STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525552	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure 1 (R44) of 12 residents was given the opportunity to be a part of their care planning process in regards to their personal belongings. Findings include: R44's diagnoses include multiple sclerosis, hypertension, anxiety, and is blind in the left eye. The quarterly MDS (minimum data set) with an assessment reference date of 2/16/24 assesses R44's short and long term memory as ok. R44 has modified independence for cognitive skills for daily decision making. R44 is assessed as not having any behavior. R44 is independent with her activities of daily living. The potential of impaired psychosocial well being care plan documents the following approaches: * Provide emotional support and validate concerns/feelings PRN (as needed). Start date of 6/26/24. * Encourage/Facilitate development of peer relationships/participation in activities PRN. Start date of 6/26/24. The at risk for impaired adjustment to new environment care plan documents the following approaches: * Follow community evaluation and monitoring process. Start date of 6/26/24. * Identify current mood and behavioral expressions, monitor for changes. Start date of 6/26/24. * Orient [R44's first name] to community layout, routines, and schedules. Start date of 6/26/24. (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R44's CNA (Certified Nursing Assistant) Worksheet for Tuesday 7/16/24 under the Cognition/Behavior section documents Cognition/Behavior/Presences: COGNITION: [R44's first name] is alert and orientated to person, place, time. Prefers to wake up around 1200 varies. Prefers to go to sleep around 2200 (10:00 p.m.) varies. Naps in AM (morning) varies. Offer and encourage as indicated non pharmacological pain management of activities, cold distraction and rest periods PRN. Maintain eye contact with client while speaking. Stand close, within client's line of vision, R (right) eye. **Blind L (left) eye**. SW (Social Worker)-O statement dated 6/8/24 documents Resident [R44's name] stated she was taken to the shower on 6/7/24 and when she returned to her room around 11 am she had missing items from her room. The items included 2 Styrofoam bowls, 1 plastic bowl, plastic silverware and plastic straws, a white robe with big blue designs on it and snapped up in front with short sleeves, a plastic container and two single dollar bills. Resident stated she did not remember that last time she saw her two $1 bills because they were kept under her cookies. Resident stated food and just (sic) were also thrown out. Resident stated she asked the CNA if she took any items out of her room and she blamed it on housekeeping. Writer asked if resident would like a police report filed. Resident stated she did not want to personally call the police or have them come to the facility to speak with her over petty missing items however requested Writer call on her behalf. Writer stated they can call, however, they likely would not proceed with filing a report or come to the facility if she did not want to provide her own statement to them. Resident expressed understanding and still wanted Writer to call. Writer called [Name] Non-Emergency police at 11 am on 6/8/24 and spoke to Operator 21. Operator 21 reported they would only come to the facility if resident personally requested to file a complaint. Writer reported back to resident and apologized staff had cleaned out her room without her consent. Facility will reimburse her $2 and contact housekeeping regarding missing robe. SW-O's note dated 6/10/24, at 10:00 a.m., documents Writer (SW) checked in on resident. Resident stated the rest of the weekend went well and thanked writer for listening to her and following up on the reported missing personal items. Resident did not appear in distress, however stated she hope she does not get anyone fired. Writer stated the facility just has to appropriately follow protocol and complete an internal investigation and apologized again resident had the experience she did. Resident expressed understanding and thanked writer. Resident did not have any further needs or concerns at this time. The progress note dated 6/18/24, at 1311 (1:11 p.m.), documents IDT (interdisciplinary team) met, reviewed, and updated resident's care plan using holistic interdisciplinary approaches. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24, at 10:02 a.m., Surveyor observed R44 in bed on left side. Surveyor asked R44 if Surveyor could speak with her. R44 then transferred self from the bed into the wheelchair to speak with Surveyor. During the conversation, R44 informed Surveyor about a month ago she was taking a shower when someone came in and stole her things. Surveyor inquired what was taken. R44 explained there were little dishes so that she can save certain things from her lunch, $2.00, my robe - it was like a moomoo that was on the bed, plastic silverware, snacks, and little containers. R44 informed Surveyor a policeman came, he was very nice but she felt so stupid. R44 informed Surveyor when she saw the things gone it made her cry all day and she felt violated. R44 informed Surveyor she didn't realize they would come in her room without notifying her. R44 informed Surveyor the first name of NHA (Nursing Home Administrator)-A told her he was going to change this so staff don't go in resident's rooms unless they are there. R44 informed Surveyor she's at the point where she can't trust anyone. Surveyor asked R44 if she goes to activities. R44 informed Surveyor she doesn't go anymore because she was robbed. Surveyor observed there are multiple articles of clothing on R44's bed, the over bed table has multiple Styrofoam glasses and Styrofoam dishes covering over 75% of the over bed table and the chair is stacked with items. On 7/16/24, at 12:54 p.m., R44 informed Surveyor she is still upset about staff coming in her room. R44 informed Surveyor their defense is they were looking for moldy food. R44 informed Surveyor she likes to snack at night. The container that was taken was old but she washes it out. R44 informed Surveyor there was a brownie in the container. R44 also informed Surveyor NHA-A did give her back her $2.00. Surveyor asked R44 if she has gone out for any appointments. R44 informed Surveyor the last time she went out was when she went to the emergency room . R44 also informed Surveyor she went out on 6/18/24 for an ear doctor and audiologist appointment. R44 indicated she left at 11:30 a.m. and came back at supper time. Surveyor asked R44 if anyone came in her room while she was at her appointment. R44 replied not that I know of I locked my checkbook and all that and took my purse with me. Surveyor asked R44 when she goes out for an appointment what would she like staff to do. R44 replied I want to be sure no one is going to come in my room and want dietary to leave the meal for me on the over bed table. R44 asked Surveyor don't I have the right to have my room the way I want it? R44 informed Surveyor she has so much in her head explaining she was worried about the lady across the hall who went to the hospital and she was worried something was going to happen to this ladies purse. On 7/16/24, at 2:00 p.m., Surveyor observed R44 sitting in a wheelchair in her room. On 7/17/24, at 7:15 a.m., Surveyor observed R44 in bed on her left side covered with an afghan. Surveyor observed R44's over bed table has approximately 8+ Styrofoam glasses along with multiple Styrofoam container. The personal type recliner continues to be piled up with multiple articles. Towards the bottom of the bed there is a [name of] bag and multiple other items. On 7/17/24, at 8:00 a.m., Surveyor asked CNA-KK what she could tell Surveyor about R44. CNA-KK informed Surveyor she is fairly new working at the facility and has been here for a week. CNA-KK informed Surveyor can't say much about R44 at all, does most for her self, and likes cups. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24, at 10:36 a.m., Surveyor asked SW-O what SW-O could tell Surveyor about R44. SW-O informed Surveyor she started working at the facility last summer. SW-O informed Surveyor R44 is a long term resident, prefers to stay in her room, and self isolates. The chaplain meets regularly with her and thinks in the past declined psych referral. R44 is most comfortable staying in her room and they encourage her to interact at least with staff if she's not comfortable with residents. Surveyor inquired about R44's 6/7/24 incident. SW-O informed Surveyor R44 tends to hoards things in her room but that's not an excuse for staff to clean up her room without her consent. R44 will keep 12 Styrofoam cups on her tray for example. Surveyor asked SW-O how she became aware of R44's incident on 6/7/24. SW-O informed Surveyor R44 wrote a statement. SW-O informed Surveyor she apologized to R44 for staff member cleaning her room and asked R44 if she wanted the police contacted. SW-O indicated R44 wanted her to call the police, initially police didn't come out because R44 didn't want to make a report herself. SW-O informed Surveyor NHA-A did reeducation staff can't throw out resident's personal belongings without their consent. Surveyor asked SW-O what the facility's plan was to reduce R44's anxiety regarding staff coming in her room and were any care plans developed after the 6/7/24 incident. SW-O informed they continue to check in on her, ask permission before going in room and when R44 goes out to appointment R44 wants a sign in the room or door that says please don't enter room, resident is not present. Surveyor informed SW-O Surveyor did not note this in R44's care plan SW-O informed Surveyor she can definitely update the care plan. On 7/17/24, at 11:28 a.m., Surveyor asked R44 if she ever leaves her room. R44 replied no I'm paranoid about leaving explaining there are new CNAs all the time that she doesn't recognize. Surveyor asked R44 what she was afraid of if she leaves her room. R44 replied they are going to take something, just the thought of someone going through my things, just my personal things hate the thought of someone going through them. Surveyor asked R44 if it makes her anxious about someone coming in her room without her knowing. R44 replied oh yes definitely. On 7/17/24, at 3:51 p.m., during the end of the day meeting Surveyor informed NHA-A facility did not develop a care plan with R44's participation to reduce her anxiety for staff coming in her room and concerns of staff taking items. On 7/18/24 Surveyor reviewed the following care plans provided to Surveyor: The alteration in mood related to Anxiety care plan documents the following approaches: * Provide reassurance and comfort. Start date 7/17/24. * Give clear, concise explanations regarding impending procedures. Start date 7/17/24. The [R44's first name] has impaired behavior related to Hoarding care plan documents the following approaches: * Avoid the following identified triggers: removing items from room without resident participation. Start date 7/17/24. Surveyor noted the above care plans were developed after Surveyor spoke with SW-O. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24, at 7:39 a.m., Surveyor asked CNA-DD what she could tell Surveyor about R44. CNA-DD informed Surveyor she's pretty independent, makes her needs known. Surveyor asked if R44 comes out of her room. CNA-DD replied no. Surveyor asked if she likes to keep things. CNA-DD replied you mean like hoarding, yes. Surveyor asked CNA-DD if R44 will let her throw her things away. CNA-DD replied no. On 7/22/24, at 7:15 a.m., Surveyor observed R44 in bed on the left side with eyes closed wearing gripper socks on her feet. Surveyor observed there are multiple articles on R44's bed, 10+ Styrofoam glasses along with Styrofoam containers on the over bed table and articles piled up on the personal type recliner. On 7/25/24 NHA-A emailed additional information which included Physician-SS progress note for R44 dated 6/25/24. Surveyor reviewed Physician-SS progress notes which includes follow up of chronic neck and back pain and heart burn. Physician-SS progress note dated 6/25/24 does not change the deficient practice.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interviews, the facility did not ensure 1 (R29) of 1 Residents with an injury of unknown origin was reported to the State Survey Agency. *Bruising to R29's left eye and left breast was noted on 5/2/24. On 5/16/24, bruising to the right eye, right foot, and a laceration between the right great toe and second toe is noted. R29's x ray documents that R29's right great toe is fractured and R29 required 2 stitches between the right great toe and second toe. The facility did not report the injuries of unknown origin from 5/2/24 and 5/16/24. Findings Include: The facility's policy Abuse Investigation and Reporting for Residents dated 9/2017 and last revised on 11/2023 documents: .Policy Statement All reports of Resident abuse, neglect, exploitation, misappropriation of Resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging of Residents, and/or injuries of unknown source(abuse) shall be promptly reported to local, state, and federal agencies and thoroughly investigated by community management. Policy Interpretation and Implementation Role of the Administrator or designee: A. If an incident or suspected incident of Resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator or designee will assign the investigation to an appropriate individual. Reporting A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designee and to the following other officials or agencies: 1. The state licensing/certification agency responsible for surveying/licensing the community. B. Alleged violations involving abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of Resident property) will be reported: 1. Abuse or Serious Bodily Harm-Immediately but not later than 2 hours. *If the alleged violation involves abuse or results in serious bodily injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. No Serious Bodily Injury-As soon as practical, but not later than 24 hours. *If the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of Resident property; does not result in serious bodily injury. R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia and Anxiety Disorder. R29 has an activated Health Care Power of Attorney (HCPOA) effective 9/16/2019. R29 has been receiving hospice service since 4/24/23. R29's Annual MDS dated [DATE] documents R29 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R29's MDS also documents that R29 is at risk for developing skin issues and has no current skin issues, osteoporosis is not documented as a current diagnosis, R29 is receiving scheduled pain medications and that a pain interview can be completed but then is documented that R29 is unable to answer any questions. R29's MDS documents R29 has range of motion impairment on both upper and lower extremities on both sides and that R29 is dependent on staff for eating, hygiene, mobility, and transfers. The following is documented in the hospice Skilled Nursing Visit Notes for R29: On 5/2/24, Hospice Registered Nurse (HRN)-S documented that HRN-S noted bruising to R29's left eye. The facility did not call hospice reporting any injuries or falls. HRN-S and hospice home health aide (HHA) noticed bruising to R29's left eye and left breast as well prior to showering. HRN-S spoke with facility nurse and reported the bruising. Facility nurse stated she did not get that during report and was not told anything about bruising. HRN-S attempted to find Director of Nursing (DON)-B and facility social worker (SW)-O, however, neither present in their office. HRN-S found the facility Nursing Home Administrator (NHA)-A and reported the bruising. NHA-A asked HRN-S and HHA for a statement. HRN-S wrote statement of finding the bruising prior to cares being provided by hospice. HRN-S updated activated HCPOA who stated that HCPOA noticed the bruising yesterday evening and thinks it could be from the Hoyer lift. HCPOA had several concerns about the facility that was shared and HRN-S told HCPOA to express the concerns to NHA-A and DON-B. On 5/16/24, HRN-S documents new bruising is noted to R29's right eyelid. Bruising is from unknown origin. R29's left eyelid remains bruised and appears purple in color suggestive of a newer bruise occurring again. DON-B completed an investigation and found R29 to be combative and capable of hitting self to create a bruise. HRN-S noted a large bruise to R29's right foot which was not reported to Hospice. R29's toes have dried blood on them as well. R29 screaming in pain when HRN-S touches foot. Shower completed. HRN-S cleansed R29' foot to assess where the bleeding was occurring. Licensed Practical Nurse (LPN)-M entered shower room and assessed R29's foot while 4 staff members held R29. Picture from LPN-M's phone of R29's foot revealed R29 had a deep laceration in between R29's right great toe and second toe. HRN-S found previous DON and new Unit Manager from the 3rd floor. HRN-S discussed new injuries and concerns related to R29. Previous DON reports hearing about a cut that a LPN wrapped yesterday. HRN-S showed previous DON the picture of the laceration and expressed that it potentially needed stitches. Director of Nursing (DON)-B entered room and HRN-S explained situation. DON-B and and new RN manager went to the 2nd floor to conduct an investigation. DON-B completed initial investigation and reports that the Broda chair has a cap missing which could have cut R29's foot. DON-B also reports R29 being combative and could have kicked or bumped into something. HRN-S updated NHA-A who states NHA-A is aware of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an investigation already being conducted and that (R29) is combative so perhaps (R29's) medications need to be adjusted. HCPOA decided to have R29 transferred to the emergency room for stitches and a foot x-ray. HRN-S documents in the hospice Interdisciplinary Group Meeting dated 7/3/24 that on 5/16/24, R29 was transferred to the emergency room and received 2 sutures and surgical glue to the laceration. Care Plan Documentation Concerns regarding facility responsibilities. R29 with new injuries not appropriately reported. On 5/21/24, HRN-S attempted to assess R29's feet, but R29 becomes agitated and yells when HRN-S attempts to do so. Updated DON-B and NHA-A regarding visit. DON-B and NHA-A tell HRN-S that they believe R29's chair caused the injury to R29's right toe. HRN-S placed a new order for another chair from the DME (durable medical equipment) company. HRN-S asked DON-B if R29's behaviors have been unmanageable for the facility staff. DON-B denied R29's behaviors as being challenging and told HRN-S that no medication adjustments were necessary at this time. On 5/22/24, an x-ray is obtained by hospice of the right foot. The finding is an acute fracture in the proximal phalanx of the first digit. On 5/23/24, HRN-S documents that facility SW-O, DON-B and R29's family along with HRN-S discussed R29's injuries. Facility staff present stated that they believe the injuries were self inflected and occurring from R29's chair. New chair was delivered. Facility reports that caregivers have been using the Hoyer lift without 2 people. R29's care plan was discussed. R29 will always be a 2 person assist according to facility. On 5/30/24, HRN-S documents HCPOA called HRN-S on 5/28/24 regarding R29's knee possibly needing an x-ray. HCPOA reports R29's knee was swollen over that weekend and that R29 needed morphine. HRN-S notified DON-B who assessed R29 and told HRN-S that DON-B's assessment did not reveal any abnormalities. HRN-S attempted to assess R29's knees on 5/29/24, however, R29 was up in Broda chair resting comfortably and anytime HRN-S attempted to touch R29, R29 cried out. HRN-S assessed R29's knees during visit today. R29's right knee is notably swollen compared to R29's left knee. DON-B made aware and assessed the knee with HRN-S. DON-B reports that R29 often crosses R29's knees which could cause swelling or perhaps R29 has fluid on R29's knee. Range of motion was attempted by HRN-S, however, R29 is unable to lift R29's right leg off of the bed which is new. HRN-S attempted to move R29's lower extremity, but R29 yelled out in pain, crying, it hurts. HRN-S updated hospice physician. Orders received for X-rays of R29's femur and tibia/fibula. Complete bed rest until x-ray results are in. On 6/1/24, an x-ray of R29's right tibia and fibula was obtained. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24, HRN-S documents upon arrival, R29 was lying in bed favoring R29's right side with eyes closed. R29 also said ouch, it hurts when cares were not being provided, but would not tell HRN-S where it hurt. X-ray results were faxed to hospice today. R29's right distal femur is fractured. HRN-S notified hospice leadership and team members, facility leadership and caregivers, and R29's HCPOA. Hospice physician ordered scheduled morphine and non-weight bearing to right lower extremity and discontinued Tramadol. Per hospice physician, R29 can be up as tolerated via the Hoyer lift. HRN-S communicated these new orders with DON-B and NHA-A. HRN-S explained that R29 should be considered bedrest, but that R29 could get up as tolerated. HRN-S gave an example of R29 not having pain and R29 actively attempting to get out of bed. Those would be signs that R29 could tolerate getting transferred into R29's Broda chair. NHA-A asked if R29 should be getting up at all and HRN-S explained no unless R29 would have a significant improvement. Facility leadership will conduct another investigation from the unknown origin of the injury. On 6/3/24, the x-ray results document there is an acute impacted fracture at the distal femur. No evidence of osteomyelitis. According to https://www.britannica.com the documented definition of an impacted fracture is a .closed fracture that occurs when pressure is applied to both ends of a bone, causing the broken ends to jam together.An impacted fracture occurs when the broken ends of the bone are jammed together by the force of the injury. On 6/5/24, HRN-S documents a care conference was held this afternoon prior to visit. Family updated during care conference and during visit. The family has concerns related to the injuries that R29 sustained. The facility reports that they have investigated each injury and concern and believe the injuries to be pathological. On 6/20/24, HRN-S documents during repositioning, R29 complained of pain by stating, Ouch. Registered Nurse (RN)-L reports that the CNAs from the facility got R29 up via the Hoyer lift and transferred R29 to the Broda chair for breakfast. RN-L and DON-B transferred R29 back to bed to remain on complete bedrest. On 7/5/24, HRN-S documents R29 is visibly in pain as evidenced by facial grimacing and moaning. R29 is stating, it hurts while grabbing towards R29's right leg. Pain 8. R29 is also very agitated. HRN-S called for assistance from the facility to assist with incontinence cares and repositioned. On 7/16/24, at 10:43 AM, Surveyor interviewed HRN-S. HRN-S observed on 5/2/24 the bruising to R29's left eye and left breast and brought it to the facility's attention. HRN-S was informed by the facility that R29 did to self (sic) by holding R29's babydoll tight and caused bruising to chest and eye. HRN-S found bruising to the right eye and right foot on 5/16/24. HRN-S confirmed R29 was being hoyered at that time. HRN-S noticed blood and found a laceration between R29's right great toe and second toe and requested for R29 be sent to the emergency room . HRN-S stated it was not getting done, so hospice called the ambulance and R29 received 2 stitches and surgical glue. Facility stated it either happened when R29 was up for meals and may have accidentally hit it and the facility stated that R29's Broda chair was missing a cap on the left side. HRN-S stated the injury was on the right side and didn't understand. HRN-S has never observed R29 to be restless or thrashing around when up in the Broda chair. R29 ends up with confirmation of a right great toes fracture on 5/22/24. HRN-S stated there was no swelling present to R29's right knee between 5/23-5/28/24. On 6/3/24, R29 is found to have a right distal femur fracture. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24, at 3:49 PM, Nursing Home Administrator (NHA)-A informed Surveyor that R29 has had no falls in the past 6 months. On 7/18/24 at 3:42 PM, Surveyor shared with NHA-A the concern that R29 had an injury of unknown origin resulting in bruising to left and right eye, and the fracture of the right great toe and the right femur fracture. NHA-A stated the fractures are a result of R29's osteoporosis. Surveyor shared the concern that R29 appeared with bruising to the left and right eye on 2 separate occasions and the fracture to the right great toe, that there is no documentation that the facility submitted the injuries of unknown injury to the state survey agency. At this time, NHA-A had no further information. On 7/22/24, at 1:23 PM, Surveyor interviewed NHA-A in regards to R29's injuries. Surveyor requested any additional information that NHA-A had on R29's injuries Surveyor notes the facility submitted a self report to the state agency dated 6/11/24 in regards to R29's femur fracture. Surveyor asked NHA-A about the documented statement in the self report summary stating, Furthermore, on 5/16, (R29) had a Broda chair transfer incident in which (R29's) right foot got caught up in the foot rest. Surveyor asked NHA-A why R29's bruising to both the left and right eye, and the right great toe fracture and laceration requiring 2 stitches was not reported to the state survey agency. NHA-A stated that a written grievance was completed in regards to the injuries which NHA-A provided a copy to Surveyor. A signed grievance dated 5/23/24 by NHA-A documents that the bruising to R29's eyes were self inflicted by R29. The intervention for R29's fractures was the buddy system. Surveyor notes implementing the buddy system is not on R29's CNA worksheet or comprehensive care plan. NHA-A stated the right great toe fracture may be related to getting caught between the foot rest and side of Broda chair and the femur fracture is related to R29's diagnosis of osteoporosis. NHA-A stated that there was always an explanation and within 2 hours we identified it was all self inflicted. Surveyor notes that the grievance was initiated on 5/16/24, however, bruising to the left eye was discovered on 5/2/24. Surveyor shared with NHA-A that R29's injuries that were not reported meet the definition of Injuries of unknown source as R29 could not explain, there was no witness, and based on the location and number of injuries sustained by R29. On 7/29/24, at 12:33 PM, Surveyor reviewed additional information provided by the facility after the survey process was completed. Surveyor continues to have concerns that R29's injuries of unknown origin at the time of discovery was not submitted to the State Survey agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interview, the facility did not ensure all allegation involving potential abuse, neglect, and misappropriation of Resident property were thoroughly investigated for 1 (R29) of 4 reported events to the state survey agency. *Bruising to R29's left eye and left breast was noted on 5/2/24. On 5/16/24, bruising to the right eye, right foot, and a laceration between the right great toe and second toe is noted. R29's x ray documents that R29's right great toe is fractured and R29 requires 2 stitches between the right great toe and second toe. The facility did not report the injuries of unknown origin from 5/2/24 and 5/16/24 and a thorough investigation of the injuries was not completed. Findings Include: The facility's policy Abuse Investigation and Reporting for Residents dated 9/2017 and last revised on 11/2023 documents: .Policy Statement All reports of Resident abuse, neglect, exploitation, misappropriation of Resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging of Residents, and/or injuries of unknown source(abuse) shall be promptly reported to local, state, and federal agencies and thoroughly investigated by community management. Policy Interpretation and Implementation Role of the Administrator or designee: A. If an incident or suspected incident of Resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator or designee will assign the investigation to an appropriate individual. Role of the investigator: A. The individual conducting the investigation will, at a minimum: 1. Review the completed documentation forms 2. Review the Resident's medical record to determine events leading up to the incident 3. Interview the person(s) reporting the incident 4. Interview any witnesses to the incident 5. Interview the Resident(as medically appropriate) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Interview the Resident's attending physician as needed to determine the Resident's current level of cognitive function and medical condition 7. Interview associate members(on all shifts) who have had contact with the Resident during the period of the alleged incident 8. Interview the Resident's roommate, family members, and visitors 9. Interview other Residents to who the accused employee provides care or services 10. Review events leading up to the alleged incident 11. Review use of community camera/video footage of incident B. The following guidelines will be used when conducting interviews: 3. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia and Anxiety Disorder. R29 has an activated Health Care Power of Attorney (HCPOA) effective 9/16/2019. R29 has been receiving hospice service since 4/24/23. R29's Annual MDS dated [DATE] documents R29 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R29's MDS also documents that R29 is at risk for developing skin issues and has no current skin issues, osteoporosis is not documented as a current diagnosis, R29 is receiving scheduled pain medications and that a pain interview can be completed but then is documented that R29 is unable to answer any questions. R29's documents R29 has range of motion impairment on both upper and lower extremities on both sides and that R29 is dependent for assistance for eating, hygiene, mobility, and transfers. The following is documented in the hospice Skilled Nursing Visit Notes for R29: On 5/2/24, Hospice Registered Nurse (HRN)-S documented that HRN-S noted bruising to R29's left eye. The facility did not call hospice reporting any injuries or falls. HRN-S and hospice home health aide (HHA) noticed bruising to R29's left eye and left breast as well prior to showering. HRN-S spoke with facility nurse and reported the bruising. Facility nurse stated she did not get that during report and was not told anything about bruising. HRN-S attempted to find Director of Nursing (DON)-B and facility social worker (SW)-O, however, neither present in their office. HRN-S found the facility Nursing Home Administrator (NHA)-A and reported the bruising. NHA-A asked HRN-S and HHA for a statement. HRN-S wrote statement of finding the bruising prior to cares being provided by hospice. HRN-S updated activated HCPOA who stated that HCPOA noticed the bruising yesterday evening and thinks it could be from the Hoyer lift. HCPOA had several concerns about the facility that was shared and HRN-S told HCPOA to express the concerns to NHA-A and DON-B. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes the facility does not have documentation that on 5/2/24 a thorough investigation was completed including but not limited to obtaining staff statements and other Resident statements for concerns with care issues in regards to R29's bruising to the left eye and left breast. There is 1 statement with a date of 5/15/24 from a nurse who believes the bruising is attributed to R29 holding R29's babydoll tight. No documentation was submitted to the state agency that the facility completed a thorough investigation. On 5/16/24, HRN-S documents new bruising is noted to R29's right eyelid. Bruising is from unknown origin. R29's left eyelid remains bruised and appears purple in color suggestive of a newer bruise occurring again. DON-B completed an investigation and found R29 to be combative and capable of hitting self to create a bruise. HRN-S noted a large bruise to R29's right foot which was not reported to Hospice. R29's toes have dried blood on them as well. R29 screaming in pain when HRN-S touches foot. Shower completed. HRN-S cleansed R29' foot to assess where the bleeding was occurring. Licensed Practical Nurse (LPN)-M entered shower room and assessed R29's foot while 4 staff members held R29. Picture from LPN-M's phone of R29's foot revealed R29 had a deep laceration in between R29's right great toe and second toe. HRN-S found previous DON and new Unit Manager from the 3rd floor. HRN-S discussed new injuries and concerns related to R29. Previous DON reports hearing about a cut that a LPN wrapped yesterday. HRN-S showed previous DON the picture of the laceration and expressed that it potentially needed stitches. Director of Nursing (DON)-B entered room and HRN-S explained situation. DON-B and and new RN manager went to the 2nd floor to conduct an investigation. DON-B completed initial investigation and reports that the Broda chair has a cap missing which could have cut R29's foot. DON-B also reports R29 being combative and could have kicked or bumped into something. HRN-S updated NHA-A who states NHA-A is aware of an investigation already being conducted and that (R29) is combative so perhaps (R29's) medications need to be adjusted. HCPOA decided to have R29 transferred to the emergency room for stitches and a foot x-ray. Surveyor notes no documentation was submitted to the state agency that the facility completed a thorough investigation for the 5/16/24 laceration and great right toe fracture. Based on limited staff statements obtained, there is no clear indication of who transferred R29 from bed to Broda chair and/or who may have been a witness to the transfer. Surveyor notes at this time there are no other Resident statements in regards to having any care concerns. HRN-S documents in the hospice Interdisciplinary Group Meeting dated 7/3/24 that on 5/16/24, R29 was transferred to the emergency room and received 2 sutures and surgical glue to the laceration. Care Plan Documentation Concerns regarding facility responsibilities. R29 with new injuries not appropriately investigated. On 5/21/24, HRN-S attempted to assess R29's feet, but R29 becomes agitated and yells when HRN-S attempts to do so. Updated DON-B and NHA-A regarding visit. DON-B and NHA-A tell HRN-S that they believe R29's chair caused the injury to R29's right toe. HRN-S placed a new order for another chair from the DME (durable medical equipment) company. HRN-S asked DON-B if R29's behaviors have been unmanageable for the facility staff. DON-B denied R29's behaviors as being challenging and told HRN-S that no medication adjustments were necessary at this time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24, and x-ray is obtained by hospice of the right foot. The finding is an acute fracture in the proximal phalanx of the first digit. On 5/23/24, HRN-S documents that facility SW-O, DON-B and R29's family along with HRN-S discussed R29's injuries. Facility staff present stated that they believe the injuries were self inflected and occurring from R29's chair. New chair was delivered. Facility reports that caregivers have been using the Hoyer lift without 2 people. R29's care plan was discussed. R29 will always be a 2 person assist according to facility. On 5/30/24, HRN-S documents HCPOA called HRN-S on 5/28/24 regarding R29's knee possibly needing an x-ray. HCPOA reports R29's knee was swollen over that weekend and that R29 needed morphine. HRN-S notified DON-B who assessed R29 and told HRN-S that DON-B's assessment did not reveal any abnormalities. HRN-S attempted to assess R29's knees on 5/29/24, however, R29 was up in Broda chair resting comfortably and anytime HRN-S attempted to touch R29, R29 cried out. HRN-S assessed R29's knees during visit today. R29's right knee is notably swollen compared to R29's left knee. DON-B made aware and assessed the knee with HRN-S. DON-B reports that R29 often crosses R29's knees which could cause swelling or perhaps R29 has fluid on R29's knee. ROM was attempted by HRN-S, however, R29 is unable to lift R29's right leg off of the bed which is new. HRN-S attempted to move R29's lower extremity, but R29 yelled out in pain, crying, it hurts. HRN-S updated hospice physician. Orders received for X-rays of R29's femur and tibia/fibula. Complete bed rest until x-ray results are in. On 6/1/24, an x-ray of R29's right tibia and fibula was obtained. On 6/3/24, HRN-S documents upon arrival, R29 was lying in bed favoring R29's right side with eyes closed. R29 also said ouch, it hurts when cares were not being provided, but would not tell HRN-S where it hurt. X-ray results were faxed to hospice today. R29's right distal femur is fractured. HRN-S notified hospice leadership and team members, facility leadership and caregivers, and R29's HCPOA. Hospice physician ordered scheduled morphine and non-weight bearing to right lower extremity and discontinued Tramadol. Per hospice physician, R29 can be up as tolerated via the Hoyer lift. HRN-S communicated these new orders with DON-B and NHA-A. HRN-S explained that R29 should be considered bedrest, but that R29 could get up as tolerated. HRN-S gave an example of R29 not having pain and R29 actively attempting to get out of bed. Those would be signs that R29 could tolerate getting transferred into R29's Broda chair. NHA-A asked if NHA-A should be getting up at all and HRN-S explained no unless R29 would have a significant improvement. Facility leadership will conduct another investigation from the unknown origin of the injury. On 6/3/24, the x-ray results document there is an acute impacted fracture at the distal femur. No evidence of osteomyelitis. According to https://www.britannica.com the documented definition of an impacted fracture is a .closed fracture that occurs when pressure is applied to both ends of a bone, causing the broken ends to jam together.An impacted fracture occurs when the broken ends of the bone are jammed together by the force of the injury. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24, HRN-S documents a care conference was held this afternoon prior to visit. Family updated during care conference and during visit. The family has concerns related to the injuries that R29 sustained. The facility reports that they have investigated each injury and concern and believe the injuries to be pathological. On 7/16/24, at 10:43 AM, Surveyor interviewed HRN-S. HRN-S observed on 5/2/24 the bruising to R29's left eye and left breast and brought it to the facility's attention. HRN-S was informed by the facility that R29 did to self (sic) by holding R29's babydoll tight and caused bruising to chest and eye. HRN-S found bruising to the right eye and right foot on 5/16/24. HRN-S confirmed R29 was being hoyered at that time. HRN-S noticed blood and found a laceration between R29's right great toe and second toe and requested for R29 be sent to the emergency room . HRN-S stated it was not getting done, so hospice called the ambulance and R29 received 2 stitches and surgical glue. Facility stated it either happened when R29 was up for meals and may have accidentally hit it and the facility stated that R29's Broda chair was missing a cap on the left side. HRN-S stated the injury was on the right side and didn't understand. HRN-S has never observed R29 to be restless or thrashing around when up in the Broda chair. R29 ends up with confirmation of a right great toes fracture on 5/22/24. HRN-S stated there was no swelling present to R29's right knee between 5/23-5/28/24. On 6/3/24, R29 is found to have a right distal femur fracture. On 7/16/24, at 3:49 PM, Nursing Home Administrator (NHA)-A informed Surveyor that R29 has had no falls in the past 6 months. On 7/18/24 at 3:42 PM, Surveyor shared with NHA-A the concern that R29 had an injury of unknown origin resulting in bruising to left and right eye, and the fracture of the right great toe and the right femur fracture. NHA-A stated the fractures are a result of R29's osteoporosis. Surveyor shared the concern that R29 appeared with bruising to the left and right eye on 2 separate occasions and the fracture to the right great toe, that there is no documentation that the facility submitted the injuries of unknown injury to the state survey agency. At this time, NHA-A had no further information. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24, at 1:23 PM, Surveyor interviewed NHA-A in regards to R29's injuries. Surveyor requested any additional information that NHA-A had on R29's injuries Surveyor notes the facility submitted a self report to the state agency dated 6/11/24 in regards to R29's femur fracture. Surveyor asked NHA-A about the documented statement in the self report summary stating, Furthermore, on 5/16, R29 had a Broda chair transfer incident in which R29's right foot got caught up in the foot rest. Surveyor asked NHA-A why R29's bruising to both the left and right eye, and the right great toe fracture and laceration requiring 2 stitches was not reported to the state survey agency. NHA-A stated that a written grievance was completed in regards to the injuries which NHA-A provided a copy to Surveyor. A signed grievance dated 5/23/24 by NHA-A documents that the bruising to R29's eyes were self inflicted by R29. The intervention for R29's fractures was the buddy system. Surveyor notes implementing the buddy system is not on R29's CNA worksheet or comprehensive care plan. NHA-A stated the right great toe fracture may be related to getting caught between the foot rest and side of Broda chair and the femur fracture is related to R29's diagnosis of osteoporosis. NHA-A stated that there was always an explanation and within 2 hours we identified it was all self inflicted. An undated signed statement from Social Worker (SW)-O documents that every Resident was interviewed on the second floor, however, Surveyor was not provided upon request those Resident interviews. NHA-A provided a copy of staff statements and none of the staff statements are signed and dated. The staff statements are specific to whether or not R29 had a fall. Surveyor notes that the grievance was initiated on 5/16/24, however, bruising to the left eye was discovered on 5/2/24. Surveyor shared with NHA-A that R29's injuries that were not reported meet the definition of Injuries of unknown source as R29 could not explain, there was no witness, and the location and number of injuries sustained by R29. Surveyor shared the concern that a thorough investigation was not completed in regards to R29's injuries. Surveyor also notes that HRN-S provided written statements for R29's observed injuries and the facility did not have documentation of these statements.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure that based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 (R13 & R25) of 12 residents. * R13 was admitted to the facility on [DATE]. R13's treatments for surgical pin sites didn't start until 3/31/24 and the left heel did not start until 3/30/24. The facility did not follow the treatment recommended by the hospital for the pin sites and the nurse who wrote the order is no longer at the facility. There are no assessments for the left heel after 4/5/24, the left upper thigh after 4/1/24, and there are no assessment for the left ankle pin site. R13 was transferred to the hospital on 5/14/24 after a wound appointment and was admitted with severe sepsis. * Neuro checks were not complete in accordance with facility policy following R25's 6/30/24 fall. Findings include: The facility's policy titled, Skin Identification, Evaluation and Monitoring last revised 11/2022 under Purpose documents: The purpose of this policy is to outline a method of identification, evaluation and monitoring for alterations in skin integrity. Communities will implement preventative measures and an individualized care plan will be formulated upon completion of findings. Under Procedure for Weekly: The Licensed Nursing Associate: A. Complete a General Skin Check to evaluate for changes in skin integrity. B. Document in medical record the findings of general skin check. 1. If wound is present and previous identified: a. Document integumentary findings i. Appearance of the wound, including measurements ii. Treatment applied/initiated per health care provider order in the medical record. 1.) R13 was admitted to the facility on [DATE] and discharged on [DATE]. The hospital discharge date d 3/28/24 under brief hospital course and important issues for outpatient follow up documents: came with ankle fracture, underwent fixation and needs follow up. For medication changes and reasoning documents Lovenox for DVT (deep vein thrombosis) prophylaxis antibiotics for left heel infection. Discharge follow up documents orthopedic surgery. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The AVS (after visit summary) for 3/20/24 to 3/28/24 under other instructions for additional discharge instructions to patient documents NWB (non weight bearing) to left LE (lower extremity). Pin site cares with 1/2 NS (normal saline) and 1/2 hydrogen peroxide BID (twice daily). Elevate. Additional discharge instructions to patient documents NWB to LLE (left lower extremity). Elevate. Pin site care BID with 1/2 strength hydrogen peroxide and normal saline. Dressing changes daily to incision with nonstick gauze, 4 x (by) 4, and wrap. Surveyor reviewed R13's March 2024 TAR (treatment administration record) and noted the facility did not implement treatment to R13's left extremity until 3/31/24. The facility did not follow the hospital AVS recommendations/orders as facility treatment with a start date of 3/30/24 documents: LLE external fixator pin sites. Swab pin sites with betadine and allow to dry twice daily. R13's left heel wound treatment of cleanse with NS pat dry. Skin prep peri wound, apply Santyl nickel thick to base of wound bed. Cover with gauze dressing and wrap with kerlix was not implemented until 3/30/24, two days after admission. The nurses note dated 3/28/24, at 14:35 (2:35 p.m.) documents: Arrived at facility at 1340 (1:40 p.m.) via ambulance from [hospital initials]. VSS (vital signs stable). hospitalized for L (left) ankle fx (fracture). Pins in place. PMH (past medical history) COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), elevated lipids, DM (diabetes mellitus), uterine cancer stage 4 with mets, currently chemo on hold. Transferred to bed with assist of 2. A & O (alert and orientated) times 3/4. Son present. This nurses note was written by RN (Registered Nurse)-FF. The nurses note dated 3/29/24, at 18:43 (6:43 p.m.), includes documentation of .Left leg dressing C/D/I (clean/dry/intact) with brace in place . This nurses note was written by LPN (Licensed Practical Nurse)-GG. The care plan [R13's first name] has impaired skin integrity related to L (left) heel wound, and LLE (left lower extremity) surgical site present upon admission documents the following approaches: * Provide treatment as ordered. Start date 3/30/24. * Pressure reducing cushion to chair Describe: WC (wheelchair) cushion. Start date 3/30/24. * Keep skin clean and dry. Start date 3/30/24. The nursing note dated 3/30/24, at 04:13 (4:13 a.m.), Pt (patient) new admit to unit after hospitalization for left ankle fx. Pt is alert and oriented with some forgetfulness noted. Has external pins to left ankle. Pt. states she has no feeling to top of left foot and 4 toes. Pt has a noted missing left great toe. Pt. states it has been amputated some time ago. Pt. states bil. (bilateral) great toes have been amputated. Denies any pain or discomfort. No apparent injury sustained from lowering to floor on PM (evening) shift. Pt. resting quietly in bed at this time. left leg on pillow. This nurses note was written by Nursing-OO. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The nurses note dated 3/31/24, at 21:52 (9:52 p.m.), documents Resident alert. Able to make needs known. Lungs clear. Denies sob (shortness of breath). No c/o (complaint of) pain noted. Left leg with pins and rods attached. Left heel wound dressing changed. Left surgical leg elevated. Requires assist of 2 with Hoyer transfers. This nurses note was written by LPN-Y. The admission MDS (minimum data set) with an assessment reference date of 4/2/24 has a BIMS (brief interview mental status) score of 14 which indicates R13 is cognitively intact. R13 is assessed as requiring substantial/maximal assistance for toileting hygiene, partial/moderate assistance for rolling left & right & toilet transfers. R13 is always continent of bowel and urine. R13 is checked for diabetic foot ulcer and surgical wound. The nurses note dated 4/6/24 at 21:33 (9:33 p.m.) documents Resident alert, pleasant and cooperative. Able to make needs known. Lungs clear. Denies sob (shortness of breath). Resident has pins and screw to lle (left lower extremity). No c/o pain noted. Area cleaned and wrapped. No apparent injuries noted r/t (related to) fall. This nurses note was written by LPN-Y. The nurses note dated 4/17/24, at 15:56 (3:56 p.m.), documents Resident out on surgical appointment at before 630 a.m. Writer got update from hospital resident will come tomorrow. This nurses note was written by RN-L. The nurses note dated 4/18/24, at 14:16 (2:16 p.m.), documents Patient transferred back at 1300 (1:00 p.m.) by [Name of] Ambulance. No complaints of pain, MD (Medical Doctor) updated. All vital signs stable. Admission tasks started. This nurses note was written by RN-PP. The care plan [R13's first name] has impaired skin integrity related to L (left) heel wound, and LLE (left lower extremity) surgical site present upon admission documents the following approaches: * Provide treatment as ordered. Start date 4/18/24. * Pressure reducing cushion to chair Describe: WC (wheelchair) cushion. Start date 4/18/24. * Keep skin clean and dry. Start date 4/18/24. * Specialized mattress on bed. Type: Pressure relief air mattress, check setting (2) and inflation Q (every) shift. Only one barrier between body and mattress, CHUX of sic (or) Brief Not Both. Start date 4/18/24. The nurses note dated 4/20/24 at 21:05 (9:05 p.m.) documents Resident alert. Able to make needs known. Lungs clear. Denies sob. Resident c/o pain to left surgical leg. Sutures intact. No warmth noted. Left heel wound improving. Dressing changed. Cam boot on. This nurses note was written by LPN-Y. The nurses note dated 5/7/24, at 14:10 (2:10 p.m.), documents Patient went out for a consult with [Name] of WI (Wisconsin) for her left foot. Sutures remain in the bottom of the foot and to the lower heel area. New order received to keep Left ankle open to air as much as possible. Cam Boot when ambulating and place a non-stick gauze and wrap to lower leg when she wears the Cam Boot. Wound care consult. Follow up with [Name] of WI in 1 week. Patient dressing redone to the heel as it was coming off. This nurses note was written by RN-JJ. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The May 2024 TAR with a start date of 4/20/24 for Left Lateral Heel: Clean site with NS (normal saline), pat dry, cover with foam dressing q (every) 3 days and PRN (as needed) 1 Every 72 hours for change dressing every three days or if soiled as needed. Report any changes to MD. Surveyor noted this treatment is not initialed as being completed on 5/8/24, & 5/11/24. The nurses notes dated 5/14/24, PM (evening shift), documents Resident went out for an appointment for (L) foot wound, was referred to the hospital and got admitted at [Name of Hospital]. This nurses note was written by LPN-QQ. The hospital ED (emergency department) dated 5/14/24 includes documentation of Seen by wound care for wound check to LLE prior to arrival. Redness, drng (draining), open wound x (times) 1 week. Under updates documents 5/14/24 1308 (1:08 p.m.) Severe sepsis secondary to cellulitis post operative infection. Patient was given broad spectrum antibiotics WBC (white blood count) 13.12, Lactate 2.9. Xrays demonstrate periprosthetic fracture. Call placed to [Physician's name], ortho. SKIN ASSESSMENTS: Left Leg: Origin date: 3/29/24, charting date 3/29/24 category documents skin condition, description documents fracture of the left ankle. There are no measurements documented. On the body diagram there is a X on the left upper thigh. This assessment was completed by LPN (Licensed Practical Nurse)-QQ. Origin date: 3/29/24, charting date 4/1/24, category documents skin condition, description documents fracture of the left ankle. There are no measurements documented. On the body diagram there is a X on the left upper thigh. This assessment was completed by RN-II. Surveyor was unable to locate evidence of any further assessments for the left upper thigh. Surveyor was unable to locate any assessments of R13's left ankle pin site. Left Heel: Origin date: 3/29/24, charting date 3/29/24, category is skin condition, cause is trauma, measurements documents length is 5.0 cm (centimeters), width 3.0 cm, depth UTD (unable to determine). Wound edge is documented as irregular. Eschar is 50%, slough 50% and granulation is 0. This assessment was completed by RN-II. Origin date: 3/29/24, charting date 4/5/24, category is skin condition, cause is trauma, measurements documents length is 5.0 cm (centimeters), width 3.0 cm, depth UTD (unable to determine). Wound edge is documented as irregular. Eschar is 50%, slough 50% and granulation is 0. This assessment was completed by RN-II. Surveyor was unable to locate evidence of any further assessment after 4/5/24 for R13's left heel wound. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/18/24, at 9:43 a.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-AA about R13. RN/UM-AA informed Surveyor R13 was on the floor but R13 left the day before she got here. RN/UM-AA informed Surveyor she has heard R13's name but doesn't know anything about her. On 7/18/24, at 9:45 a.m., Surveyor asked CNA (Certified Nursing Assistant)-DD if R13 wore a boot. CNA-DD replied yes she had to wear the boot. Surveyor asked when R13 would wear this boot. CNA-DD informed Surveyor anytime R13 was bearing weight on that foot. Surveyor asked CNA-DD if she remembers R13 having wounds. CNA-DD informed Surveyor R13 had a wound on the heel with that boot and was pretty sure it was the left heel. On 7/18/24, at 9:53 a.m., Surveyor asked PTA (Physical Therapy Assistant)-EE if R13 had any wounds on her foot. PTA-EE replied yes she did. Surveyor inquired if therapy did anything with R13's wounds. PTA-EE replied nursing generally does wound care. Surveyor asked PTA-EE if R13 ever voiced any concerns about her wounds. PTA-EE replied yes she did and there were days when we had to take it easier. PTA-EE informed Surveyor some days she didn't feel comfortable standing as her foot hurt. On 7/18/24, at 10:40 a.m., Surveyor asked DON (Director of Nursing)-B if she knew R13. DON-B informed Surveyor the day she came back to the facility, R13 went out to the hospital. DON-B informed Surveyor she doesn't have any information regarding R13. On 7/18/24, at 11:00 a.m. Surveyor asked COTA/DOR (Certified Occupational Therapy Assistant/Director of Rehab)-N if R13 had any wounds on her foot. COTA/DOR-N informed Surveyor she knew she had a surgical site. On 7/18/24, at 12:22 p.m., Surveyor asked NHA (Nursing Home Administrator)-A for all R13's wound assessments while she was at the facility from 3/28/24 to 5/14/24. On 7/22/24, at 8:35 a.m., NHA-A provided Surveyor with R13's wound assessments. Surveyor reviewed the wound assessments. Surveyor was not provided with any assessments for R13's left upper thigh after 4/1/24, was not provided with any assessments for R13's left ankle pin site, and was not provided with any assessments for R13's left heel after 4/5/24. R13 was discharged from the facility on 5/14/24. On 7/22/24, at 9:15 a.m., Surveyor spoke with LPN-GG on the telephone. Surveyor asked when a resident is admitted to the facility who reviews the discharge summary to ensure the hospital treatment is transcribed and started. LPN-GG informed Surveyor she's not a regular nurse at the facility and doesn't know. On 7/22/24, at 9:55 a.m., Surveyor asked DON-B when a resident is admitted to the facility who reviews the hospital records to ensure the hospital treatment is transcribed and started. DON-B informed Surveyor the nurses of course as well as the nursing manager and she also reviews it. Surveyor inquired if they follow the hospital treatment orders. DON-B explained they have to call the doctor and verify orders. They let them know the resident is a new admission, diagnoses and medication, and treatments. They will ask the doctor if they should continue the treatment or change it. The doctor will tell us to get a wound consult and the wound doctor may change the treatment unless the wound is surgical then he won't mess with that. Surveyor asked DON-B who Surveyor could speak with regarding R13. DON-B informed Surveyor she remembers when she came back on the 15th (May 15) R13 wasn't here. DON-B informed Surveyor name of LPN-Y was here and the majority of the nurses are agency. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/22/24, at 10:01 a.m., Surveyor spoke to LPN-Y regarding R13. LPN-Y informed Surveyor she remembers R13's ankle, left heel was broken up. Surveyor asked LPN-Y if she was involved with admitting R13. LPN-Y replied no. Surveyor asked when a resident is admitted who reviews the hospital information. LPN-Y informed Surveyor it would be the floor nurse and then go to the manager. Surveyor informed LPN-Y R13 was admitted on [DATE] but her treatment for her left heel didn't start until 3/30/24 and pin site until 3/31/24. LPN-Y replied can't answer that. Surveyor inquired about the treatment for R13's pin sites as the hospital ordered 1/2 normal saline and 1/2 hydrogen peroxide and the facility's order was betadine. LPN-Y informed Surveyor she sees the order but she doesn't change the order. LPN-Y informed Surveyor this order is definitely not from her. Surveyor asked LPN-Y if there was anyone Surveyor should speak with. LPN-Y informed Surveyor the nurse who wrote the order is no longer here. Surveyor asked LPN-Y if she was involved with R13's wound assessments. LPN-Y replied not so much with wound assessments and explained if she found something she would notify the nurse manager and DON at that time. Surveyor informed LPN-Y Surveyor has for the left heel only assessments dated 3/29/24 & 4/5/24 and left leg 3/29/24 & 4/1/24. LPN-Y informed Surveyor that's what I'm seeing. Surveyor asked LPN-Y if she is able to locate any assessment for R13's left ankle. LPN-Y replied no, I don't see any. On 7/22/24, at 10:23 a.m., Surveyor spoke with Physician-RR on the telephone. Surveyor asked Physician-RR if he recalls changing R13's treatment to the pin sites when R13 was admitted on [DATE]. Physician-RR replied you know what, I don't know, explaining the facility has went through a lot of changes. Physician-RR informed Surveyor he saw R13 on 3/28/24 & 4/18/24. Physician-RR informed Surveyor he has to actually copy the orders into his notes as he can't upload into [name of computer system]. Physician-RR informed Surveyor he just wrote the note per wound service and how they changed that he doesn't know. Physician-RR informed Surveyor when he receives a call for wounds with specific questions he tells the staff to call the wound service. On 7/22/24, at 1:10 p.m., Surveyor informed NHA-A R13 was admitted on [DATE] and treatments for the pin sites didn't start until 3/31/24 and left heel treatment did not start until 3/30/24. The facility did not follow the treatment recommended by the hospital for the pin sites and the nurse who wrote the order is no longer at the facility. There are no assessments for the left heel after 4/5/24, the left upper thigh after 4/1/24, and there are no assessments for the left ankle pin site. R13 was transferred to the hospital after a wound appointment and was admitted with severe sepsis. NHA-A informed Surveyor he had given Surveyor R13's left ankle assessments. Surveyor informed NHA-A Surveyor has not received any assessments for the left ankle. Surveyor informed NHA-A it's Surveyor's understanding R13 was not seen by Wound Doctor-W. NHA-A reviewed Wound Doctor-W's assessments and verified R13 was not seen by Wound Doctor-W. 38829 2.) R25 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis, Type 1 Diabetes Mellitus, Alcoholic Cirrhosis of Liver with Ascites. Legal Blindness, Acquired Absence of Right Leg Below Knee, Kidney Transplant, Pancreas Transplant, and Depression. R25's Admission MDS completed on 2/23/24 documents R25 has a Brief Interview for Mental Status(BIMS) score of 11, indicating R25 demonstrates moderately impaired skills for daily decision making. R25's MDS also documents that R25 has an indwelling catheter, is on a mechanically altered diet with a feeding tube, has range of motion impairment on 1 side of lower extremity, requires partial/moderate assistance for mobility and substantial/maximum assistance for transfers. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility's Accidents and Incidents-Investigating and Reporting for Residents dated 12/2016 and last revised 1/2020 documents: .Policy Statement Accidents or incidents involving Residents shall be investigated and reporting completed, per State and Federal requirements. Policy Interpretation and Implementation C. If the Resident sustains a witnessed head trauma or an unwitnessed fall, the Resident should be observed for neurological abnormalities. Neurological checks are initiated and completed for 72 hours. If abnormal symptoms occur, the health care provider should be notified. On 7/16/24, at 1:49 PM, Surveyor reviewed R25's unwitnessed fall investigation. R25 was trying to reach for a Gatorade, forgot R25 had 1 leg, and fell in the process. R25 was helped off the floor and placed back in bed. Surveyor is unable to locate any neurological checks (neuro checks) completed for R25's 6/30/24 unwitnessed fall in R25's medical record. On 7/17/24, at 7:26 AM, Surveyor interviewed Unit Manager (UM)-J. UM-J confirmed that if a resident has an unwitnessed fall, that neuro checks should be completed. Surveyor shared that Surveyor is unable to locate the neuro checks for R25's unwitnessed fall on 6/30/24. UM-J stated UM-J will look for R25's neuro checks. On 7/17/24, at 3:51 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that there are no documented neuro checks for R25's 6/30/24 unwitnessed fall. No further information was provided at this time by the facility. The facility has been unable to provide completed neuro checks for R25's 6/30/24 unwitnessed fall. On 7/22/24, at 9:07 AM, Surveyor interviewed Director of Nursing (DON)-B in regards to neuro checks. DON-B stated that neuro checks are documented on paper. DON-B stated the initial neuro check is completed right after the fall. DON-B then stated that neuro checks should be every 15 minutes times 4, every 30 minutes times 4, every hour times 4, and once a shift (3) for 3 days. DON-B confirmed that all neuro checks should be completed with all unwitnessed falls. Surveyor shared the concern with DON-B that neuro checks have not been located for R25's 6/30/24 unwitnessed fall. DON-B stated DON-B will need to look for R25's neuro checks. On 7/22/24, at 2:47 PM, Surveyor received from NHA-A neuro checks for R25. Surveyor notes the initial neurological check is completed. There are only 2 15-minute neuro checks completed, not 4. There are only 2 30-minute neuro checks completed, not 4. There are only 2 every hour assessments completed, not 4. Only 1 shift is completed with a date of 6/30/24. 2 shifts for 7/2/24 completed with 1 not signed and 2 shifts dated 7/3/24 that are not signed. Surveyor notes there are no documented neuro checks completed for 7/1/24. Surveyor shared with NHA-A that R25 not having neuro checks completed for R25's 6/30/24 fall remains a concern. NHA-A had no further information at this time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/29/24, at 12:33 PM, Surveyor reviewed additional information provided by the facility after the survey process was completed. Surveyor noted the submitted forms reviewed do not identify a resident name or room number on the forms. Surveyor continues to have concerns that R25's neuro checks are not completed per procedure of the facility that was provided by the DON-B on 7/22/24.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation, interview, and record review the facility did not ensure each resident (R) received adequate supervision and assistance devices to prevent accidents for 3 (R29, R25, and R13) of 4 residents. *R29 had an injury of unknown origin of bruising to left eye on 5/2/24. On 5/16/24, R29 had bruising to right eye and right foot. R29 sustained a laceration requiring 2 stitches between the right big toe and second toe and had an acute fracture in the proximal phalanx of the first digit. On 6/3/24, R29 sustained an acute impacted fracture at the distal femur. The facility stated the injuries were by different safety concerns that were not assessed or thoroughly investigated to prevent future injury. *R25 had a fall on 6/30/24 and the intervention of having a reacher accessible was put in place. *R13 was transferred by 1 staff instead of 2 by Hoyer lift and was lowered to the ground on 3/29/24. Findings Include: The facility's Accidents and Incidents-Investigating and Reporting for Residents dated 12/2016 and last revised 1/2020 documents: .Policy Statement Accidents or incidents involving Residents shall be investigated and reporting completed, per State and Federal requirements. Policy Interpretation and Implementation A. The nurse should promptly initiate and document investigation of the accident or incident. B. The following information shall be included in the investigation, as applicable. 1. The date and time the accident or incident took place. 2. The nature of the injury, if indicated. 3. The circumstances surrounding the accident or incident. 4. Where the accident or incident took place. 5. The name(s) of witnesses and their accounts of the accident or incident. 6. The Resident's account of the accident or incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7. The time the Resident's Health Care Provider was notified, as well as the time the Health Care Provider responded and his/her instructions. 8. The date/time the Resident representative was notified and by whom. 9. The condition of the Resident, including vital signs. 10. The disposition of the Resident. 11. Interventions initiated. 12. Follow-up information. 13. Other pertinent data as necessary or required. 14. The signature and title of the associate completing the report. D. Document the accident or incident in the Resident's clinical record, including health care provider and legal representative notification. E. The Health Care Administrator, Director of Nursing, or designee, shall initiate reporting per state and federal requirements and internal reporting. 1.) R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia, and Anxiety Disorder. R29 has an activated Health Care Power of Attorney (HCPOA) effective 9/16/2019. R29 has been receiving hospice service since 4/24/23. R29's Annual MDS dated [DATE] documents R29 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R29's MDS also documents that R29 is at risk for developing skin issues and has no current skin issues, osteoporosis is not documented as a current diagnosis, R29 is receiving scheduled pain medications, and that a pain interview can be completed but then it's documented that R29 is unable to answer any questions. R29's MDS documents R29 has range of motion impairment on both upper and lower extremities on both sides and that R29 is dependent for assistance with eating, hygiene, mobility, and transfers. R29's fall Care Area Assessment (CAA) dated 4/3/24 documents that R29 entered hospice on 4/24/23 and is either chair or bedfast due to dementia, anxiety, and anemia. Staff anticipates the resident's needs. Staff will continue to monitor and report any concerns. R29's comprehensive care plan has the following documented: 1. (R29) has potential for falls related to recent admission to community with the following interventions: -Keep pathways clear and provide adequate lighting 4/24/23 -Keep personal items within reach 4/24/23 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Orient to room and call light 4/24/23 -Low bed 4/24/23 -Encourage gripper socks when up 4/24/23 2. (R29) has potential for falls related to medication use, history of falls, decreased mobility and dexterity, poor safety awareness with the following interventions: -Provide proper non skid footwear 4/24/23 -Place fall mat beside the bed 4/24/23 -Place bed in lowest position while in bed 4/24/23 -Encourage to attend activities of choice 4/24/23 -Keep personal items within reach 4/24/23 -Keep room neat, orderly, and organized 4/24/23 -Proper peri care provided, R29 repositioned and replaced in bed 6/16/23 -Offer and assist to get up in Broda chair to common/supervised areas if observed awake during last night rounds 12/27/23 The following is documented in the hospice Skilled Nursing Visit Notes for R29: On 5/2/24, Hospice Registered Nurse (HRN)-S documented that HRN-S noted bruising to R29's left eye. The facility did not call hospice reporting any injuries or falls. HRN-S and hospice home health aide noticed bruising to R29's left eye and left breast as well prior to showering. HRN-S spoke with facility nurse and reported the bruising. Facility nurse stated she did not get that during report and was not told anything about bruising. HRN-S attempted to find Director of Nursing (DON)-B and facility social worker (SW)-O, however, neither present in their office. HRN-S found the facility Nursing Home Administrator (NHA)-A and reported the bruising. NHA-A asked HRN-S and HHA (Home Health Aide) for a statement. HRN-S wrote statement of finding the bruising prior to cares being provided by hospice. HRN-S updated activated HCPOA who stated that HCPOA noticed the bruising yesterday evening and thinks it could be from the Hoyer lift. HCPOA had several concerns about the facility that was shared and HRN-S told HCPOA to express the concerns to NHA-A and DON-B. Surveyor reviewed R29's facility nursing progress notes. There is no documentation located in R29's medical record and notes prior to 5/2/24 of R29 having bruising to the left eye. On 5/12/24, there is facility documentation that R29 is noted to have bruising to the right eyelid. On 5/15/24, there is facility documentation that DON-B was notified about a cut under the right great toe and dressing applied. Per DON-B, R29 is to be added to the facility wound MD list. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/16/24, HRN-S documents new bruising is noted to R29's right eyelid. Bruising is from unknown origin. R29's left eyelid remains bruised and appears purple in color suggestive of a newer bruise occurring again. DON-B completed an investigation and found R29 to be combative and capable of hitting self to create a bruise. HRN-S noted a large bruise to R29's right foot which was not reported to Hospice. R29's toes have dried blood on them as well. R29 screaming in pain when HRN-S touches foot. Shower completed. HRN-S cleansed R29's foot to assess where the bleeding was occurring. Licensed Practical Nurse (LPN)-M entered shower room and assessed R29's foot while 4 staff members held R29. Picture from LPN-M's phone of R29's foot revealed R29 had a deep laceration in between R29's right great toe and second toe. HRN-S found previous DON and new Unit Manager from the 3rd floor. HRN-S discussed new injuries and concerns related to R29. Previous DON reports hearing about a cut that an LPN wrapped yesterday. HRN-S showed previous DON the picture of the laceration and expressed that it potentially needed stitches. Director of Nursing (DON)-B entered room and HRN-S explained situation. DON-B and and new RN manager went to the 2nd floor to conduct an investigation. DON-B completed initial investigation and reports that the Broda chair has a cap missing which could have cut R29's foot. DON-B also reports R29 being combative and could have kicked or bumped into something. HRN-S updated NHA-A who states NHA-A is aware of an investigation already being conducted and that R29 is combative so perhaps R29's medications need to be adjusted. HCPOA decided to have R29 transferred to the emergency room for stitches and a foot x-ray. HRN-S documents in the hospice Interdisciplinary Group Meeting dated 7/3/24 that on 5/16/24, R29 was transferred to the emergency room and received 2 sutures and surgical glue to the laceration. Surveyor noted there is no indication the facility reviewed R29's Broda chair or made repairs, or investigated to determine how R29's foot sustained a laceration from the Broda chair to prevent future accidents. On 5/21/24, HRN-S attempted to assess R29's feet, but R29 became agitated and yelled when HRN-S attempted to do so. Updated DON-B and NHA-A regarding visit. DON-B and NHA-A tell HRN-S that they believe R29's chair caused the injury to R29's right toe. HRN-S placed a new order for another chair from the DME company. HRN-S asked DON-B if R29's behaviors have been unmanageable for the facility staff. DON-B denied R29's behaviors as being challenging and told HRN-S that no medication adjustments were necessary at this time. On 5/22/24, an x-ray is obtained by hospice of the right foot. The finding is an acute fracture in the proximal phalanx of the first digit. Surveyor notes there is no facility documentation addressing R29's right great toe fracture. The care plan for R29 documents: (R29) has a diagnosis of osteopenia with a history of fractures presented 5/22 and 6/3/24. -Broda chair will be used to support trunk weakness with pillows in use as needed 5/22/24 -Hoyer lift will be used for safe transfers with a 2 person assist 5/22/24 -Limbs and extremities will be clear of entanglement of slings, gait belts, clothing, blanket, sheet, or anything else that could endanger (R29) 5/22/24 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-(R29) will have a facility staff accompany hospice staff for any and all visits 5/22/24 -Per MD orders as of 6/5/24 as discussed in the care conference, (R29) will be on permanent bedrest due to transitioning -Remove immobilizer every shift (qs) for skin assessment 5/22/24 On 5/23/24, HRN-S documented that facility SW-O, DON-B, and R29's family along with HRN-S discussed R29's injuries. Facility staff present stated that they believe the injuries were self inflected and occurring from R29's chair. New chair was delivered. Facility reports that caregivers have been using the Hoyer lift without 2 people. R29's care plan was discussed. R29 will always be a 2 person assist according to facility. On 5/30/24, HRN-S documents HCPOA called HRN-S on 5/28/24 regarding R29's knee possibly needing an x-ray. HCPOA reports R29's knee was swollen over that weekend and that R29 needed morphine. HRN-S notified DON-B who assessed R29 and told HRN-S that DON-B's assessment did not reveal any abnormalities. HRN-S attempted to assess R29's knees on 5/29/24, however, R29 was up in Broda chair resting comfortably and anytime HRN-S attempted to touch R29, R29 cried out. HRN-S assessed R29's knees during visit today. R29's right knee is notably swollen compared to R29's left knee. DON-B made aware and assessed the knee with HRN-S. DON-B reports that R29 often crosses R29's knees which could cause swelling or perhaps R29 has fluid on R29's knee. ROM was attempted by HRN-S, however, R29 is unable to lift R29's right leg off of the bed which is new. HRN-S attempted to move R29's lower extremity, but R29 yelled out in pain, crying, it hurts. HRN-S updated hospice physician. Orders received for X-rays of R29's femur and tibia/fibula. Complete bed rest until x-ray results are in. On 6/1/24, an x-ray of R29's right tibia and fibula was obtained. On 6/3/24, HRN-S documents upon arrival, R29 was lying in bed favoring R29's right side with eyes closed. R29 also said, ouch, it hurts when cares were not being provided, but would not tell HRN-S where it hurt. X-ray results were faxed to hospice today. R29's right distal femur is fractured. HRN-S notified hospice leadership and team members, facility leadership and caregivers, and R29's HCPOA. Hospice physician ordered scheduled morphine and non-weight bearing to right lower extremity and discontinued Tramadol. Per hospice physician, R29 can be up as tolerated via the Hoyer lift. HRN-S communicated these new orders with DON-B and NHA-A. HRN-S explained that R29 should be considered bedrest, but that R29 could get up as tolerated. HRN-S gave an example of R29 not having pain and R29 actively attempting to get out of bed. Those would be signs that R29 could tolerate getting transferred into R29's Broda chair. NHA-A asked if NHA-A should be getting up at all and HRN-S explained no unless R29 would have a significant improvement. Facility leadership will conduct another investigation from the unknown origin of the injury. On 6/3/24, the x-ray results document there is an acute impacted fracture at the distal femur. No evidence of osteomyelitis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted the facility indicated R29's injuries were caused either by missing/damaged parts to R29's Broda chair, the facility notes staff were not transferring R29 with the correct amount of staff for safety, and implied R29 may have been sustaining injury/bruising from holding a hard doll too tight. None of the possible safety concerns were thoroughly assessed by the facility with a root cause analysis to prevent future safety concerns. On 7/17/24, at 8:55 AM, Surveyor reviewed a statement dated 6/5/24 written by R29's primary physician (MD)-U. MD-U documents R29 has a pathological right distal diaphyseal fracture of the right femur, most likely secondary to osteoporosis per history, non traumatic. Surveyor noted R29 does not have a diagnosis of osteoporosis and xray results reference osteopenia as being present (this is less severe than osteoporosis). On 7/18/24, at 9:32 AM, Surveyor interviewed DON-B in regards to R29. DON-B confirmed the bruising on the left eye but does not recall bruising on the right eye. On 7/18/24, at 9:47 AM, Surveyor interviewed DON-B again in regards to R29. DON-B explained the chair R29 was using was supposed to have a cover on the clamp, but did not and there were sharp edges. DON-B stated R29 moves around a lot and staff needed to make sure a pillow was in place when R29 was up in the chair. DON-B thinks R29's pillow probably fell out and R29 sustained a clean straight cut. DON-B stated both caps were off and the edges were sharp as a razor blade. DON-B stated DON-B sent R29 to the ER because DON-B was very concerned about the injury and needed to know what happened. DON-B stated DON-B could not obtain any answers from talking with staff. DON-B confirmed that DON-B was notified of the first x-ray that stated the injury was acute and wanted to get a second opinion. DON-B was informed that R29 has severe osteopenia and staff should be very careful with R29 and wouldn't be surprised if R29 has more fractures. DON-B stated the intervention was to keep R29 on bedrest. On 7/18/24, at 11:20 AM, Surveyor made observations with HRN-S of R29's chair. R29's Broda chair was located in R29's bathroom and had black plastic caps on either side. Surveyor and HRN-S made observations of 2 empty Broda chairs pushed at the end of the hallway. The 2 Broda chairs are identical to R29's new Broda chair. Both chairs have missing black caps on either side. Surveyor observed pointy, jagged metal on either side. The jagged metal on each side is very sharp and uneven to the touch. On 7/18/24, at 12:21 PM, Nursing Home Administrator (NHA)-A informed Surveyor there is no hospital record from R29's visit to theER on [DATE] because the computer system was down. On 7/18/24, at 10:27 AM, Surveyor interviewed R29's primary physician MD-U over the phone. MD-U stated that the conclusion was R29 has severe osteoporosis and can have spontaneous fractures due to R29's bones being brittle. On 7/18/24 at 3:42 PM, Surveyor shared with NHA-A the concern that R29 had an injury of unknown origin resulting in bruising to left and right eye, and the fracture of the right great toe and the right femur fracture. NHA-A stated the fractures are a result of R29's osteoporosis. Surveyor expressed the concern if the facility knew R29 was susceptible to fractures, what was the facility doing to prevent R29 from injury? At this time, NHA-A had no further information. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/22/24, at 1:23 PM, Surveyor interviewed NHA-A in regard to R29's injuries. Surveyor requested any additional information that NHA-A had on R29's injuries Surveyor notes the facility submitted a self report to the state agency dated 6/11/24 in regard to R29's femur fracture. Surveyor asked NHA-A about the documented statement in the self report summary stating, Furthermore, on 5/16, R29 had a Broda chair transfer incident in which R29's right foot got caught up in the foot rest. A signed grievance dated 5/23/24 by NHA-A documents that the bruising to R29's eyes were self inflicted by R29. The intervention for R29's fractures was the buddy system. Surveyor notes implementing the buddy system is not on R29's CNA worksheet or comprehensive care plan. NHA-A stated the right great toe fracture may be related to getting caught between the foot rest and side of Broda chair and the femur fracture is related to R29's diagnosis of osteoporosis. 2) R25 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis, Type 1 Diabetes Mellitus, Alcoholic Cirrhosis of Liver with Ascites, Legal Blindness, Acquired Absence of Right Leg Below Knee, Kidney Transplant, Pancreas Transplant, and Depression. R25's Admission MDS completed on 2/23/24 documents R25 has a Brief Interview for Mental Status (BIMS) score of 11, indicating R25 demonstrates moderately impaired skills for daily decision making. R25's MDS also documents that R25 has an indwelling catheter, is on a mechanically altered diet with a feeding tube, has range of motion impairment on 1 side of lower extremity, requires partial/moderate assistance for mobility, and substantial/maximum assistance for transfers. R25's Care Area Assessment (CAA) dated 2/23/24 documents R25 is at significant risk for falls related to fall assessments. R25 has had two fall assessments completed: 2/20/24-fall risk assessment completed on admission has a score of 39 indicating significant risk for falls 6/30/24-fall risk assessment completed after R25's fall has a score of 27 indicating moderate risk for falls. On 7/16/24, at 1:49 PM, Surveyor reviewed R25's unwitnessed fall investigation. R25 was trying to reach a Gatorade, forgot R25 had 1 leg, and fell in the process. R25 was helped off the floor and placed back in bed. A root cause analysis was completed and the intervention was to provide R25 with a reacher. Surveyor is unable to locate a registered nurse (RN) assessment to rule out any injuries of R25 prior to moving R25 off the floor and back into bed. R25's Certified Nursing Assistant (CNA) Worksheet as of 7/16/24 documents that R25 is a fall prevention program participant and reacher assist device is to be accessible as of 6/30/24. R25 has a potential for falls care plan established 2/19/24 with the following interventions: -Keep pathways clear and provide adequate lighting -Keep bed at the appropriate height (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Keep personal items within reach -Transfer per intake information until seen by therapy, then follow therapy recommendations/plan of treatment -Orient to room -Encourage to wear gripper socks -Monitor orthostatic blood pressures as needed-added 2/20/24 -Provide comfort measures/pain management as needed-added 2/20/24 -Fall prevention program participant-added 2/20/24 -Reacher assist device accessible-provided by therapy department-added 7/2/24 On 7/15/24, at 2:24 PM, Surveyor observed R25 in bed eating lunch and Surveyor does not observe a reacher at R25's bedside, within reach. On 7/16/24, at 11:52 AM, Surveyor observed no reacher at R25's bedside and cannot find one anywhere in R25's room. R25 informed Surveyor that R25 does not know where the reacher is. On 7/17/24, at 7:12 AM, Surveyor observed no reacher at R25's bedside, within reach On 7/17/24, at 7:35 AM, Surveyor interviewed Director of Rehabilitation (DOR)-N. DOR-N recalls providing R25 with a reacher. On 7/17/24, at 8:09 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K who believes CNA-K saw R25's reacher last week. CNA-K and Surveyor went into R25's room and CNA-K was able to locate R25's reacher which was in the corner of the room, behind a chair, on the floor, and not accessible to R25. On 7/17/24, at 3:53 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern that there is no documented RN assessment for injury after R25's 6/30/24 unwitnessed fall, and the intervention of having a reacher accessible for R25 has not been observed for 3 days during the survey process. No further information was provided by the facility at this time. 20483 3.) R13 was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses include fracture of left ankle, diabetes mellitus, coronary artery disease, chronic kidney disease, osteomyelitis of left ankle, peripheral vascular disease, and cellulitis of the left leg. The hospital AVS (after visit summary) for 3/20/24 to 3/28 under other instructions for additional discharge instructions to patient documents: NWB (non weight bearing) to left LE (left extremity.) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The potential for fall care plan documents the following approaches with a start date of 3/28/24 * Keep pathways clear and provide adequate lightening. * Keep bed at the appropriate height. * Keep personal items within reach. * Transfer per intake information until seen by therapy, then follow therapy recommendations/plan of treatment. * Orient to room and call light. The [R13's first name] has fall history documents the following approaches with a start date of 3/29/24: * Monitor Orthostatic BPs (blood pressure) as needed. * Provide proper non skid footwear. * Place fall mat beside the bed. * Therapy review transfer status. The nurses note dated 3/28/24, at 14:35 (2:35 p.m.), documents: Arrived at facility at 1340 (1:40 p.m.) via ambulance from [hospital's initials]. VSS (vital signs stable). hospitalized for L (left) ankle fx (fracture). Pins in place. PMH (primary medical history) COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), elevated lipids, DM (diabetes mellitus), uterine cancer stage 4 with mets, currently chemo is on hold. Transferred to bed with assist of 2. A & O (alert and orientated) times 3/4. Son present. This nurses note was written by RN (Registered Nurse)-FF. The [NAME] fall risk assessment dated [DATE] has a score of 14. A score of 0-15 is minimal risk for falls. The nurses note dated 3/29/24, at 18:43 (6:43 p.m.) documents resident had witnessed fall. CNA (Certified Nursing Assistant) was transferring resident from chair to bed. Resident had unsteady gait so CNA eased resident to the floor. Resident was sitting on the floor with back behind the chair. Resident alert and oriented x (times) 3. No c/o (complaint of) pain noted. No injury noted. Denies hitting her head. ROM (range of motion) WNL (within normal limits). Left leg dressing C/D/I (clean/dry/intact) with brace in place. B/P (blood pressure) 142/55, P (pulse) 65, R (respirations) 18, SPO2 95% ra (room air). T (temperature) 98.0. [Physician name] was here and assessed resident. This nurses note was written by LPN (Licensed Practical Nurse)-GG. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R13's fall investigation dated 3/29/24. Surveyor noted the fall occurrence interview-staff dated 3/29/24 for CNA (Certified Nursing Assistant)-HH for the question how did you find out this resident fell documents, I lowered her to the floor. For the question what was the resident doing at the time of the fall documents, Transferring into bed. This interview was conducted by RN-II, who is no longer employed at the facility. The investigation does not address why CNA-HH transferred R13 by herself when at the time R13 was a Hoyer transfer and was non weight bearing. The SBAR (situation, background, assessment, recommendation) dated 3/29/24 for the change in condition, symptoms, or signs observed and evaluated is/are: documents fall. Under resident evaluation for 2. Functional status evaluation is checked for falls. Under describe symptoms or signs documents CNA eased her to the floor. This SBAR was completed by LPN-GG. On 7/18/24, at 9:43 a.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-AA if she remembers R13. RN/UM-AA informed Surveyor R13 was on her floor but she left the day before she got here. RN/UM-AA informed Surveyor she has heard her name but doesn't know anything about her. On 7/18/24 at 9:45 a.m. Surveyor asked CNA (Certified Nursing Assistant)-DD what she could tell Surveyor about R13. CNA-DD informed Surveyor when she first got here she was a Hoyer lift because of all the hardware on her foot, she worked with therapy and when R13 left she was a one assist. Surveyor asked CNA-DD when R13 was admitted to the facility was she total care. CNA-DD replied yes, total care. Surveyor asked CNA-DD if R13 had any falls while at the facility. CNA-DD informed Surveyor not that she was aware of. On 7/18/24, at 9:53 a.m., Surveyor spoke with PTA (physical therapy assistant)-EE and asked PTA-EE what he could tell Surveyor about R13. PTA-EE informed Surveyor R13 came in with a left external fixator, was non weight bearing for a while, she was weak, and very motivated to work with therapy. Surveyor asked PTA-EE when R13 was admitted what was her transfer status. PTA-EE replied Hoyer because of the external fixator. Surveyor asked if R13 was a Hoyer transfer during the entire stay. PTA-EE replied no did get weight bearing on that leg because the external fixator was taken out. Surveyor asked PTA-EE when R13's transfer status changed. PTA-EE informed Surveyor he didn't know. Surveyor asked PTA-EE if he could find out when R13 was no longer a Hoyer transfer and could bear weight. On 7/18/24, at 10:40 a.m., Surveyor asked DON (Director of Nursing)-B if she knew R13. DON-B informed Surveyor the day she came back, R13 went to the hospital and doesn't have any information regarding R13. On 7/18/24, at 11:00 a.m., Surveyor spoke with COTA/DOR (Certified Occupational Therapy Assistant/Director of Rehab)-N. COTA/DOR-N informed Surveyor R13 went back to the hospital on 4/17/24 to get the fixator removed and when she came back she was weight bearing as tolerated with a cam boot. COTA/DOR-N informed Surveyor she doesn't have a copy of the order but they all go into the system. Surveyor asked COTA/DOR-N if R13 was a Hoyer transfer on 3/29/24. COTA/DOR-N replied yes because she was non weight bearing with left foot and per the therapist at the end of her stay she was walking about 60 feet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525552	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/18/24, at 12:22 p.m., Surveyor asked NHA (Nursing Home Administrator)-A who Surveyor could speak with regarding R13's fall on 3/29/24 as at the time of the fall R13 was non weight bearing with a Hoyer lift and the CNA transferred R13 by herself. NHA-A informed Surveyor the staff here now weren't here. NHA-A informed Surveyor he will get the number of 3 staff who were here and see if they will speak with Surveyor. On 7/18/24, at 4:06 p.m., during the end of the day meeting Surveyor informed NHA-A Surveyor has a concern the facility's investigation for R13's fall on 3/29/24 does not address the CNA transferring R13 by herself when R13 was a Hoyer lift. Surveyor informed NHA-A R13 was a Hoyer lift transfer until 4/17/24 when she went to the hospital to have the external fixator removed. On 7/22/24, at approximately 8:00 a.m., NHA-A provided Surveyor with LPN-GG's name and phone number. Surveyor was not provided with any other staff to contact. On 7/22/24, at 9:15 a.m., Surveyor spoke with LPN-GG on the telephone. Surveyor informed LPN-GG Surveyor wanted to speak with her about R13 who had a fall on 3/29/24. Surveyor asked LPN-GG if she remembers R13. LPN-GG informed Surveyor she doesn't remember R13 and then informed Surveyor she remembers one time on the 3rd floor there was a resident who was lowered to the floor. LPN-GG informed Surveyor she was by herself and called the manager. LPN-GG informed Surveyor she wasn't sure if she did the SBAR or the manager did. Surveyor read LPN-GG her nurses note dated 3/29/24 and asked if she was involved in the investigation. LPN-GG replied no. LPN-GG informed Surveyor the manager was going to take care of everything. Surveyor inf [TRUNCATED]