistance for toilet transfer with 1 helper. On 6/5/25 at 8:47 AM, R96 was interviewed in her room and indicated she uses a brief to urinate in at times as she doesn't always feel the need to urinate. and sometimes doesn't get to the toilet on time and requests assistance when needed. On 6/5/25, R96's complete care plan was reviewed and the only documentation of R96's bladder incontinence interventions were under self care deficit with a start date of 8/7/24 with the intervention of offer toileting every 2-3 hours and as needed. Wears small/med brief. The care plan does not document any reasons for urinary incontinence, type of urinary incontinence, goals for urinary incontinence care or any other interventions for urinary incontinence care. R96 has no documentation in the self deficit care plan that indicates she had renal disease or dysuria. On 6/10/25, R96's Certified Nursing Assistant (CNA) care card was reviewed and the only instructions for R96's bowel and bladder incontinence documented: offer toileting every 2-3 hours and as needed. Wears small/med brief. On 6/10/25 at 10:00 AM, Director of Nursing (DON)-B was interviewed and indicated there was nothing else for R96's bowel and bladder incontinence care plan. The Surveyor asked if DON-B thought R96 had a comprehensive care plan for her incontinence. DON-B would not answer. On 6/9/25, The facilities policy and procedure titled Careplans and Carecards dated 10/4/19 documented: The careplan will include at a minimum: goals, assistance with activities of daily living, considerations of risks affecting the residents health. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 3:00 PM, the above findings were shared with the Nursing Home Administrator (NHA)-A and DON-B. Additional information was requested, if available as to why R96 did not have a comprehensive plan of care for her urinary incontinence. None was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R87 was admitted to the facility on [DATE], with diagnoses including [NAME]-[NAME] syndrome (a rare autoimmune disorder of the neuromuscular junction where the immune system attacks nerves and muscles, leading to muscle weakness and other symptoms), neuromuscular dysfunction of bladder (a condition where the nerves controlling bladder function are damaged or not functioning properly, leading to difficulty in controlling urination), pain, cellulitis (a bacterial skin infection affecting the deeper layers of the skin and underlying tissue, often caused by bacteria like Streptococcus or Staphylococcus entering through a break in the skin) of right lower limb and urine retention (the inability to fully or completely empty the bladder, resulting in a buildup of urine). R87's quarterly Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact), is able to understand and be understood, is dependent on staff for toileting hygiene, substantial/maximal assistance with shower/bathing and has an indwelling urinary catheter. R87's Annual MDS, dated [DATE], documents that it is very important for R87 to choose between a tub bath, shower, bed bath, or sponge bath. Surveyor reviewed R87's care plan which documents in part, R87 has an ADL self-care performance deficit and documents R87 prefers showers with an extensive assist of 1. Surveyor reviewed R87's physician orders in R87's electronic health record, and noted R87 is to have a shower every Monday. On 06/09/2025, at 06:50 AM, Surveyor observed Certified Nursing Assistant (CNA)-K assist R87 with getting out of bed for the morning. CNA-K informed Surveyor that R87 will stay in R87's night gown because today is R87's shower day. CNA-K indicated that there is a shower aide who provides showers to residents on their shower days. On 06/09/2025, at 08:33 AM, Licensed Practical Nurse (LPN)-L informed Surveyor that the shower aide left sick, and R87 would have to reschedule R87's shower. LPN-L indicated that LPN-L informed R87 of this as well. On 06/09/2025, at 08:59 AM, Surveyor spoke with R87 regarding R87's shower. R87 informed Surveyor that R87 was not informed that R87 would not be receiving a shower today. R87 voiced concern that R87 did not want to wait to have a shower since R87 did not receive a shower last week either. R87 indicated that R87 requires assistance to shower and has no choice but to wait until staff are able to assist R87 with a shower. Surveyor reviewed R87's bathing/shower task document and noted that R87's last documented shower was on 05/29/2025 and documented R87 was dependent on staff to bathe/shower. On 06/09/2025, at 01:04 PM, Surveyor informed Director of Nursing (DON)-B of concerns regarding R87's showers. DON-B informed Surveyor that DON-B would get back to Surveyor on that. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why the facility did not provide R87 with showers or baths per R87's preferences and physician orders. Based on interview and record review the facility did not ensure 2 (R77, R87) of 26 residents needing assistance with Activities of Daily Living (ADL) cares, received the necessary services for cares. *R77 did not receive nail care per care plan, policy and resident's preference. *R87 did not receive scheduled shower per care plan and resident's preference. Findings include: The Facilities Policy titled, Standards of Care at Lutheran Home. Revised 6/1/2023. Documents: Policy Statement: Lutheran Home will provide routine interventions for all residents. These interventions do not to be addressed on the resident's individual care plan or care card. If the standard is different for a resident, the individual plan of care will reflect the variance. Standards: . Resident will receive a weekly shower or bath. Regular nail care provided as needed. 1) R77 was admitted on [DATE] with diagnosis of Type 2 diabetes mellitus with diabetic neuropathy, polyneuropathy, difficulty in walking, need for assistance with personal care. R77's admission Minimum Data Set (MDS) completed on 4/28/2025 documents a Brief Interview for Mental Status (BIMS) score of 9, indicating that R77 is cognitively intact. R77 section B in the MDS documents that R77 is understood and usually understands. R77's (diabetes Mellitus) care plan, dated 4/10/2025, documents: Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. On 6/9/2025, at 1:34 PM, Surveyor observed R77 nails on her feet, they nails were long and surveyor asked R77 if she liked her toenails to be long. R77 indicated that she preferred them short, and stated we should cut them, if they are long, they should be cut. On 6/9/2025, at 3:43 PM, Surveyor interviewed Registered Nurse (RN)-T, who stated R77's nails were long and that they look like they need to be trimmed, RN-T stated R77 is diabetic and should be seen by podiatry for nail trimming. On 6/9/2025, at 3:59 PM, Surveyor interviewed Unit manager RN-C, who stated that podiatry comes every 60 days and that R77 son will be called as podiatry needs consent from POA to see R77. RN-C indicated not knowing how long R77's nails were long, as staff will go directly to unit secretary to add residents to the podiatry list and not include RN-C on those residents. On 6/10/2025, at 9:38 AM, Surveyor interviewed unit manager RN-C, who stated R77 is not on the list currently to see podiatry, RN-C acknowledged R77's toenails were long and stated she did clip R77's toenails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/2025, at 9:48 AM, RN-C informed surveyor that POA of R77 will be coming into the facility today to sign the paperwork for R77 to see podiatry. On 6/10/2025, at 12:16 PM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern with R77's long toenails and no podiatry visit per care plan and policy. No additional information received as to why R77 had long toenails and no received services from podiatry services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R20 was admitted to the facility on [DATE] with diagnoses of dementia, CHF (congestive heart failure) and type 2 diabetes. R20's nurses note dated 5/25/25 documents that R20 developed a pressure injury. The nurses note documents, staff noted open area to left gluteal fold during cares. Cleansed with NS (normal saline) pat dry. Skin prep applied to peri wound. Medi Honey applied and covered with foam dressing. Resident was repositioned to side. Air mattress in place. Will continue to monitor for s/s (signs and symptoms) of infection. R20's annual MDS dated [DATE] documents R20 has severe cognitive impairment and is dependent for moving in bed and transfers. R20's CAA dated 4/15/25 documents: R20 triggered r/t (related to) staff giving assist with her adl's (activity of daily living) and mobility. she is weak and deconditioned and has cognitive deficit and needing staff to assist with her adl's/transfers and mobility. w/c for mobility and ez stand for transfers . Staff provide pressure reducing interventions. skin remain intact / staff provide dressing to sacrum for protection. and skin care given see TAR (treatment administration record). R20's alteration in skin integrity care plan date initiated 8/7/2024 revised date 5/28/25, documents the following interventions: Encourage resident to wear socks in bed as tolerated initiated 5/19/25 Pressure reducing measures: Staff to assist with repositioning every 2-3 hours while in bed. Encourage resident to keep pressure off of her bottom as she prefers to lay on back while in bed. Resident to wear pressure relieving boots on bil (bilateral) feet as tol (tolerated) while in bed. Resident may remove them from her feet independently. Staff should attempt to suspend heels off of bed with pillow while in bed if boots are not worn. Date initiated 8/7/24 revision on 10/23/24. Resident was provided w(with)/roho cushion for w/c (wheelchair) and low air loss mattress for bed. Prostat was ordered for wound healing. Staff to complete txs (treatment) to pressure injury on bottom per order. Date initiated 8/7/24 and revision on 10/23/24. Staff encouraging resident to wear pressure relieving boots at all times on left foot. Does decline to wear at times. Date initiated 8/7/24. Staff to continue to keep shoes off at this time due to hx (history) blistered areas on bilateral heels. Date initiated 8/7/24. On 5/28/25, Wound MD-O assessed R20 pressure injury on the left ischium as Stage 3 pressure injury measuring 2.9 cm (centimeter) by 2.4 cm by 0.2 cm with 30% slough and 70% granulation tissue. On 6/4/25, Wound MD-O assessed R20 pressure injury on the left ischium as healing Stage 3 measuring 1.6 cm by 2.8 cm by 0.2 cm with 30% slough and 70% granulation tissue. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25, Wound MD-O assessed R20 pressure injury on the left ischium as healing Stage 3 measuring 1.6 cm by 2.8 cm by 0.2 cm with 30% slough and 70 % granulation tissue. The treatment order dated 5/25/25 documents cleanse pressure ulcer with NS , pat dry . Apply skin prep to peri wound . Apply MediHoney , cover with Foam dressing. Change daily and PRN (as needed). This order remains the same. On 6/9/25 at 9:38 a.m. Surveyor observed Nurse Manager-R provide treatment to R20 pressure injury. R20 was observed with bilateral boots on her feet. Surveyor observed R20 pressure injury and there was no signs of odor or drainage. After the treatment R20 was repositioned on her right side to off load. On 6/9/25 at 3:10 p.m., during the daily exit meeting with DON (director of nursing)-B and NHA (nursing home administrator)-A, Surveyor asked for the initial comprehensive wound assessment for R20. On 6/10/25, DON-B provided Surveyor with the facility incident form dated 5/25/25. The incident form documents, Staff noted open area to left gluteal fold. Open area noted about 3.5 cm by 4.5 cm, irregular shape wound bed noted clean. The incident form does not provide a comprehensive assessment of the pressure injury On 6/10/25 at 10:45 a.m., Surveyor interviewed DON-B. Surveyor explained R20 developed a pressure injury on 5/25/25 and a comprehensive assessment was not completed. DON-B stated she understood the incident form did not include an assessment of the wound bed, peri wound and staging of the pressure injury. DON-B understood the concern and had no additional information. Based on record review, interview and observation, the facility did not ensure residents with pressure injuries received the necessary treatment and services, consistent with professional standards of practice, to promote hearling, prevent infection and prevent new ulcers from developing for 2 (R112 and R20) of 7 residents reviewed with pressure injuries. * R112 was transferred to the hospital with a pressure injury. Upon readmission, R112's pressure injury was not comprehensively assessed until 3 days later. R112 did not have a comprehensive plan of care related to a comprehensive assessment. *R20 developed a pressure injury in the facility that was not comprehensively assessed. The facility's policy and procedure titled Skin Care Program and dated 6/17/2019, documents: -The policy is for every resident who enters the facility will be evaluated within 8 hours to prevent the formation of pressure injuries. -Measuring Wounds As Follows: size, length, width, top of wound, depth and any undermining/tunneling; location, stage and measurements, wound base, periwound, drainage, pain/tenderness and wound edges. Findings include: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) On 6/04/25 at 10:31 AM, Surveyor interviewed R112 while R112 was in bed. R112 was laying on their side with an air mattress on the bed. R112 had no concerns with the wound treatment to their sacrum. R112 verbalized their bottom is better. R112 was admitted to the facility on [DATE] with a diagnoses of Cancer. R112 admission Minimum Data Set (MDS) assessment was completed on 3/11/25 and documented that R112 is a risk for a pressure injury and has no current pressure injuries. R112 has no cognitive impairments. R11's Care Area Assessment (CAA) for Pressure Injury documents: Resident had no pressure related open area initially but post Assessment Reference Date (ARD) resident does have an area to the coccyx that upon admission was healed but has reopened. Area has a treatment in place and staff monitors it with dressing changes. Resident has a pressure relieving wheelchair cushion and pressure reducing mattress. Resident is at risk r/t (related to) decreased mobility d/t (due to) weakness r/t diagnosis that include CA s/p (cancer status post) radiation to right thigh for myxofibrosarcoma. At this time staff assist with bed mobility and transfers at a supervision/touching to partial moderate assistance for bed mobility and transfers. On 3/16/25, R112 develops a pressure injury to the sacrum. This is a re-opened area and is appropriately assessed with treatment. The last assessment, before R112's hospital stay, was from the Wound Medical Doctor (MD) on 3/19/25 that documented R112's wound as a stage 3 to the coccyx. The wound size is documented as (Length x Width x Depth): 2.6 x 0.7 x 0.2 cm, drainage is Light Sero - sanguinous with granulation tissue of 100 %. The assessment documents that the pressure ulcer re-opened. A treatment is ordered, along with recommendations for healing the wound. This includes: Off-Load Wound ; Reposition per facility protocol ; Limit sitting to 60 minutes. R112 plan of care (POC) documents: The resident has potential/actual impairment to skin integrity of the coccyx related to fragile skin and incontinence with a start date of 3/16/25. Under the Interventions it documents: -Start date 3/17/25 Alternating air mattress requested. -Start date 5/29/25 Treatment to wound per providers order. There is no documentation of additional interventions to prevent, and promote, skin integrity. On 3/21/25, R112 was transferred to the hospital with a change in condition. R112 returned to the facility on 4/4/25. R112's 5-day entry MDS assessment completed on 4/10/25 documents a stage 4 pressure injury for R112. There are interventions documented for pressure relief devices with positioning. R112's nurses note date 4/7/25 written by Registered Nurse (RN)-C documents: A 1.7 x 0.7 cm unstageable wound remains on Sacrum, with mod serosang drainage on dressing. Wound edges defined and attached, base 100% slough and 1 x 0.7 cm abrasion on right buttock. Bilateral buttocks significant dry flaky skin from excoriation. Will continue Medi-honey gel TX until seen by wound physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R112's Wound MD (medical doctor) notes on 4/9/25 document a stage 4 pressure injury to R112's sacrum. The wound size is documented as (L x W x D): 3.9 x 2.7 x 0.3 cm; with drainage of light sero- sanguinous; characteristics of slough 40%, granulation tissue 40%, intact normal skin 20% this was exacerbated from hospital stay. This wound was debrided on 4/9/25 with this assessment. Recommendations are to off-load wound ; reposition per facility protocol ; limit sitting to 60 minute. R112's pressure injury was not comprehensively assessed with readmission on [DATE]. The POC for the pressure injury did not reflect an actual pressure injury, along with comprehensive interventions. R112's Treatment Administration Record (TAR) for April 2025 documented a treatment to the sacrum with readmission on [DATE]. R112's pressure injury to the sacrum was assessed by the Wound MD on 6/4/25. The Wound MD assessed the wound as resolved and to continue zinc oxide to the area. On 06/09/25, at 10:37 AM, Surveyor interviewed Registered Nurse (RN)-[NAME]. RN-C stated The nurses do skin assessments with admissions and readmissions and I personally try to assess the resident the next day. Wound MD usually follows up on the wound weekly. The plan of care for R112 was comprehensive before the hospital transfer. Someone must have modified the care plan with readmission. On 6/09/25 at 1:52 PM, Director of Nurses (DON)-B provided Surveyor R112's Nurse admission Screen for 4/4/25. Surveyor noted that the screen is not a comprehensive assessment of the coccyx wound and that it only has wound measurements. Surveyor noted that a comprehensive assessment and care plan of R112's pressure injuries was not provided. On 6/9/25, at 3:15 PM, at the facility exit meeting with, Surveyor informed Nursing Home Administrator(NHA)-A and DON-B of the concerns with R112 pressure injury. On 6/10/25, at 9:07 AM, NHA-A provided Surveyor R112's plan of care for skin. Their were no changes from the original plan of care. The skin assessments provided to Surveyor only have measurements and not characteristics of the sacrum wound. R112 did not have a documented comprehensive wound assessment, along with a comprehensive plan of care. No additional information was provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 2 (R59 and R96) of 5 residents reviewed were provided pain management services consistent with professional standards of practice, including completing comprehensive assessment, developing a comprehensive person-centered care plan and evaluating the resident's goals and preferences. Findings include: On 6/9/25, the facilities policy and procedure titled Pain Management dated 1/16/19 was reviewed and documented: The 0-10 pain scale will be used for the alert resident. A pain data collection tool will be completed at a minimum on admission, readmission, quarterly and with any change of condition. The pain data tool will include: pain history, description of pain, non-pharmacological approaches that work for the resident. Location of pain, Resident's goal of pain management. Care plan is to include the residents underlying diagnosis or conditions that are causing or contributing to pain, residents goal for pain management, and pharmalogic and non-pharmalogic interventions, 1.) R59 was admitted to the facility on [DATE] with diagnosis of unspecified pain and fibromyalgia (pain disorder). R59's Annual Minimum Data Set (MDS) dated [DATE] documented that R59 was on scheduled pain medication, as needed pain medication and received a non-medication intervention for pain. The MDS also documented R59 had almost constant pain over the past 5 days. The worst pain R59 indicated was an 8 on a scale of 1-10. R59's brief interview for mental status on this assessment documented a score of 14 (cognitively intact). The MDS did trigger for a pain care area assessment (CAA)which documented: R59 verbalizes pain related to fibromyalgia/chronic pain that is almost constant, and disturbs sleep, and limits day to day activities at times. R59 states pain can get up to a 9 on a 0-10 pain scale. Resident states pain is decreased with medications which include scheduled medications for neuropathic pain as well as scheduled and prn (as needed) opioid analgesics. The MDS documented a care plan should be developed for R59's pain. On 6/5/25 at 8:22 AM, R59 was interviewed in her room and indicated she could only have pain medication every 4 hours and it wears off in 2.5 hours. R59 indicated she's never been offered anything but medication for pain and that she would be open to trying non-pharmaceutical interventions. R59 indicated her pain is not well controlled and is severe at times. On 6/5/25, R59's care plan was reviewed and no care plan for pain or any interventions for pain were found on the current care plan. On 6/5/25, R59's current physician orders were reviewed and documented and included: Oxycodone/acetaminophen 10-325 milligrams (MG) every morning and bedtime related to pain with a start date of 6/25/24. Oxycodone/acetaminophen 10-325 MG every 4 hours as needed related to pain with a start date of 5/20/24. Gabapentin 300 MG give once a day for pain with a start date of 4/16/24. On 6/9/25, R59's Medication Administration Record (MAR) was reviewed from 3/1/25 to 6/9/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R59's March 2025 MAR indicated she received as needed oxycodone/acetaminophen 10-325 MG 60 times with a pain rating of 5-9 all 60 times before administration. The MAR does indicated the medication was effective each time but does not give a pain rating. R59's April 2025 MAR indicated she received as needed oxycodone/acetaminophen 10-325 MG 62 times with a pain rating of 5-10 all 62 times before administration. The MAR documents the medication was effective 53 times but does not give a pain rating and ineffective 9 times but does not indicate was was done about the continued pain. R59's May 2025 MAR indicated she received as needed oxycodone/acetaminophen 10-325 MG 63 times with a pain rating of 5-10 all 63 times before administration. The MAR documents the medication was effective 57 times but does not give a pain rating and ineffective 6 times but does not indicate was was done about the continued pain. On 6/9/25, R59's Long Term Care Evaluation dated 2/19/25 was reviewed and documented: pain level 4. No change. Generalized aching, multiple times a day. Scheduled pain medication. None of the questions's relating to how the pain is affecting R59 or what is the worst pain R59 experiences is filled out. The assessment also does not indicate that R59 takes as needed pain medication. On 6/10/25 at 10:00 AM, Director of Nursing (DON)-B was interviewed and indicated there was nothing else for R59's pain care plan or assessment of R59's pain. Surveyor asked if DON-B thought R59 had a comprehensive care plan and assessment for her pain. DON-B would not answer. On 6/9/25 at 3:00 PM, during the daily exit meeting, the above findings were shared with the Nursing Home Administrator (NHA)-A and DON-B. Additional information was requested, if available as to why R59 did not have a comprehensive plan of care and assessment for her pain. None was provided. 2.) R96 was admitted to the facility on [DATE] with diagnoses that included unspecified pain, low back pain and dysuria (pain with urination). On 6/5/25, R96's Annual Minimum Date Set (MDS) dated [DATE] was reviewed and documented R96 was on scheduled pain medication and received a non-medication intervention for pain. R96's brief interview for mental status on this assessment documented a score of 13 (cognitively intact). The MDS did not trigger for a pain care area assessment. On 6/5/25 at 8:47 AM, R96 was interviewed and indicated she had pain in her neck and back mainly and that her current pain medications did a good job controlling her pain. R96 indicated she was never offered anything but medication for her pain and indicated a hot pack once in awhile may help. On 6/5/25, R96's care plan was reviewed and the only interventions for pain management were listed under the care plan titled Self Care Deficit. No problems or goals related to pain were documented and the interventions included documented Non pharmalogical interventions for pain management; rest, repositioning with a start date of 8/7/24 and plan for pain management. Resident is receiving scheduled Tylenol three times a day and as needed. Staff to report any episodes of unrelieved pain to Medical doctor. Able to use pain scale 0-10 with a start date of 8/7/24. (Care plan only mentions Tylenol bur R96 also receives Lidocaine and Gabapentin daily). On 6/5/25, R96's current physician orders were reviewed and documented and included: Lidocaine pad 4%. Apply to left knee and left hip every morning for pain with a start date of 4/30/24. Tylenol two 325 milligram (MG) tablets 3 times a day for low back pain with a start date of 3/1/24. Gabapentin 100 MG give 2 capsules by mouth every morning and bedtime for pain with a start date of 4/30/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25, R96's Vitals and Pain Only Evaluation dated 2/27/25 was reviewed and documented 1/14/25. R96 was asked id she had pain in the last 5 days and indicated yes and that it was frequent. R96 indicated her worst pain on a scale of 1-10 was a 5. No documentation was made as to a location of R96's pain, location of pain, acceptable level of pain or if current interventions were effective. On 6/9/25, R96's Medication Administration Record (MAR) was reviewed from 3/1/25 to 6/9/25. No pain levels using the 0-10 scale were found. R96's pain medications were documented as given daily. On 6/10/25 at 10:00 AM, Director of Nurses (DON)-B was interviewed and indicated there was nothing else for R96's pain care plan or assessment. The Surveyor asked if DON-B thought R96 had a comprehensive care plan and assessment for her pain. DON-B would not answer. The above findings were shared with the Administrator-A and DON-B on 6/9/25 at 3:00 PM. Additional information was requested, if available as to why R96 did not have a comprehensive plan of care and assessment for her pain. None was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, drugs used in the facility were not labeled in accordance with currently accepted professional principles, to include the expiration date when applicable for 2 of 2 medication rooms and 1 of 3 medication carts observed. Medication rooms and carts contained insulin that was expired, and insulin and eye drops that were not dated when opened. Findings include: The facility policy and procedure titled Medication and Vaccine Storage effective date [DATE] documents (in part) . . Policy statement: Medications will be stored safely, securely and properly. The medication supply will only be accessible to licensed nursing personnel, pharmacy personnel, and staff members authorized to pass medications. 5. Outdated or contaminated medications or those in cracked or soiled or without secure closures are removed from the medication cart and disposed of properly. Medications will be reordered as needed. 9. Medications will be stored in their original packing until ready for administration. If multi-dose, medication should be dated. 11. Insulin is to be refrigerated until opened. Once open, insulin can remain at room temperature until expiration, based on guidelines for specific product. The facility provided a Health Direct Pharmacy Services form Titled Insulin Expiration Dates: Update dated [DATE], which documented (in part) . . All insulin's should be stored in the refrigerator until opening and protected from light. Once opened or removed from the refrigerator for storage in the medication cart, the insulin should be dated as it will expire in a specific time per manufacturer. The facility provided a Health Direct Pharmacy Services form titled Ophthalmic Medication Beyond Use Date Guide dated [DATE], which documented (in part) . . It is good standard of practice to date an ophthalmic (eye) medication upon opening, as the date should be tracked according to the facility policy to reduce the risk of using contaminated products. 1.) On [DATE] at 12:26 PM, Surveyor observed the 2nd floor medication room. Inside the refrigerator, Surveyor located a Lispro insulin vial belonging to R52 dated opened 5/5 expired 6/2. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:00 PM, Surveyor observed the 3 North [NAME] medication room. Inside the refrigerator, Surveyor located the following: A Novolin 70/30 insulin vial belonging to R45 which was open and used, but not dated when opened. The label read expires 28 days after opening. A plastic bag containing 3 Lantus insulin pens belonging to R55. Two of the insulin pens were open and used, but not dated when opened. The label read expires 28 days once opened. A bottle of Brimonidine 0.2% eye drop solution belonging to R55, which was open and used, but not dated when opened. The label read expires 28 days after opening. A Lantus insulin vial belonging to R25, dated opened [DATE] expired [DATE]. 2.) On [DATE] at 1:14 PM, Surveyor observed the 3 North [NAME] medication cart. Inside the cart, Surveyor located a bottle of Prednisolone 1% eye drop solution belonging to R71, which was open and used, but not dated when opened. The label read expires 28 days after opening. Surveyor showed Licensed Practical Nurse (LPN)-E all the above medications. LPN-E reported all of the medications should have been dated when opened and thrown away once expired. On [DATE] during the daily exit meeting, the facility was notified of the above concerns regarding insulin and eye drops that were not dated when opened and/or were expired. No additional information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review the facility did not ensure each resident receives, and the facility provides food prepared by methods that conserve nutritional value, flavor, and appearance. This deficient practice had the potential to affect 8 residents receiving a puree diet. The recipe for preparing pureed diet was not followed to ensure puree food is prepared by methods that conserve nutritional value, flavor and appearance. Findings include: The facility policy and procedure titled General Food Preparation reviewed 6/2025 documents (in part) . . Policy Statement: All food must be prepared in a manner that maintains its safety, quality, and nutritional value. Proper food handling techniques must be followed at all times to prevent forborne illness and ensure resident satisfaction. 3. Special Diets and Resident Needs: Follow individualized dietary plans as ordered by the registered dietician or physician. Ensure consistency-modified diets (e.g., pureed, mechanical soft) are prepared correctly to reduce the risk of choking. 1.) On 6/5/25 at 9:00 AM, Surveyor observed Cook-F prepare pureed greens. Surveyor observed the recipe on the table and Cook-F looked at the recipe before preparation. Cook-F informed Surveyor he is making enough for 10-12 servings. Using a metal strainer, cook-F removed a scoop of greens from the metal cooking tub. Surveyor noted the strainer to be approximately 1/2 - 3/4 full. Cook-F placed the greens in the food processor. Surveyor asked how much greens were added, Cook-F pointed to the strainer and said, That's a quart. Cook-F then picked up a metal pitcher containing a white powder and added the contents all at once into the food processor. Surveyor asked what the white powder was. Cook-F replied thickener. Surveyor asked how much thickener was in the container that was added. Cook-F stated I don't know, it was maybe a 1/4 full. Cook-F then poured water from a pitcher into the food processor, mixed the contents together, looked in and added more water. Surveyor asked if there is a specific measured amount of thickener to add. Cook-F stated No, I just add it and then keep checking it. Surveyor asked if there is a specific measured amount of water to add. Cook-F stated No, I just keep adding it as I need to for it to get to like pudding or mashed potatoes. Surveyor asked if he adds anything besides water to achieve the desired consistency. Cook-F stated, No, when I was trained I was told to add water. Surveyor stated So you just add as much thickener as you think you will need and then as much water as you think you will need to get to the desired consistency. Cook-F stated Yes. Surveyor noted nothing else was added to the food processor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed the Dining Manager recipe used titled Pureed Greens copyright 2025 which documented: Ingredients: Greens 10 servings - 1 qt (quart) 1 cup. Margarine, solids - 1/4 cup Place prepared vegetables and margarine in a washed and sanitized food processor; blend until smooth. *Note: Any liquid specified in the recipe is a suggested amount of liquid (if needed). Some recipes items will require no liquid added to achieve the desired consistency. 1. If product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato consistency. 2. If the product needs thickening, gradually add a commercial or natural food thickener (ex, potato flakes or baby rice cereal) to achieve a smooth, pudding or soft mashed potato consistency. 3. Follow any facility policies/procedures, such as the puree volume method procedure, to ensure a correct portion is served. Top pureed foods with appropriate sauces or gravies, as needed, to ensure adequate moisture for safe consumption and enhance flavor. On 6/5/25 at 9:17 AM, Surveyor spoke with Dining Director-G. Surveyor advised the recipe for pureed greens did not indicate an amount of how much thickener should be added. Dining Director-G stated I would think that would be listed on there somewhere. Surveyor advised the recipe indicates to add liquid (not water in capital letters) if product needs thinning, and asked what liquid should be used to thin. Dining Director-G stated Like a vegetable based broth or something similar to that. Surveyor asked if the strainer used to remove the greens has an amount on it to indicate how much it holds. Dining Director-G replied I don't think so. Surveyor advised Dining Director-G of observation and concern the recipe for pureed greens was not followed. The amount of greens was not measured, margarine was not added, the amount of thickener was not measured, was added all at once (not gradually as recipe indicates), amount of water was not measured, was added all at once (not gradually as recipe indicates), and the recipe indicates in capital letters not to use water to thin. Dining Director-G reported she believed there is another more detailed recipe that is kept in binders, and she will look for it. Surveyor advised this is the recipe cook-F followed during observation. On 6/5/25 at 10:29 AM, Dining Director-G advised Surveyor she spoke to the company that creates the recipes. She reported they do not specify the amount of thickener because it varies, and they recently discussed liquid for thinning. Dining Director-G stated Going forward they will specify what liquid to use for thinning, for example broth, water, milk. Dining Director-G advised Surveyor cook-F is currently going through ServSafe training. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 at 11:05 AM, Surveyor advised Assistant Director of Nursing (ADON)-I of the above concerns regarding observation of the recipe not followed during pureed food preparation. No additional information was provided. On 6/10/25 at 8:12 AM, Surveyor spoke with Executive Chef-H and viewed the strainer that was used to remove the greens for puree food preparation. Surveyor advised cook-F reported the strainer was a quart size. Surveyor asked how do you know this holds a quart. Executive Chef-H stated I don't know, I did look at it after and could not find any measurement on it, maybe it is worn off or something. Surveyor confirmed there was no measurement indicated on the strainer to to confirm it is indeed a quart. Executive Chef-H stated No, not unless we put something in it to verify the measurement. No additional information was provided.

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	525545	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home	7500 W North Ave Wauwatosa, WI 53213

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 3 resident unit refrigerators in the facility. This deficient practice had the potential to affect 46 residents residing on the affected unit. Residents' food stored in the refrigerator was not labeled and/or dated. The refrigerator temperature was not within the recommended temperature for safe food storage. Findings include: The facility policy and procedure titled Food Storage-Resident reviewed 1/29/24 documents (in part) . Policy statement: All perishable food items brought in by family and visitors must be refrigerated and labeled. 1.0 Perishable food brought in by family or visitors will be labeled by nursing staff and refrigerated. 2.0 Labels will state residents name, date received/opened and discard date. 3.0 A food chart is maintained on each refrigerator indicating the discard date for each food item. Any questions regarding discard dates should be directed to Dining and Hospitality. 4.0 All food items must be monitored daily by nursing staff to ensure food items are within labeled dates. 5.0 Daily temperature logs will be maintained by nursing staff to ensure proper temperature of refrigerators. 6.0 Any items found outside of the discard date will be discarded and the resident and/or family will be notified. The facility policy and procedure titled General Food Preparation reviewed 6/2025 documents (in part) . 3. Label and date all prepared and stored meals for specific residents. 4. Food Storage. Label all foods with the date of receipt and/or preparation. Maintain proper refrigeration and freezer temperatures: Refrigerator </= (less than or equal to) 41 degrees F (Fahrenheit). 6. Maintain temperature logs for food storage and cooking. Conduct routine audits and inspections to ensure compliance with policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) On 6/4/25 at 9:35 AM, Surveyor observed the unit refrigerator on 3 North [NAME] (NW). Surveyor noted the temperature gauge inside the refrigerator read 68 degrees Fahrenheit. Inside the refrigerator, Surveyor located a plastic bag with 2 Styrofoam containers containing food which was not labeled with a name and was not dated. Surveyor observed a plate covered with with aluminum foil labeled with R111's name which was not dated. Surveyor noted a log on the side of the refrigerator was complete for temperature checks dating back to January 2025. The top of the form documents: Daily Food Refrigerator Temperature Monitoring. Temperature should be kept between 37-41 degrees Fahrenheit. By initialing below you are acknowledging the temperature is within range, the fridge is clean and all resident food is labeled/unexpired. Surveyor reviewed the temperature log from January though June 2025. January: All temperatures documented were greater than (>) 41 degrees. February: All temperatures documented were >41 degrees. March: All temperatures (with exception of 3 dates) documented were >41 degrees. April: All temperatures (with the exception of 3 dates) documented were >41 degrees. May: All temperatures documented were >41 degrees. June all temperatures documented were >41 degrees. The documented temperatures ranged from 48-52 degrees from 6/1 through 6/4/25. On 6/4/25 at 11:15 AM, Surveyor recheck of the 3NW unit refrigerator and noted the thermometer read 58 degrees Fahrenheit. On 6/4/25 at 1:58 PM, Surveyor asked Nurse Manager (NM)-J to view 3NW refrigerator temperature with Surveyor. The temperature gauge inside the refrigerator read 58 degrees. Surveyor advised the log indicates the temperature to be kept between 37-41 degrees. Surveyor asked what is the protocol if the refrigerator temperature is this high. NM-J stated They should be turning the temperature down so that it's within the range. Surveyor advised NM-J of the resident food containers inside the refrigerator that are not labeled and/or dated. NM-J stated I will throw that out because anything that doesn't have a name or date should be thrown out. Surveyor advised NM-J of the temperature log dating back to January 2025 documentation of temperatures above the recommended range. NM-J stated I think this log was from the old fridge that wasn't working, this might be a new fridge from like a month ago, but don't quote me. On 6/4/25 at 2:00 PM, During the daily exit meeting, the facility was advised of concern regarding the 3NW unit refrigerator temperature above the recommended range and resident food items not labeled and/or dated. On 6/5/25 at 8:30 AM, Surveyor noted the 3NW unit refrigerator had been removed. No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3.) On 6/09/25, at 9:52 AM, Surveyor observed a wound treatment on R77. There was a sign for Enhanced Barrier Precautions, which directs gown and gloves with touching R77 body. The wound treatment was performed by Registered Nurse (RN) -C. R77 has 3 wounds and RN-C did not utilize a gown for personal protective equipment (PPE) during the wound treatments. RN-C set-up wound supplies on the over bed table. The RN-C did not have a gown and wore a surgical mask and gloves. R77 has a pressure injury of eschar on the left heel. RN-C removed pressure relief boot and sock from the left foot. The RN-C applied a skin prep wipe to the left heel eschar area. RN-C performed the treatment without a PPE gown. R77 has a pressure injury, stage 4 wound, on the right outer ankle. RN-C performed the treatment without a PPE gown. RN-C re-applied R77 socks and pressure relief boots. R77 has a Foley catheter for their bladder. RN-C unfastened R77 incontinence brief and assisted in turning R77 on their side. RN-C did not utilize a PPE gown. R77 has a pressure injury, stage 3 wound, on the sacrum. RN-C performed the treatment without a PPE gown. On 6/09/25. at 10:36 AM, Surveyor interviewed RN-C. RN-C stated They forgot to wear the PPE gown. On 6/9/25, at 3:10 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A and Director of Nurses (DON-B. Surveyor shared the concerns with the observation with R77's wound care. Based on observation, interview, and record review, the facility did not maintain an infection and control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases for 4 (R87, R12, R77 and R528) of 26 residents reviewed for Infection Control practices. * Surveyor observed Wound Medical Doctor (MD)-O, Nurse Manager-J, and Wound tech-P perform wound care for R87 without wearing proper Personal Protective Equipment (PPE). *Surveyor observed Certified Nursing Assistant (CNA)-K provide bowel incontinence care for R87 and did not change gloves and wash hands prior to performing peri care/catheter care. *Surveyor observed Advanced Practice Nurse Practitioner (APNP)- Q assess R87's right lower leg wound without proper PPE. *Surveyor observed Wound MD-O not wearing a glove while performing wound debridement for R12's wound care. *Surveyor observed PPE not worn while providing incontinence cares for R12. *PPE not used for R528 while performing tube feeing cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*PPE not used during wound care for R77. Findings: The Facility's policy titled Enhanced Barrier Precautions (EBP), dated 05/01/2024, documents in part . PROCEDURE: . 5. Staff caring for residents in EBP will need to wear proper PPE with high contact resident care activities. High contact resident care activities include bathing, dressing, transfers, toileting, hygiene, changing linen wound care or device care. 6. Gowns and gloves MUST be worn when performing any high-contact resident care activities: a. Dressing, bathing, showering, hygiene b. Transferring c. Changing linens or briefs d. Toileting e. Device care: central line, urinary catheter, feeding tube, etc. f. Wound care . 1.) R87 was admitted to the facility on [DATE], with diagnoses including [NAME]-[NAME] syndrome (a rare autoimmune disorder of the neuromuscular junction where the immune system attacks nerves and muscles, leading to muscle weakness and other symptoms), neuromuscular dysfunction of bladder (a condition where the nerves controlling bladder function are damaged or not functioning properly, leading to difficulty in controlling urination), pain, cellulitis (a bacterial skin infection affecting the deeper layers of the skin and underlying tissue, often caused by bacteria like Streptococcus or Staphylococcus entering through a break in the skin) of right lower limb and urine retention (the inability to fully or completely empty the bladder, resulting in a buildup of urine). R87's quarterly Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) for R87, that R87 is able to understand and be understood, is dependent on staff for toileting hygiene, substantial/maximal assistance with shower/bathing and has an indwelling urinary catheter. On 06/04/2025, at 11:35 AM, Surveyor noted an Enhanced Barrier Precaution (EBP) sign on R87's door. Surveyor was speaking with R87 in R87's room, when Wound MD-O, Nurse Manager-J, and Wound tech-P came into R87's room, Surveyor noted none of the staff were not wearing gowns. Surveyor observed Wound MD-O measure and clean R87's right lower leg wound without gloves. Surveyor left the room with Wound MD-O, Nurse Manager-J, and Wound tech-P. Surveyor noted Wound MD-O began typing on his computer and did not wash or sanitize his hands. On 06/04/2025, at 11:46 AM, Surveyor interviewed Wound MD-O. Surveyor asked Wound MD-O why Wound MD-O did not don EBP PPE to perform wound care for R87. Wound MD-O indicated that Wound MD-O was early, and the nurse was not ready. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/09/2025, at 06:50 AM, Surveyor observed CNA-K provide bowel incontinence care and catheter care for R87. Surveyor noted that R87's bowel movement was a loose consistency and was covering R87's peri area as well. CNA-K cleaned R87's bowel movement. CNA-K then began cleaning R87's peri area and providing catheter care with unchanged dirty gloves. Surveyor observed CNA-K begin to put R87's clean brief on with unchanged dirty gloves. Surveyor intervened and encouraged CNA-K to change gloves, perform hand hygiene and re-clean R87's peri area and catheter. Surveyor observed CNA-K clean R87's peri area and noted fecal matter being cleaned that was left behind. On 06/10/2025, at 10:04 AM, Surveyor observed APNP-Q, and student, enter R87's room to assess R87's right lower leg wound. Surveyor noted that neither staff were wearing gowns for EBP PPE. Surveyor observed APNP-Q and student remove R87's wound bandage and assess R87's wound. Once APNP-Q was done assessing R87, Surveyor asked APNP-Q if R87 is on EBP, APNP-Q indicated yes. Surveyor asked APNP-Q why APNP-Q did not follow EBP, APNP-Q informed Surveyor that it was an oversight. On 06/09/2025, at 12:50 PM, Surveyor interviewed NHA-A, DON-B and ANHA-M of the concerns for R87. DON-B indicated that EBP should be followed for wounds and catheters and is expectation to be worn when providing cares. DON-B indicated that proper PPE would include gown and gloves. On 06/10/2025, at 10:19 AM, Surveyor informed NHA-A and DON-B of above findings. No further information was provided at time of write up. 2.) R12 was admitted to the facility on [DATE], with diagnoses which include need for assistance with personal cares, pressure ulcer (a skin and soft tissue injuries caused by prolonged pressure on the skin, often leading to tissue death and open wounds) of right heal, scoliosis (a condition where the spine curves abnormally, often appearing as an S or C shape) and adult failure to thrive (a condition where a child's physical growth and development slow down or stop, usually due to inadequate nutrition). R12 admission MDS, dated [DATE], documents that R12 is able to understand and be understood, a BIMS (brief interview for mental status) of 13 (cognitively intact), that R12 is at risk for pressure ulcers/injuries and that R12 has unhealed pressure ulcers/injuries. On 06/04/2025, at 11:41 AM, Surveyor observed an EBP sign on R12's door. Surveyor observed Wound Tech-P enter R12's room without a gown and assist R12 into bed and removed R12's wound dressing. On 06/04/2025, at 11:54 AM, Surveyor observed Wound MD-O and Nurse Manager-J come into R12's room wearing gowns. Surveyor noted Wound MD-O only had one glove on his left hand. Surveyor observed Wound MD-O perform wound debridement of R12's wound using Wound MD-O 's ungloved right hand. On 06/04/2025, at 11:58 AM, Surveyor asked Wound MD-O again why Wound MD-O did not use a glove while performing wound debridement for R12. Wound MD-O indicated that gloves are to protect yourself and not to protect the resident. Surveyor asked Wound MD-O if not wearing proper PPE during wound cares is common practice for Wound MD-O. Wound MD-O indicated that EBP are to prevent transmission of bacteria from one patient to another, and that nothing actually touched the patient. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/09/2025, at 07:21 AM, Surveyor observed CNA-K provide incontinence cares for R12 and observed CNA-K did not wear a gown during this high contact care activity. Surveyor observed CNA-K clean R12's peri area with the same washcloth, and unchanged dirty gloves CNA-K used to clean fecal matter. CNA-K started to put a new brief on R12, Surveyor intervened CNA-K and encouraged CNA-K to change gloves and perform hand hygiene. CNA-K changed gloves, preformed hand hygiene and re-washed R12's peri area with a clean washcloth. On 06/09/2025, at 11:42 AM, Surveyor interviewed Infection Preventionist (IP)-N regarding the concerns for R12 and R87. IP-N indicated that any resident with a urinary catheter, tube feed, chest tube, intravenous line or chronic wounds is on EBP. IP- indicated that the expectation is that gown and gloves are worn during high contact activities and any staff performing any type of cares for those residents should be using PPE. IP-N indicated that it would be expected that staff wear gloves during wound care and there is never a time where it is ok to not wear gloves during wound care. On 06/09/2025, at 12:50 PM, Surveyor interviewed NHA-A, DON-B and ANHA-M of the concerns for R12. DON-B indicated that EBP should be followed for wounds and catheters and is expectation to be worn when providing cares. DON-B indicated that proper PPE would include gown and gloves. On 06/10/2025, at 10:19 AM, Surveyor informed NHA-A and DON-B of above findings. No further information was provided at time of write up. 4.) R528 was admitted to the facility on [DATE] with diagnosis of malignant neoplasm of tongue, Barrett's esophagus without dysplasia, dysphasia, adult failure to thrive, cachexia. R528's admission Minimum Data Set (MDS) assessment, dated 5/22/2025, documented a Brief Interview Mental Status (BIMS) score of 15, indicating cognitive awareness. Section B, documents that R528 is understood and understands. R528's (requires enhanced barrier precautions) care plan, dated 5/17/2025, documents: Resident requires enhanced barrier precautions related to Percutaneous Endoscopic Gastrotomy (PEG) tube. Surveyor observed no sign on R528's door indicating a need for enhanced barrier precautions with cares. On 6/5/2025, at 8:37 AM, Surveyor observed Licensed Practical Nurse (LPN)-S, flushing R528's tube feeding. LPN-S did not have on a gown. Surveyor interviewed LPN-S who indicated that if Personal Protective Equipment (PPE) was needed it would indicate it on the door. LPN-S stated that with R528 being a tube feeding resident, that a sign should be there. LPN-S indicated that with all residents with tube feeding that they should have a sign and PPE should be worn. On 6/10/2025, at 9:38 AM, Surveyor interviewed the Unit Manager, Registered Nurse (RN)-C, who stated that during cares with the tube feeding that staff needs to wear PPE. RN-C indicated that would include a gown and that per facility policy a sign should be on the door to notify staff of enhanced barrier needs. RN-C indicated that last week there was an extra sign for enhanced barrier on the treatment cart and believes that might be when the sign fell off R528's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/2025, at 12:16 PM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern with R528's enhanced barrier not being followed per care plan and policy. No additional information received as to why R528 had cares completed with no gown being used by staff and no sign on the door to notify staff of need for enhanced barrier PPE.