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	04/01/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents' physician was notified when the residents were not administered their medications per the physician's order for 7 of 7 residents reviewed for physician notification Resident (R) R10, R18, R19, R23, R22, R21 and R17. This failure placed the residents at risk for unmet treatment needs and the physician notified to address the resident's treatment. Findings include: Review of the facility's policy titled, Administering Medications, revised 12/2024 revealed, Q. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document on the MAR or eMAR [electronic medication administration record] for that drug and dose .3. Notify health care provider (physician) of 2 consecutive refused doses .Y The policy did not address notification of the physician for mediation not being available to be administered. 1. Review of R10's Profile Face Sheet dated 03/28/25 and found in the Electronic Medical Record (EMR) under the Information tab indicated the resident was admitted to the facility on [DATE]. The resident's diagnoses included multiple myeloma, alcoholic cirrhosis of the liver, Congestive Heart Failure (CHF), Benign Prostatic Hyperplasia (BPH), Amyloidosis, and Chronic Obstructive Pulmonary Disease (COPD). Review of R10's quarterly Minimum Data Set (MDS) with an Assessment Reference (ARD) Date of 02/20/25 and found in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. Review of R10's Physician Orders dated 03/25/25 and found in the EMR under the Orders tab revealed current orders for the resident to receive Midodrine (a blood pressure medication) five milligram (mg) three times daily for blood pressure control, Calcium (a vitamin supplement) 600 mg twice daily, Finasteride (a medication used to treat BPH five mg daily, Atorvastatin (a cholesterol controlling medication) 40 mg daily for hyperlipidemia, Bumex (a diuretic medication) one mg daily for blood pressure control, and Acyclovir (an anti-viral medication) 400 mg twice daily for Amyloidosis. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R10's Medication Administration Records (MARs) dated 03/01/25 through 03/27/25 and found in the EMR under the Orders tab revealed R10 did not receive any of the above as scheduled on the 8:00 AM medication administration time on 03/10/25, 03/11/25, 03/15/25, 03/18/25, or 03/25/25. The MAR indicated the medications were not administered due to the resident being out of the facility. There was nothing to indicate any of the medications were given at a different time on any of the above dates. Review of R10's record revealed nothing to indicate the resident's physician had been notified of any of the above referenced missed medication doses. During an interview with the Director of Nursing (DON-B)-B on 03/28/25 at 11:45 AM, she confirmed R10 did not receive his morning dose of ordered medications on the above dates based on review of the resident's MAR. The DON-B confirmed nothing could be found in the EMR to show the resident's physician had been notified of the missed medication doses. She stated her expectation was the resident's physician would be notified of any medication not administered appropriately/timely and confirmed the physician should have been notified if nursing staff was not able to administer medication routinely due to a resident not being available to request a potential revision in the ordered times of administration. 2. Review of R18's undated Profile Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE] with diagnoses which included acute osteomyelitis of right and left ankle and foot. Review of R18's Physician Order, dated 02/28/25 and provided by the facility revealed Vancomycin (antibiotic used to treat bacterial infections) 1.5 gram/300 mL [milliliter] in dextrose [glucose] 5% intravenous piggyback-166.7ml intravenous Every Day .for foot wound .Last Dose 03/11/25. Review of R18's MAR dated 03/2025 revealed the resident was not administered her vancomycin from 03/01/25 through 03/04/25, which indicated she missed four intravenous antibiotic infusions. 3. Review of R19's undated Profile Face Sheet revealed the resident was admitted to the facility on [DATE] with diagnoses which included glaucoma. Review of R19's Physician Orders revealed the resident was ordered Dorzolamide-timolol and Latanoprost (both medicated eye drops to treat glaucoma). Review of R19's MAR dated 03/2025 revealed the resident was not administered her medicated eye drops as ordered by her physician. During an interview on 03/28/25 at 5:53 PM, the DON-B stated that when the medication was not available, the physician should have been notified. The DON-B confirmed there was no documented evidence that the residents' physician was notified. During an interview on 03/28/25 at 6:30 PM, Attending Physician (AP)-M stated if a resident was out of medication and did not receive the medication as ordered, it was his expectation he would have been notified. 36898 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Policy and Procedure titled, Administering Medications last revised 12/2024, states in part: Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . C. Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines (60 minutes before the due time and 60 minutes after the due time) . Q. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document on the MAR (Medication Administration Record) or eMAR (electronicMAR) for that drug and dose . R. The individual administering the medication to document on the MAR or eMAR after giving each medication and before administering the next ones . 4.) R23 was readmitted to the facility on [DATE] with pertinent diagnoses that include hemiplegia following cerebral infarction, type 2 diabetes mellitus, legal blindness, dependence on renal dialysis and muscle weakness. On 3/27/2025, at 1:12pm, Surveyor observed medications being prepared and administered to R23 by Registered Nurse (RN)-H. The following medications were administered that were scheduled for 8am: Midodrine 5mg, the dose scheduled at noon was then not signed out on the MAR Omeprazole 20mg Miralax Eliquis 5mg Sertraline 50mg Metformin 500mg Metoprolol Succinate ER (extended release) 25mg Surveyor noted this was over 4 hours beyond the allotted 60 minutes after the due time of the physician ordered administration time. After record review, Surveyor was unable to locate any documentation in R23's medical record on 3/27/25 regarding R23's physician being consulted with when R23's medication was administered late. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25, at 1:55pm, RN-H told Surveyor they needed to go speak with Director of Nursing (DON-B)-B because the 8am medications were not DON-Be and RN-H needs to know policy on calling the doctor. On 3/27/25, at 2:15pm, Surveyor observed DON-B-B and RN-H having a conversation in the charting room with the door closed. On 3/31/25, at 10:31am, Surveyor interviewed RN-I about the procedure when a medication is administered late and was told the nurse needs to let the doctor know and ask the doctor what they want DON-Be. Also need to let the DON-B know. On 3/31/25. At 2:48pm, Surveyor interviewed DON-B-B regarding late medication administration, DON-B-B stated that if a medication is given outside the window the nurse should call the DON-B or another manager and the nurse needs to let the doctor know so the nurse can get an order to give the medications late or change administration times. On 4/1/25, at 9:50am, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated that medication administration is a lot for the nurses on second or third floor. LPN-E stated there should be an extra nurse to help, even if that extra nurse did the wound care, it would be beneficial. On 4/1/25, at 11:25am, Surveyor interviewed LPN-E about the expectation to call the physician regarding late medication administration and was told there is no expectation. On 4/1/25, at 3:45pm, Surveyor meet with DON-B-B and Nursing Home Administrator (NHA)-A regarding the medications being administered late on 3/27/25 and not being able to locate documentation that the physician was contacted and updated. DON-B-B replied that RN-H was having trouble making progress notes in the eMAR and that a paper progress note was created for the four residents RN-H was late to administer medications to. Surveyor requested the documentation. No additional information was provided to Surveyor at time of write up regarding the documentation and notification of the physician when medications are administered late. 5.) On 4/1/25, at 9:37am, Surveyor observed medications being prepared and administered to R22 by Licensed Practical Nurse (LPN)-E. The following medications were administered that were scheduled for 8am: Amlodipine 10mg Levetiracetam 500mg Aspirin EC 81mg Acetaminophen 325mg (2 pills to equal 650mg) Metoprolol ER 25mg Surveyor noted this was over 30 minutes beyond the allotted 60 minutes after the due time of the physician ordered administration time. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After record review, Surveyor was unable to locate any documentation in R22's medical record on 4/1/25 regarding R22's physician being consulted with when R22's medication was administered late. On 3/31/25, at 10:31am, Surveyor interviewed RN-I about the procedure when a medication is administered late and was told the nurse needs to let the doctor know and ask the doctor what they want DON-Be. Also need to let the Director of Nursing (DON-B)-B know. On 3/31/25. At 2:48pm, Surveyor interviewed DON-B-B regarding late medication administration, DON-B-B stated that if a medication is given outside the window the nurse should call the DON-B or another manager and the nurse needs to let the doctor know so the nurse can get an order to give the medications late or change administration times. On 4/1/25, at 9:45am, Surveyor interviewed LPN-E about medication administration not being completed and was told LPN-E has the whole rest of the floor to complete, LPN-E is behind. Surveyor asked if LPN-E could call for help and was told LPN-E does not believe there is anyone to help. Surveyor asked about DON-B-B helping and was told there is only one laptop and one cart so two people can't do the job. On 4/1/25, at 9:50am, Surveyor interviewed LPN-E who stated that medication administration is a lot for the nurses on second or third floor. LPN-E stated there should be an extra nurse to help, even if that extra nurse did the wound care, it would be beneficial. On 4/1/25, at 11:25am, Surveyor interviewed LPN-E about the expectation to call the physician regarding late medication administration and was told there is no expectation. On 4/1/25, at 3:45pm, Surveyor meet with DON-B-B and Nursing Home Administrator (NHA)-A regarding the medications being administered late on 4/1/25 and not being able to locate documentation that the physician was contacted and updated. DON-B-B replied that LPN-E was following up with the doctor right now, LPN-E had been busy up till now trying to finish up everything else. The doctor is on the way here so can talk to the doctor once here. DON-B-B stated that LPN-E should have notified the unit manager or DON-B at the time. No additional information was provided to Surveyor at time of write up regarding the documentation and notification of the physician when medications are administered late. 6.) On 4/1/25, at 9:50am, Surveyor observed medications being prepared and administered to R21 by Licensed Practical Nurse (LPN)-E. The following medications were administered that were scheduled for 8am: Alopurinol 100mg Losartan 25mg Methenamine Hippurate 1 gram Aspirin Chewable 81mg Escitalopram 20mg (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	And Pantoprazole 40mg was administered that was scheduled for ac (before) breakfast. Surveyor noted this was over 30 minutes (and well past breakfast) beyond the allotted 60 minutes after the due time of the physician ordered administration time. After record review, Surveyor was unable to locate any documentation in R21's medical record on 4/1/25 regarding R21's physician being consulted with when R21's medication was administered late. On 3/31/25, at 10:31am, Surveyor interviewed RN-I about the procedure when a medication is administered late and was told the nurse needs to let the doctor know and ask the doctor what they want DON-Be. Also need to let Director of Nursing (DON-B)-B know. On 3/31/25. At 2:48pm, Surveyor interviewed DON-B-B regarding late medication administration, DON-B-B stated that if a medication is given outside the window the nurse should call the DON-B or another manager and the nurse needs to let the doctor know so the nurse can get an order to give the medications late or change administration times. On 4/1/25, at 9:45am, Surveyor interviewed LPN-E about medication administration not being completed and was told LPN-E has the whole rest of the floor to complete, LPN-E is behind. Surveyor asked if LPN-E could call for help and was told LPN-E does not believe there is anyone to help. Surveyor asked about DON-B-B helping and was told there is only one laptop and one cart so two people can't do the job. On 4/1/25, at 9:50am, Surveyor interviewed LPN-E who stated that medication administration is a lot for the nurses on second or third floor. LPN-E stated there should be an extra nurse to help, even if that extra nurse did the wound care, it would be beneficial. On 4/1/25, at 11:25am, Surveyor interviewed LPN-E about the expectation to call the physician regarding late medication administration and was told there is no expectation. On 4/1/25, at 3:45pm, Surveyor meet with DON-B-B and Nursing Home Administrator (NHA)-A regarding the medications being administered late on 4/1/25 and not being able to locate documentation that the physician was contacted and updated. DON-B-B replied that LPN-E was following up with the doctor right now, LPN-E had been busy up till now trying to finish up everything else. The doctor is on the way here so can talk to the doctor once here. DON-B-B stated that LPN-E should have notified the unit manager or DON-B at the time. No additional information was provided to Surveyor at time of write up regarding the documentation and notification of the physician when medications are administered late. 7.) On 4/1/25, at 11:20am, Surveyor observed medications being prepared and administered to R17 by Licensed Practical Nurse (LPN)-E. The following medications were administered that were scheduled for 8am: Furosemide 20mg Metoprolol ER 25mg (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following medications were administered that were scheduled for 9am: Amiodarone 200mg Eliquis 5mg Spironolactone 25mg Entresto 24/26mg Clopidogrel 75mg Jardiance 10mg Famotidine 20mg Duloxetine 60mg Surveyor noted this was over 2 hours for the 8am and over an hour for the 9am beyond the allotted 60 minutes after the due time of the physician ordered administration time. After record review, Surveyor was unable to locate any documentation in R17's medical record on 4/1/25 regarding R17's physician being consulted with when R17's medication was administered late. On 3/31/25, at 10:31am, Surveyor interviewed RN-I about the procedure when a medication is administered late and was told the nurse needs to let the doctor know and ask the doctor what they want DON-Be. Also need to let Director of Nursing (DON-B)-B know. On 3/31/25. At 2:48pm, Surveyor interviewed DON-B-B regarding late medication administration, DON-B-B stated that if a medication is given outside the window the nurse should call the DON-B or another manager and the nurse needs to let the doctor know so the nurse can get an order to give the medications late or change administration times. On 4/1/25, at 9:45am, Surveyor interviewed LPN-E about medication administration not being completed and was told LPN-E has the whole rest of the floor to complete, LPN-E is behind. Surveyor asked if LPN-E could call for help and was told LPN-E does not believe there is anyone to help. Surveyor asked about the DON-B-B helping and was told there is only one laptop and one cart so two people can't do the job. On 4/1/25, at 9:50am, Surveyor interviewed LPN-E who stated that medication administration is a lot for the nurses on second or third floor. LPN-E stated there should be an extra nurse to help, even if that extra nurse did the wound care, it would be beneficial. On 4/1/25, at 11:25am, Surveyor interviewed LPN-E about the expectation to call the physician regarding late medication administration and was told there is no expectation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25, at 3:45pm, Surveyor meet with DON-B and Nursing Home Administrator (NHA)-A regarding the medications being administered late on 4/1/25 and not being able to locate documentation that the physician was contacted and updated. DON-B replied that LPN-E was following up with the doctor right now, LPN-E had been busy up till now trying to finish up everything else. The doctor is on the way here so can talk to the doctor once here. DON-B stated that LPN-E should have notified the unit manager or DON-B at the time. No additional information was provided to Surveyor at time of write up regarding the documentation and notification of the physician when medications are administered late. 49011

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, interviews, and review of facility procedure, the facility failed to ensure routine bathing services were provided for one resident (R9) of a total of 33 residents reviewed in the sample. This failure created the potential for R9 to experience hygienic complications related to going without care planned bathing for extended periods of time. Findings include: Review of the facility's Shower/Tub Bath Procedure dated 02/2024 indicated, The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin . Documentation: The following information should be recorded on the resident's ADL (Activities of Daily Living) record and/or in the resident's medical record: A. The date and time the shower/tub bath was performed; and D. If the resident refused the shower/tub bath, the reason why and the intervention taken; and E. The signature and title of the person recording the data; and Reporting: A. Notify the supervisor if the resident declines the shower/bath. Review of R9's Profile Face Sheet dated 03/28/25 and found in the Electronic Medical Record (EMR) under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnoses included cellulitis of the right lower limb, morbid obesity, and chronic kidney disease. Review of R9's admission Minimum Data Set (MDS) with an Assessment Reference (ARD) Date of 02/12/25 and found in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated R9 required substantial to maximum assistance from staff to complete her bathing. Review of R9's Activities of Daily Living (ADL) Care Plan dated 02/07/25 and found in the EMR under the Care Plan tab indicated the resident required assistance from staff to complete all of her ADLs, including bathing. The care plan indicated R9 preferred to receive a bed bath and was to be bathed/showered twice weekly. Review of R9's bathing records dated 02/12/25 through 03/28/25 and found in the EMR under the POC (Point of Care) tab revealed the resident received a bath/shower only one time during that time period on 02/15/25 (almost six weeks prior to the review of the resident's shower records). There was nothing in the resident's record to indicate the resident refused bathing during that period of time. Review of the facility's paper Shower Sheets dated 02/01/25 through 03/27/28 and kept by the Director of Nursing (DON-B) in her office revealed no record of R9 having been showered during that period of time. During an interview on 03/27/25 at 10:13 AM, R9 stated she had only been bathed one time since her admission to the facility, about a week after she had initially been admitted to the facility. She stated she would like to be bathed. The resident stated she felt unclean and had requested assistance from staff to be bathed multiple times during her admission to the facility, but staff always told her they would check to see what her bathing schedule was and then they would never return. R9 stated she wanted to be bathed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant (CNA)-N on 03/25/25 at 11:20 AM, she stated she thought residents were supposed to be bathed twice weekly. She stated that the she thought R9 was supposed to be bathed on the evening shift but was unsure. CNA-N stated it was sometimes difficult to get showers DON-Be due to staffing concerns. During an interview with CNA-O on 03/25/25 at 11:26 AM, she stated most residents were supposed to be bathed twice weekly, some on the day shift and some on the evening shift. She stated it was hard to get showers DON-Be at times due to short staffing. During an interview with CNA-W on 03/25/25 at 11:412 AM, she stated residents were usually bathed twice weekly. She stated she was not always able to get to all of her assigned baths due to staffing concerns. During an interview with the DON-B on 02/28/25 at 11:53 AM, she confirmed she was not able to locate any addition information to show R9 had been bathed during her admission to the facility and stated her expectation was that all residents were to be assisted with bathing according to their plan of care (generally twice weekly and as needed). She stated any refusal by a resident to bathe was expected to be documented in the resident's record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents with non-pressure wounds received treatment and care in accordance with professional standards for 3 (R7, R16, and R9) of 3 residents reviewed for non-pressure wounds. Additionally, the facility did not ensure residents had emergency medical equipment available to provide treatment and care in accordance with professional standards of practice due to 3 of 3 crash carts not maintained and fully supplied potentially affecting 39 of the 62 residents that elected to be full code status. * R7 developed a non-pressure wound to the lower mid spine on 2/6/2025. A comprehensive assessment was not completed; no wound measurements or descriptors of the wound were documented. R7 was seen by the wound physician on 2/12/2025 when a treatment was ordered to the wound; the treatment was not initiated until 2/19/2025. R7 was seen by a dermatologist on 3/3/2025 and no assessment of the wound was documented after 3/20/2025. Observation of R7's wound did not correlate with the wound documentation. * R16 developed a rash to the right leg on 2/6/2025. The area was not comprehensively assessed. R16 was seen by the wound physician on 2/12/2025 and a treatment was ordered for the right shin lymphedema wound; the treatment was not initiated until 2/19/2025. The wound resolved on 3/7/2025. * R9 was admitted on [DATE] with treatment orders for the right thigh, the left buttock, and the right anterior leg. A skin assessment was not completed until 2/12/2025. R9 had a non-pressure wound to the right calf that had no description of the wound base. R9 was seen by the wound physician on 2/12/2025 and a treatment was ordered for the right calf trauma wound; the treatment was not initiated until 2/19/2025. The wound resolved on 3/26/2025. * The facility does not have a process in place to maintain and monitor the 3 code carts within the facility. Code carts include supplies for residents experiencing an unresponsive episode and/or emergent purposes such as suctioning or a respiratory crisis. This has the potential to affect 62 residents residing in the facility with 39 residents being a full code who would require resuscitation if found unresponsive. Findings include: The facility policy and procedure titled Skin Identification, Evaluation and Monitoring dated 11/2022 documents: Licensed nursing associate will evaluate the skin integrity through a physical skin evaluation and use of the Braden Skin at Risk tool. Upon admission, weekly for three weeks, quarterly and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse. Upon Admission: The Licensed Nursing Associate: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Complete physical skin evaluation, document findings. If a skin condition is present on admission: 1. Initiate protective dressing 2. Notify healthcare provider with findings and for further treatment orders 3. Notification/Education of resident and resident representative of findings and physician orders 4. Document evaluation in the medical record. A. Complete Braden Skin at Risk on admission, then weekly for the next 3 weeks, following admission. B. Initiate preventative and/or treatment intervention, as indicated. C. Notify Dietitian of Pressure Injury identified. D. Document findings, notifications and interventions. Weekly: The Licensed Nursing Associate: A. Complete a General Skin Check to evaluate for changes in skin integrity. B. Document and medical record the finding of general skin check 1. If wound is present and previously 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. 2. If new wound is identified: a. Initiate protective dressing b. Notify healthcare provider of findings and for further treatment orders. 3. Notification/Education of resident and resident representative of finding and physician orders. 4. Document evaluation in the medical record. C. Update plan of care with each intervention. The Certified Nursing Assistant (CNA) should: A. Observe skin for changes when assisting with activities of daily living. B. Cleanse skin with bath/shower and after each incontinence episode C. Apply barrier cream, as indicated D. Report skin integrity changes to nurse. The Director of Nursing/Wound Champion or designee should: A. Review skin and wound documentation to identify opportunity, as indicated. B. Review medical record to identify need for diagnostic review for comorbidity relation. Communicate with physician, as indicated. C. Review newly identified skin integrity changes identified by CNA and/or Licensed Nursing Associate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pressure reducing mattress on bed, wheelchair cushion on bed. R7's Pressure Ulcers/Skin Prevention Care Plan was revised on 9/16/2022 due to having impaired skin integrity from multiple biopsy sites related to follow up dermatology/biopsy appointments and a right shin nodule with interventions: -Minimize force and friction applied to skin. -Treatment per physician orders, resident and family updated. -Follow up dermatology consult, treatment in place, physician/resident/family updated. -Arterial ulcer to left lower extremity stable, physician updated, continue with plan of care, resident/family updated. R7's Pressure Ulcers/Skin Prevention Care Plan was revised on 12/13/2024 due to impaired skin integrity related to multiple warts with interventions: -Treatment provided by dermatologist. -Keep skin clean and dry. Surveyor reviewed R7's medical record. Surveyor noted no wound physician documentation was found. On 3/27/2025 at 2:50 PM, Surveyor requested from Nursing Home Administrator (NHA)-A all of R7's wound documentation. NHA-A stated NHA-A would have to obtain copies from the wound clinic. Surveyor noted and shared the concern with NHA-A that facility staff would not be able to see what the wound physician documented to determine if there is a change in the wound or to put ordered treatments in place. NHA-A agreed. NHA-A provided the wound physician documentation and Surveyor used that documentation to get a more clear picture of R7's wound status. On 2/6/2025 on the Skin Evaluation Form, Director of Nursing (DON)-B documented R7 had a non-pressure wound, other, to the lower mid spine, the dermatologist was called, and they were awaiting treatment orders. No measurements or description of the wound was documented. On 2/12/2025 on the Skin Evaluation Form, DON-B documented R7 had a non-pressure wound, other, to the lower mid spine, the dermatologist was called, and they were awaiting treatment orders. The wound measured 6.1 cm x 0.1 cm x 1 cm with no description or etiology of the wound. R7 was seen by the wound physician on that date and documented the non-pressure full thickness wound to the back measured 6 cm x 1 cm x 0.1 with 20% granulation and 80% skin. Surveyor noted the width and depth measurements were not the same as DON-B documented. The wound physician documented R7 reported the wound was from a fall, but there had been no report of a fall, and a biopsy of the wound would provide clearer etiology. The wound physician ordered a treatment of alginate calcium with a foam border daily. The treatment was not initiated until 2/19/2025, seven days later. R7's Pressure Ulcers/Skin Prevention Care Plan was revised on 2/18/2025 due to impaired skin integrity related to biopsy tissue from the back with the intervention wound care physician or primary physician will help monitor for any complications. Surveyor noted a biopsy of the wound on the back had not been completed at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/2025 on the Skin Evaluation Form, DON-B documented the other non-pressure wound to the mid lower spine measured 6.1 cm x 0.1 cm x 1 cm with no description of the wound, the dermatologist was called, and they were awaiting treatment orders. R7 was seen by the wound physician on that date and documented the non-pressure full thickness wound to the back measured 5 cm x 1 cm x 0.1 cm with 20% granulation and 80% skin. Surveyor noted the measurements were not the same as DON-B documented. On 2/26/2025 on the Skin Evaluation Form, DON-B documented the other non-pressure wound to the mid lower spine measured 1 cm x 1 cm x 0 cm with no description of the wound, the dermatologist was called, and they were awaiting treatment orders. R7 was seen by the wound physician on that date and documented the non-pressure full thickness wound to the back measured 1 cm x 1 cm x 0.1 cm with 100% granulation. On 2/27/2025 on the Nutrition Risk Assessment form, the dietician documented R7's skin was intact. Surveyor noted the Quarterly MDS dated [DATE] documented R7 did not have any skin concerns. On 3/7/2025 on the Skin Evaluation Form, DON-B documented the other non-pressure wound to the mid lower spine measured 1 cm x 1 cm x 0 cm with no description of the wound, the dermatologist was called, and they were awaiting treatment orders. The wound physician documented on that date R7's visit had been rescheduled because R7 was seen by the dermatologist that week for the wound. Surveyor noted no documentation for a dermatology appointment was found. On 3/31/2025 at 3:00 PM, Surveyor requested from NHA-A any documentation of R7's dermatology appointment. On 3/1/2025 at 8:20 AM, NHA-A stated NHA-A had just called the dermatologist office to get their notes. Surveyor noted the dermatology notes were not available in R7's record for review. R7 was seen by the dermatologist on 3/3/2025. The dermatologist documented R7 was a new patient who was being seen for a chief complaint of a rash on the right arm. R7 had painful bumps on the hands. Previous dermatology provider was treating with liquid nitrogen, but the bumps were not going away. The examination revealed a neoplasm on the second web space of the right hand for which a biopsy was performed, a neoplasm on the right distal thumb for which a biopsy was performed, neoplasms on the left ulnar dorsal hand and right dorsal index metacarpophalangeal joint with numerous hyperkeratotic crusted plaques on both hands, and a nodule on the left upper back. The lesions on the back were covered with a mepilex border silicone dressing. R7 was unable to give any history of the lesions and will inquire regarding these lesions when talking to the primary care physician; advise a biopsy if etiology unknown. A follow up will be scheduled after the biopsy results are reviewed. Surveyor noted the dermatologist did not document any measurements or description of the wound to the back other than there was a nodule present. The wound physician had been assessing an open area prior to the appointment and the facility had been assessing an open area. Surveyor noted R7 had two biopsies taken on the right hand which were not documented in R7 facility medical record. DON-B documented on 3/12/2025 and 3/20/2025 the other non-pressure wound to the mid lower spine measured 1 cm x 1 cm x 0 cm with no description of the wound, the dermatologist was called, and they were awaiting treatment orders. R7 was not seen by the wound physician after 2/26/2025. No further documentation of the wound to the back was found. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/1/2025 at 9:17 AM, Registered Dietician (RD)-C stated if a resident is admitted with a wound, RD-C would look at the admission skin assessment and the hospital record so RD-C would know right away if the resident had a wound. RD-C stated if an existing resident developed a new wound, RD-C would not be aware of the wound until RD-C completes the monthly review. RD-C stated the facility staff is not consistent in relaying wound information. Surveyor asked RD-C if RD-C is told directly if a resident develops a wound. RD-C stated RD-C is not notified directly by facility staff. RD-C stated when RD-C becomes aware of a wound, RD-C would do a nutritional assessment and would increase protein or order supplements. RD-C stated RD-C can put in an order for supplements directly without having to go through the physician. RD-C stated a quarterly nutrition review had been completed on 2/27/2025 that indicated R7's skin was intact. RD-C stated R7's medical record had documentation that R7 had something on the lower mid back, but it was not a wound. RD-C stated RD-C was unable to determine what R7 had on the back and if RD-C had run a report on wounds, R7 would not have shown up on that report because of how the wound was documented. RD-C stated RD-C could not tell if it was a growth or what was there. Surveyor shared with RD-C that R7 was getting a daily treatment to the wound. RD-C stated if staff are doing a treatment on it, RD-C stated RD-C should know about it. On 4/1/2025 at 10:19 AM, Surveyor accompanied Registered Nurse (RN)-D to observe R7's wound to the back. RN-D stated R7 had a wound to the upper mid back. A dressing was in place over the mid spine. RN-D removed the dressing which had been put in place by RN-D earlier that morning. R7 had a blister that measured approximately 1 cm x 1 cm that was fluid filled and directly below the blister was an open wound that measured approximately 1.5 cm x 1 cm x 0.1 cm with a red wound bed with dark tissue scattered throughout the middle of the wound. The dressing covered both the blister and the open wound. Surveyor noted no documentation had been found of the blistered area above the open area. Surveyor observed scarred areas on R7's upper back. Surveyor observed R7's right inner thumb with a black scabbed area that measured approximately 1 cm x 1 cm x 0.1 cm. Surveyor asked RN-D if RN-D was aware of the wound on R7's thumb. RN-D stated no. Surveyor was unable to observe the webbing between the fingers due to the puffiness of R7's right hand. On 4/1/2025 at 3:35 PM, Surveyor shared with NHA-A and DON-B the concerns R7 developed a non-pressure wound to the lower mid spine on 2/6/2025 and a comprehensive assessment was not completed; no wound measurements or descriptors of the wound were documented. R7 was seen by the wound physician on 2/12/2025 when a treatment was ordered to the wound and the treatment was not initiated until 2/19/2025. R7 was seen by a dermatologist on 3/3/2025 where R7 had biopsies done of two areas on the right hand and no assessments of the wounds were documented. Surveyor shared the concern of the observation of R7's wound on the back did not correlate with the wound documentation; R7 had a blister above an open wound and the blister had never been documented and the open wound did not have a comprehensive assessment in the medical record since it was discovered. Surveyor shared the concern the wound physician documentation and the dermatology documentation was not in R7's medical record. Surveyor shared the concern the dietician is not notified of wounds. 2.) R16 was admitted to the facility on [DATE] with diagnoses of diabetes, congestive heart failure, coronary artery disease, atrial fibrillation, and dysfunction of the bladder requiring an indwelling urinary catheter. R16's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R16 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and did not have any skin integrity concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's Pressure Ulcers/Skin Prevention Care Plan was initiated on 8/13/2024 with interventions: -Braden Scale to be completed. -Keep bed linens wrinkle free and do not use excess pads. -Observe skin for redness and breakdown during routine care. -Use pressure relieving devices, cushion on wheelchair and off of heels, as indicated. -Follow community skin care protocol. -Treatments, as indicated, see physician order sheet. -Pressure reducing mattress on bed. Surveyor reviewed R16's medical record. Surveyor noted no wound physician documentation was found. On 3/27/2025 at 2:50 PM, Surveyor requested from Nursing Home Administrator (NHA)-A all of R16's wound documentation. NHA-A stated NHA-A would have to obtain copies from the wound clinic. Surveyor noted and shared the concern with NHA-A that facility staff would not be able to see what the wound physician documented to determine if there is a change in the wound or to put ordered treatments in place. NHA-A agreed. NHA-A provided the wound physician documentation and Surveyor used that documentation to get a more clear picture of R16's wound status. On 2/6/2025 on the Skin Evaluation Form, Director of Nursing (DON)-B documented R16 had a rash to the right leg that resembled cellulitis. No measurement or wound description was documented. R16 was seen by the wound physician on 2/12/2025. Surveyor noted this documentation was not available in R16's medical record. The wound physician documented R16 had a wound to the right shin due to lymphedema that measured 0.5 cm x 0.5 cm x unable to determine depth; the depth is unmeasurable due to presence of dried fibrinous exudate. The wound physician ordered a treatment of ammonium lactate ointment and tubigrips daily. The treatment was not initiated until 2/19/2025, seven days after the order was given. The facility did not document an assessment for this date. On 2/21/2025 on the Skin Evaluation Form, DON-B documented R16's rash to the right leg measured 0.5 cm x 0.5 cm with redness that resembled cellulitis. Surveyor noted no depth or description of the wound bed was documented. R16 was seen by the wound physician on the same date and documented R16 had a wound to the right shin due to lymphedema that measured 0.5 cm x 0.5 cm x unable to determine depth; the depth is unmeasurable due to presence of dried fibrinous exudate. On 2/26/2025 on the Skin Evaluation Form, DON-B documented R16's rash to the right leg measured 0.5 cm x 0.5 cm that healed. Surveyor noted DON-B documented measurements that conflicted with the documentation the wound had healed. R16 was seen by the wound physician on the same date and documented R16 had a wound to the right shin due to lymphedema that measured 0.5 cm x 0.5 cm x unable to determine depth; the depth is unmeasurable due to presence of dried fibrinous exudate. R16 was seen by the wound physician on 3/7/2025 and documented the wound to the right shin had healed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Follow community skin care protocol. -Treatments, as indicated, see physician order sheet. -Pressure reducing mattress on bed. On 2/7/2025 on the Admission Observation/Evaluation form, the Skin Evaluation section had nothing documented. The Treatment Administration Record (TAR) had the following treatments ordered to start on 2/8/2025: -Right thigh Stage 2 pressure injury: clean with normal saline; clean blisters and cover with foam dressing daily. -Left buttock Stage 2 pressure injury: clean with normal saline, apply Santyl and foam dressing daily. -Right anterior leg: clean with normal saline, apply xeroform and ABD pad and wrap with gauze; secure with medipore or mepilex tape daily. Surveyor noted treatments were not consistently signed out on the TAR as being administered as ordered. No documentation of wounds was found on admission. Surveyor reviewed R9's medical record. Surveyor noted no wound physician documentation was found. On 3/27/2025 at 2:50 PM, Surveyor requested from Nursing Home Administrator (NHA)-A all of R9's wound documentation. NHA-A stated NHA-A would have to obtain copies from the wound clinic. Surveyor noted and shared the concern with NHA-A that facility staff would not be able to see what the wound physician documented to determine if there is a change in the wound or to put ordered treatments in place. NHA-A agreed. NHA-A provided the wound physician documentation and Surveyor used that documentation to get a more clear picture of R9's wound status. On 2/12/2025 on the Skin Evaluation Form, Director of Nursing (DON)-B documented R9 had a non-pressure injury to the right calf that measured 6 cm x 2.5 cm x 0.2 cm. No description or etiology of the wound was documented. R9 was seen by the wound physician on the same date and documented R9 had a non-pressure full thickness wound to the right calf due to trauma and measured 6 cm x 2.5 cm x 0.2 cm with 70% granulation and 30% intact normal skin. The wound physician ordered a treatment of leptospermum honey with alginate calcium covered with an island gauze border dressing daily. This treatment was not initiated until 2/19/2025, seven days after it was ordered. DON-B documented the measurements of the right calf non-pressure injury on 2/21/2025, 2/26/2025, 3/7/2025, 3/9/2025, 3/12/2025, 3/19/2025, and twice on 3/26/2025 with two different measurements for the same wound. On 3/26/2025, DON-B documented the right calf wound measured 0.4 cm x 0.4 cm x 0.1 cm and also measured 0.8 cm x 0.7 cm x 0.1 cm. No description of the wound was documented by DON-B on any assessment since admission. DON-B documented the wound resolved on 3/27/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The wound physician assessed the non-pressure full thickness trauma wound on 2/21/2025, 2/26/2025, 3/7/2025, 3/12/2025, 3/19/2025, and 3/26/2025. The wound physician documented the wound had resolved on 3/26/2025. On 4/1/2025 at 8:27 AM, Surveyor observed R9 lying in bed on a regular scoop mattress. Surveyor asked R9 if R9 had any wounds or open areas on the skin. R9 stated R9 had wounds, but they had all healed. On 4/1/2025 at 3:35 PM, Surveyor shared with NHA-A and DON-B the concerns R9 was admitted on [DATE] with treatment orders for the right thigh, the left buttock, and the right anterior leg yet no assessment was completed on admission. A skin assessment was not completed until 2/12/2025, five days after admission. R9 had a non-pressure wound to the right calf that had no description of the wound base. R9 was seen by the wound physician on 2/12/2025 and a treatment was ordered for the right calf trauma wound and the treatment was not initiated until 2/19/2025. Wound treatments were not consistently signed out in the TAR indicating the treatment had been completed. Surveyor shared the concern the wound physician documentation was not in R9's medical record. 48391 4.) On 3/27/25, at 11:10 AM, Surveyor observed the 1st floor code cart located in the nursing station that is locked with the key visible in the lock. Surveyor was unable to locate an Inventory Checklist that is signed off by staff or evidence of facility staff are performing maintenance checks. On 3/27/25, at 10:29 AM, Surveyor observed the 2nd floor code cart that is in the nursing station. Surveyor notes an Inventory Checklist with instructions to complete weekly on Thursday. Surveyor notes documentation to the first page on 1/3/25 (Friday), 1/10/25 (Friday), 1/17/25 (Friday), 1/24/25 (Friday), and 2/25/25 (Tuesday) with no documentation on the second page for these dates. Surveyor notes the second page on the Inventory Checklist includes oxygen (O2) tank, manual resuscitator, suction canister, body board, and blood and body fluids spill kit. Surveyor notes there is only one day documented on 2/25/25 for the month of February 2025 and there is no documentation for the month of March 2025. Surveyor also noted there is no O2 tank in the nursing station or on the code cart. On 3/27/25, at 10:21 AM, Surveyor observed the 3rd floor code cart that is in the nursing station. Surveyor observed a daily Inventory Checklist filled out by facility staff. Surveyor notes missing documentation on 1/9/25, 1/10/25, 1/24/25, 2/2/25, 2/6/25, 2/7/25, 3/15/25, and half the day is missing on 3/9/25. Surveyor notes the O2 tank standing upright on the side of the code cart that is empty. Surveyor also notes a portable O2 concentrator machine hanging on the side of the code cart that is empty. Surveyor notes the glucometer strips expiration date on the Inventory Checklist is empty with no date listed. Surveyor notes staff initials located on the Inventory Checklist but no signature to indicate who is checking the code cart. Surveyor noted a red note on top of code cart indicating the Automated External Defibrillator (AED) is located on the 1st floor next to elevators. On 3/27/25, at 3:02 PM, Surveyor observed the AED on the 1st floor next to the elevators. Surveyor observed the AED in a glass case that is clearly visible for staff to locate and labeled AED with the screen on the AED indicating ok for use. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/25, at 10:09 AM, Surveyor interviewed Certified Nursing Assistant (CNA)- J who states care cards are provided daily for staff before every shift, that indicate the resident's code statues. CNA- J states staff can look in the Electronic Medical Record (EMR) for code status also. CNA- J states she typically works on the 3rd floor and states there is a code cart in every nursing station on each floor. CNA- J indicated the facility has an AED on the 1st floor by the elevators. On 3/27/25, at 10:17 AM, Surveyor interviewed CNA- K who states she is agency staff but works at the facility frequently. CNA- K indicates she reviews the care card, EMR and receives report from the previous staff member for resident's code status. CNA- K stated she thinks the code cart is in the nursing station but would have to verify. CNA- J overheard the conversation and noted to CNA- K that the code cart was in the nursing station on each floor. On 3/27/25, at 11:10 AM, Surveyor interviewed Licensed Practical Nurse (LPN)- L who states she is the 1st floor unit manager. LPN- L states the 1st floor recently received a brand-new code cart. LPN- L states staff verify code status for residents in the EMR or on the care card. Surveyor asked LPN- L who maintains and monitors the code cart. LPN- L stated, that's a good question and did not know who is responsible for maintaining and checking the code cart. LPN- L notified Surveyor there is a checklist of supplies indicating what is in the code cart. Surveyor asked LPN- L if staff verify supplies in the code cart and if there is documentation of this being done. LPN- L was unable to provide documentation of the code cart being checked and maintained. LPN- L indicates if a resident is found unresponsive, staff will immediately grab the code cart from the nursing station and take it to the resident's room. LPN- L stated the facility has an AED on the 1st floor by the elevators. On 3/31/25, at 1:44 PM, Surveyor observed the 1st floor code cart that is locked with the key visible in the lock and located in the nursing station. Surveyor is unable to locate an Inventory Checklist that is signed off by staff or evidence of facility staff performing maintenance checks. Surveyor noted there are no changes from 3/27/25, including documentation of the code cart being signed off on from facility staff. On 3/31/25, at 1:40 PM, Surveyor observed the 2nd floor code cart that has no additional inventory checks from the previous observation on 3/27/25, at 10:29 AM [TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents received care consistent with professional standards of practice to prevent development of pressure injuries or received care to promote healing and prevent new ulcers from developing for 4 (R4, R16, R13, and R9) of 4 residents reviewed with pressure injuries. *R4 did not have skin assessments completed timely when readmitted to the facility with the development of pressure injuries. Treatments were not initiated when ordered or completed as ordered, and weekly comprehensive assessments of the pressure injuries were not documented. Surveyor observed R4 with a pressure injury to the right buttock that the facility staff was not aware of. * R16 developed a Stage 2 pressure injury to the left buttock on 2/13/2025 that was not comprehensively assessed and a Stage 2 pressure injury to the right buttock developed on 2/26/2025. The treatment order was not implemented and was documented as an intervention on the Communication Care Plan. Treatments were not consistently signed out as being completed. The Stage 2 pressure injury resolved on 3/7/2025. Surveyor observed a pressure injury to the left heel and the right buttock that the facility staff was not aware of. The Registered Dietician had not been informed of the Stage 2 pressure injury to the right buttock that developed on 2/13/2025 or 2/26/2025. *R13 developed a Stage 3 pressure injury to the left buttock and an Unstageable pressure injury to the sacrum on 1/15/2025 and a treatment was not started until 1/20/2025. Treatments were not consistently signed out as being completed. The Registered Dietician had not been informed of the Stage 3 or Unstageable pressure injuries. The pressure injuries healed on 2/21/2025. *R9 was admitted on [DATE] with treatment orders for a Stage 2 pressure injury to the right thigh and a Stage 2 pressure injury to the left buttock. A skin assessment was not completed until 2/12/2025. On 2/12/2025, the facility documented R9 had a Stage 2 pressure injury to the sacrum that had no description of the wound base. The right thigh and left buttock did not have an assessment documented. R9 was seen by the wound physician on 2/12/2025 and a treatment was ordered for the Stage 2 sacrum pressure injury. The treatment was not initiated until 2/19/2025. Treatments were not consistently signed out as being completed. The wound resolved on 3/26/2025. Findings include: The facility policy and procedure titled Skin Identification, Evaluation and Monitoring dated 11/2022 documents: Licensed nursing associate will evaluate the skin integrity through a physical skin evaluation and use of the Braden Skin at Risk tool. Upon admission, weekly for three weeks, quarterly and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse. Upon Admission: The Licensed Nursing Associate: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A. Complete physical skin evaluation, document findings. If a skin condition is present on admission: 1. Initiate protective dressing 2. Notify healthcare provider with findings and for further treatment orders 3. Notification/Education of resident and resident representative of findings and physician orders 4. Document evaluation in the medical record. A. [sic] Complete Braden Skin at Risk on admission, then weekly for the next 3 weeks, following admission. B. Initiate preventative and/or treatment intervention, as indicated. C. Notify Dietitian of Pressure Injury identified. D. Document findings, notifications and interventions. Weekly: The Licensed Nursing Associate: A. Complete a General Skin Check to evaluate for changes in skin integrity. B. Document and medical record the finding of general skin check 1. If wound is present and previously 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. 2. If new wound is identified: a. Initiate protective dressing b. Notify healthcare provider of findings and for further treatment orders. 3. Notification/Education of resident and resident representative of finding and physician orders. 4. Document evaluation in the medical record. C. Update plan of care with each intervention. The Certified Nursing Assistant (CNA) should: A. Observe skin for changes when assisting with activities of daily living. B. Cleanse skin with bath/shower and after each incontinence episode C. Apply barrier cream, as indicated D. Report skin integrity changes to nurse. The Director of Nursing/Wound Champion or designee should: A. Review skin and wound documentation to identify opportunity, as indicated. B. Review medical record to identify need for diagnostic review for comorbidity relation. Communicate with physician, as indicated. C. Review newly identified skin integrity changes identified by CNA and/or Licensed Nursing Associate. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	D. The interdisciplinary team (IDT) will review for completion of documentation and assist with identification of further resident centered interventions as needed. E. Care plan updated as indicated. F. The report will be available for review by the interdisciplinary team (IDT). Skin Integrity Treatment Program The treatment program will focus on the following strategies: A. Eliminate or reduce 1. the source of pressure using positioning techniques 2. other sources of skin injury by evaluating the cause and providing interventions B. Pain Control C. Preventative measures to reduce the risk of further tissue loss D. Managing and reducing the risk of infections E. Interventions that increase the potential for healing F. Nutritional evaluation and intervention as indicated G. Managing systemic issues (edema, venous insufficiency, etc.). H. Debridement, when needed as ordered by the physician. 1.) R4 was admitted to the facility on [DATE] with diagnoses of anemia, coronary artery disease, peripheral vascular disease, obstructive uropathy requiring an indwelling urinary catheter, depression, and anxiety. R4's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R4 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and did not have any skin integrity concerns. R4's Activities of Daily Living (ADL)/Rehab Potential Care Plan was initiated on 2/19/2024 with the intervention R4 needs extensive assistance with one person for bed mobility. R4's Pressure Ulcers/Skin Prevention Care Plan was initiated on 2/19/2024 with the following interventions in place as of 9/27/2024: -Braden Scale to be completed. -Observe skin for redness and breakdown during routine care. -Use pressure relieving devices, cushion on wheelchair and off of heels, as indicated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Follow community skin care protocol. -Treatments, as indicated, see physician order sheet. -Pressure reducing mattress on bed. -Encourage to float left heel and right stump on pillows when able. -Provide treatment as ordered. -Keep skin clean and dry. -Wound physician assessed with recommendations: left heel treatment as preventative, moisture associated skin damage (MASD) to gluteal crease barrier cream, physician updated, continue treatment per recommendations. (added to Care Plan 2/26/2024) Surveyor reviewed R4's medical record. Surveyor noted no wound physician documentation was found. On 3/27/2025 at 2:50 PM, Surveyor requested from Nursing Home Administrator (NHA)-A all of R4's wound documentation. NHA-A stated NHA-A would have to obtain copies from the wound clinic. Surveyor noted and shared the concern with NHA-A that facility staff would not be able to see what the wound physician documented to determine if there is a change in the wound or to put ordered treatments in place. NHA-A agreed. NHA-A provided the wound physician documentation and Surveyor used that documentation to get a more clear picture of R4's wound status. On 2/20/2024, a treatment was initiated: Remedy dimethicone cream (house stock) to buttocks and peri area every shift and as needed. Surveyor noted the treatment was not consistently signed out as being administered. This order was in place at the time of survey. On 9/20/2024 at 12:55 PM in the progress notes, nursing documented R4 was admitted to the hospital with hypoglycemia and elevated lactic acid. On 9/27/2024, R4 was readmitted to the facility. The Admission Observation/Evaluation form was completed by a Licensed Practical Nurse who documented R4 did not have any skin concerns. On 9/28/2024 on the Skin Evaluation Form, Director of Nursing (DON)-B documented: -Left mid back Deep Tissue Injury (DTI) measured 1.4 cm x 0.7 cm x 0.1 cm with intact skin. Surveyor noted a DTI wound is not an open wound so no depth would be measured. -Right lower buttock pressure injury measured 1.5 cm x 2.3 cm with epithelial tissue. Surveyor noted the pressure injury was not staged, no depth was measured, and no percentage of epithelial tissue was documented. -Left outer heel Stage 3 pressure injury measured 1 cm x 0.9 cm x 0.1 cm. No tissue type was documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/28/2024 at 1:10 PM in the progress notes, DON-B documented the wound physician made wound rounds and R4 had new orders for the Stage 3 pressure injury to the left heel and the wound to the mid back. Treatments were initiated on 9/28/2024: -Mid back: clean with normal saline and cover with a foam dressing three times weekly. (discontinued 11/20/2024) -Right buttock: cleanse with normal saline and apply foam dressing daily. (discontinued 12/8/2024) -Left heel: cleanse with half Dakins solution and cover with foam dressing three times weekly. (discontinued 11/20/2024) R4's Quarterly MDS dated [DATE] documented R4 had a Stage 3 pressure injury that was present upon readmission, an Unstageable pressure injury that was present upon readmission, and a DTI that was present upon readmission. No documentation of wound assessments was found from 9/28/2024 to 12/8/2024. On 12/8/2024 on the Skin Evaluation Form, DON-B documented: -Right lower buttock pressure injury measured 1.5 cm x 2.3 cm with epithelial tissue. Surveyor noted the pressure injury was not staged, no depth was measured, and no percentage of epithelial tissue was documented. -Left outer heel Stage 3 pressure injury measured 1 cm x 0.9 cm x 0.1 cm. No tissue type was documented. Surveyor noted both pressure injuries had the same documentation as 9/28/2024. No documentation of wound assessments for the right lower buttock or the left outer heel was found after 12/8/2024. Surveyor noted the treatment to the left outer heel had been discontinued on 11/20/2024 and the treatment to the right buttock was discontinued on 12/8/2024 while both wounds continued to have measurements. R4's Annual MDS assessment dated [DATE] documented R4 did not have any pressure injuries. On 1/12/2025 at 12:15 PM in the progress notes, DON-B documented R4 was sent to the hospital after vomiting and having a low blood pressure. On 1/22/2025, R4 was readmitted to the facility. The Admission Observation/Evaluation form was not completed, and the skin section was blank. No skin assessment documentation was found. Review of the Treatment Administration Record (TAR) showed no treatments were in place for any wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/14/2025 at 1:25 AM in the progress notes, nursing documented R4 was minimally responsive and sent to the hospital. On 2/27/2025, R4 was readmitted to the facility. The Admission Observation/Evaluation Form documented R4 did not have any skin concerns. No skin assessment documentation was found. On 3/7/2025 at 12:54 PM in the progress notes, DON-B documented the wound physician saw R4 and evaluated R4's admission wounds. Surveyor noted R4's medical record did not have any skin documentation on readmission indicating R4 had any wounds on admission. On 3/7/2025 on the Skin Evaluation Form, DON-B documented: -Right elbow Stage 2 pressure injury measured 0.5 cm x 0.5 cm with granulation tissue. The right elbow Stage 2 pressure injury was documented a second time that measured 0 cm x 0 cm. -Left heel pressure injury measured 1.0 cm x 0.8 cm x 0.2 cm with granulation tissue. This was documented twice. The left heel pressure injury was not staged. The wound physician assessed R4 on 3/7/2025 and documented: -Right elbow Stage 2 pressure injury measured 0.5 cm x 0.5 cm x not measurable due to presence of dried fibrinous exudate with open areas with exposed dermis. -Left heel Stage 3 pressure injury measured 1 cm x 0.8 cm x 0.2 cm with 100% granulation tissue. -Left buttock Stage 2 pressure injury measured 0.5 cm x 0.5 cm x 0.1 cm with open areas with exposed dermis. -Left upper back Stage 2 pressure injury measured 2 cm x 6.5 cm x 0.1 cm with open areas with exposed dermis. The wound physician ordered treatments to the pressure injuries. The treatments were not initiated until 3/10/2025, three days after the treatments were ordered. Surveyor noted no wounds were documented on readmission to the facility on [DATE] and R4 developed four pressure injuries with no treatment in place. The facility documented R4 had two pressure injuries on 3/7/2025 to the right elbow and the left heel while the wound physician assessed R4 to have four pressure injuries. R4's Significant Change MDS assessment dated [DATE] documented R4 did not have any pressure injuries. On 3/10/2025 on the Skin Evaluation Form, DON-B documented the pressure injuries were evaluated by the wound physician on 3/7/2025. DON-B entered the wound physician treatment orders into R4's TAR at that time, delaying treatment by three days. On 3/10/2025 at 1:19 PM in the progress notes, nursing documented R4 was hypoxic with oxygen saturations in the 70s and was sent to the hospital. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/24/2025, R4 was readmitted to the facility. The Admission Observation/Evaluation form was not completed, and the skin section was blank. On 3/24/2025 on the Skin Evaluation Form, DON-B documented Existing wounds noted no change(s). No other documentation was found to elaborate on the statement. On 3/25/2025 on the Skin Evaluation Form, DON-B documented: -Right elbow Stage 2 pressure injury measured 0.4 cm x 0.4 cm x 0.1 cm. No wound description was documented. -Left upper back Stage 2 pressure injury measured 0.6 cm x 0.7 cm x 0.1 cm with epithelial tissue. No percentage of tissue type was documented. -Left heel Stage 2 pressure injury measured 1 cm x 0.5 cm x 0.2 cm with granulation tissue. No percentage of tissue type was documented. -Right buttock MASD. No measurements or wound description was documented. The wound physician assessed R4 on 3/26/2025 and documented: -Right elbow Stage 2 pressure injury measured 0.4 cm x 0.4 cm x 0.1 with open areas with exposed dermis. -Left heel Stage 3 pressure injury measured 1 cm x 0.5 cm x 0.2 cm with 100% granulation tissue. -Left buttock Stage 2 pressure injury resolved. -Left upper back Stage 2 pressure injury measured 0.6 cm x 0.7 cm x 0.1 cm with open areas with exposed dermis. -Right buttock Stage 2 pressure injury measured 0.6 cm x 2 cm x 0.1 cm with open areas with exposed dermis. Surveyor noted the facility documented the left heel to be a Stage 2 and not a Stage 3, and the right buttock to be MASD and not a Stage 2 as the wound physician had assessed. On 3/26/2025, the wound physician changed the treatment to the right elbow and added a treatment order for the right buttock. The treatment to the right elbow was not initiated until 3/30/2025 and the treatment to the right buttock was not initiated at all. R4's Pressure Ulcers/Skin Prevention Care Plan was revised on 3/27/2025 with interventions: -Monitor labs as ordered and notify the physician of abnormal values. -Educate resident and/or family to the importance of frequent turning/shifting and repositioning. On 3/29/2025 on the Skin Evaluation Form, DON-B documented: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Left heel Stage 2 pressure injury measured 1 cm x 0.5 cm x 0.2 cm with granulation tissue. No percentage of tissue type was documented. -Right buttock MASD was documented three times, one assessment had no measurements, one assessment documented 0.5 cm x 2 cm x 0.2 cm with no description of the wound bed, and one assessment documented 0.6 cm x 2 cm x 0.1 cm and had resolved on 3/26/2025. No wound physician assessment was provided to compare and clarify what pressure injuries were present. On 4/1/2025 at 8:32 AM, Surveyor observed R4 lying in bed on a regular mattress. R4 was asleep and appeared to be emaciated. Tube feeding was running at 60cc/hour and the head of the bed was elevated slightly, less than 30 degrees. R4 was lying flat on the back with a heel boot to the left foot. R4 had an amputation of the right leg. No pillows were on the bed other than one pillow under R4's head. Surveyor asked LPN-E who does the treatments to R4's wounds. LPN-E stated LPN-E would have to check with DON-B to see when the wound team was coming because if the wound team was coming, they would do the treatments. If the wound team was not coming, LPN-E would do the treatment. In an interview on 4/1/2025 at 9:17 AM, Registered Dietician (RD)-C stated if a resident is admitted with a wound, RD-C would look at the admission skin assessment and the hospital record so RD-C would know right away if the resident had a wound. RD-C stated if an existing resident developed a new wound, RD-C would not be aware of the wound until RD-C completes the monthly review. RD-C stated the facility staff is not consistent in relaying wound information. Surveyor asked RD-C if RD-C is told directly if a resident develops a wound. RD-C stated RD-C is not notified directly by facility staff. RD-C stated when RD-C becomes aware of a wound, RD-C would do a nutritional assessment and would increase protein or order supplements. RD-C stated RD-C can put in an order for supplements directly without having to go through the physician. Surveyor asked RD-C if RD-C was aware of R4 having wounds. Surveyor shared with RD-C R4's pressure injuries. RD-C reviewed R4's medical record and stated the RD documented on 3/27/2025 R4 had a Stage 2 pressure injury to the upper back, but did not mention the right elbow pressure injury. RD-C stated the right buttock is listed as MASD and RD-C was not sure when the left heel pressure injury was found. Surveyor asked RD-C if any changes had been made to R4's tube feeding formula to account for wound healing. RD-C stated there have not been any changes to the tube feeding formula and was meeting the estimated needs for maintenance and healing. RD-C stated if the skin assessment is documented, RD-C will see it, but if it is not documented until after the nutritional assessment is completed, the RD does not catch the wound concerns. On 4/1/2025 at 10:45 AM, Surveyor observed R4 in the same position as at 8:32 AM, lying flat on the back with a heel boot to the left foot. The head of the bed was slightly elevated, but less than 30 degrees with tube feeding running. No pillows were on the bed other than one pillow under R4's head. A pillow with no pillowcase was observed to be on top of a shelving unit in the room. Surveyor asked Certified Nursing Assistant (CNA)-F how often R4 was repositioned in bed. CNA-F stated R4 gets checked and changed every two hours and repositioned then, too. CNA-F stated R4 does not take anything orally. CNA-F left without any opportunity for follow up questions. On 4/1/2025 at 1:49 PM, Surveyor observed R4 in the same position as at 8:32 AM and 10:45 AM, lying flat on the back with a heel boot to the left foot. The head of the bed was slightly elevated, but less than 30 degrees with tube feeding running. No pillows were on the bed other than one pillow under R4's head. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/1/2025 at 2:20 PM, Surveyor asked LPN-E what wounds R4 currently had. LPN-E stated R4 had a wound to the upper back, the right elbow and the left heel. LPN-E was looking at R4's TAR to gather supplies for wound care. Surveyor asked LPN-E if R4 had a wound to the right buttock. LPN-E stated according to the computer, no. Surveyor accompanied LPN-E and DON-B into R4's room to observe wound care. The dressing to R4's elbow was dated 3/24/2025, eight days ago. The Stage 2 pressure injury measured approximately 1 cm x 1 cm x 0.1 cm with 100% pink tissue. The left upper back wound was located on the upper back to the right of the spine. The dressing to R4's back wound was dated 3/24/2025, eight days ago. Surveyor asked DON-B if the wound that was being treated was considered the left upper back. DON-B stated DON-B tries to use the same terminology as the wound physician, so it is not always accurate, and the wound physician put mid upper back. Surveyor noted R4 had scarred circular areas to multiple places on the back. The back wound measured approximately 1 cm x 1 cm x 0.1 cm with 100% pink tissue. The left heel dressing was dated 3/25/2025, seven days ago. The Stage 3 pressure injury measured approximately 2 cm x 1 cm x 0.1 cm with dark tissue to the upper aspect and pink/white tissue to the rest of the wound. Surveyor requested to see R4's right and left buttock to verify if any wounds were present. No dressings were observed to the right or left buttock. Surveyor observed an open wound to the right buttock that measured approximately 1 cm x 2 cm x 0.2 cm with a dark red wound base. Surveyor asked DON-B if R4 was receiving a treatment to the right buttock. DON-B stated Remedy cream is applied with incontinence care. Surveyor asked DON-B if DON-B was aware of this wound. DON-B stated R4 did not have a wound there last week. DON-B stated the wound must be from friction and not pressure and must have just opened up. DON-B stated DON-B would contact the wound physician to let them know. Surveyor asked DON-B how R4 was being repositioned when no pillows were observed to be used that day. DON-B stated R4 had a wedge for positioning and thought maybe it was in R4's closet. DON-B looked and was not able to find the wedge. DON-B saw the pillow on top of the shelving unit and requested a pillowcase for the pillow. DON-B stated the CNAs would have to be questioned as to how they were repositioning without a pillow. On 4/1/2025 at 3:04 PM, Surveyor asked CNA-G if CNA-G helped R4 reposition that day. CNA-G stated CNA-F covered R4's hallway for the first shift while CNA-G worked on the other hallway for first shift and was working R4's hallway for second shift. Surveyor asked CNA-G if CNA-G assisted CNA-F to reposition R4 during the first shift. CNA-G stated yes. Surveyor asked CNA-G if pillows were used when repositioning R4. CNA-G stated no, they did not use any pillows to reposition R4. On 4/1/2025 at 3:06 PM, Surveyor asked LPN-E if LPN-E was aware of the open area to R4's right buttock. LPN-E stated nobody reported the open area to LPN-E. On 4/1/2025 at 3:35 PM, Surveyor shared with NHA-A and DON-B the concerns R4 did not have skin assessments completed timely when readmitted to the facility with the development of pressure injuries. Treatments were not initiated when ordered or completed as ordered, and weekly comprehensive assessments of the pressure injuries were not documented. Facility documentation did not match what the wound physician was documenting. Surveyor observed R4 with a pressure injury to the right buttock that the facility staff was not aware of and the concern R4 was not repositioned that day. Surveyor shared the concern the wound physician documentation was not in R4's medical record. DON-B stated DON-B would have to look into why there was a delay in starting treatments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2.) R16 was admitted to the facility on [DATE] with diagnoses of diabetes, congestive heart failure, coronary artery disease, atrial fibrillation, and dysfunction of the bladder requiring an indwelling urinary catheter. R16's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R16 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and did not have any skin integrity concerns. R16's Pressure Ulcers/Skin Prevention Care Plan was initiated on 8/13/2024 with interventions: -Braden Scale to be completed. -Keep bed linens wrinkle free and do not use excess pads. -Observe skin for redness and breakdown during routine care. -Use pressure relieving devices, cushion on wheelchair and off of heels, as indicated. -Follow community skin care protocol. -Treatments, as indicated, see physician order sheet. -Pressure reducing mattress on bed. On 8/13/2024, a treatment order was initiated for skin prep to heels at bedtime daily. Surveyor noted the treatment was not consistently signed out as being administered as ordered. Surveyor reviewed R16's medical record. Surveyor noted no wound physician documentation was found. On 3/27/2025 at 2:50 PM, Surveyor requested from Nursing Home Administrator (NHA)-A all of R16's wound documentation. NHA-A stated NHA-A would have to obtain copies from the wound clinic. Surveyor noted and shared the concern with NHA-A that facility staff would not be able to see what the wound physician documented to determine if there is a change in the wound or to put ordered treatments in place. NHA-A agreed. NHA-A provided the wound physician documentation and Surveyor used that documentation to get a more clear picture of R16's wound status. On 2/13/2025 at 1:45 PM in the progress notes, nursing documented R16 received a shower, and a body check was performed. R4 had a 2 cm x 2 cm open area to the left buttock. The physician and Director of Nursing (DON)-B was notified. No new orders were obtained. On 2/13/2025 on the Skin Evaluation Form, DON-B documented R16 had a Stage 2 pressure injury to the left buttock that measured 2 cm x 2 cm x 0 cm. No description of the wound bed was documented. No further documentation of the left buttock Stage 2 pressure injury was found. On 2/21/2025, R4 was assessed by the wound physician. The wound physician did not document any wounds to R4's left buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/26/2025 on the Skin Evaluation Form, DON-B documented R16's Stage 2 pressure injury to the right buttock measured 0.5 cm x 0.5 cm. No depth or description of the wound bed was documented. Surveyor noted DON-B documented the right buttock rather than the left buttock. Surveyor was unable to determine if the left buttock pressure injury had healed and a new pressure injury developed on the right buttock, or if the location of the original wound was not documented accurately. R16 was seen by the wound physician on the same date and documented R16 had a Stage 2 pressure injury to the right buttock that measured 0.5 cm x 0. 5 cm x not measurable due to presence of dried fibrinous exudate with open areas with exposed dermis. The wound physician ordered skin prep daily. The Treatment Administration Record did not have the treatment order initiated. On 2/26/2025, the Communication Care Plan had the intervention: apply skin prep to stage 2 pressure ulcer. Surveyor noted the order was not initiated on the TAR and was not added to the Pressure Ulcers/Skin Prevention Care Plan. On 3/7/2025, R4's Stage 2 pressure injury to the right buttock had resolved. On 4/1/2025 at 8:39 AM, Surveyor observed R16 in their room. R16 had just finished breakfast and was sitting in a recliner chair with feet elevated resting on the seat of the wheeled walker. Surveyor asked R16 if R16 had any concerns regarding their skin. R16 stated they had a sore at the bottom of the spine that has had a sore for ages. R16 stated R16 puts some cream on the area that the nurses give R16. Surveyor asked R16 if any of the nurses look at the area to see if there is a wound. R16 stated they look once in a while. R16 stated the wound formed a scab. Surveyor asked R16 if R16 currently had a scab. R16 stated yes, but no one has looked at it. R16 stated the scab came off a while ago, but a new scab has formed because R16 can feel it. Surveyor asked R16 if R16 had any problems with the heels since R16 had their feet up on the hard cushion of the wheeled walker seat. R16 stated the left heel hurts. R16 removed R16's sock and Surveyor observed a nonblanchable red area that measured approximately 1 cm x 1 cm. R16 stated the heel was open at one time and puts Vaseline on the heel to protect it. In an interview on 4/1/2025 at 9:17 AM, Registered Dietician (RD)-C stated if a resident is admitted with a wound, RD-C would look at the admission skin assessment and the hospital record so RD-C would know right away if the resident had a wound. RD-C stated if an existing resident developed a new wound, RD-C would not be aware of the wound until RD-C completes the monthly review. RD-C stated the facility staff is not consistent in relaying wound information. Surveyor asked RD-C if RD-C is told directly if a resident develops a wound. RD-C stated RD-C is not notified directly by facility staff. RD-C stated when RD-C becomes aware of a wound, RD-C would do a nutritional assessment and would increase protein or order supplements. RD-C stated RD-C can put in an order for supplements directly without having to go through the physician. Surveyor asked RD-C when a nutritional assessment was last done for R16. RD-C stated a quarterly assessment was completed in January 2025. RD-C reviewed R16's medical record and stated a Stage 2 pressure injury to the right buttock was found on 2/26/2025 per the skin documentation. RD-C stated R16 needs to be assessed. Surveyor asked RD-C if RD-C was aware R16 had a pressure injury to the right buttock. RD-C stated no. Surveyor shared with RD-C the observation of the pressure injury to the left heel. RD-C stated RD-C would do a nutritional assessment. RD-C stated Ensure Enlive 4 ounces three times daily had been added to R16's orders in 11/2024 to address decreased appetite, but no other supplements had been ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/1/2025 at 10:27 AM, Surveyor requested Registered Nurse (RN)-D go with Surveyor to look at R16's skin. Surveyor shared with RN-D the concern R16 was complaining of pain to the sacrum with a scab to the area and the observation of a pressure injury to the left heel. RN-D observed R16's left heel and agreed R16 had a pressure injury to the heel. R16 exposed the sacral area and a scab that measured approximately 1 cmx 1 cm was present with redness to the peri wound and excoriation to the inner crease. RN-D was not aware of either pressure area. On 4/1/2025 at 3:35 PM, Surveyor shared with NHA-A and DON-B the concerns R16 developed a Stage 2 pressure injury to the left buttock on 2/13/2025 that was not comprehensively assessed and a Stage 2 pressure injury to the right buttock developed on 2/26/2025. The treatment order was not implemented and was documented as an intervention on the Communication Care Plan. Treatments were not consistently signed out as being completed. The Stage 2 pressure injury resolved on 3/7/2025. Surveyor observed a pressure injury to the left heel and the right buttock that the facility staff was not aware of. The Registered Dietician had not been informed of the Stage 2 pressure injury to the right buttock that developed on 2/13/2025 or 2/26/2025. Surveyor shared the concern the wound physician documentation was not in R16's medical record. DON-B stated DON-B would have to look into why the treatment was not started. 3.) R13 was admitted to the facility on [DATE] with diagnoses of respiratory failure, atrial fibrillation, anemia, and diabetes. R13's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R13 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 and had impairment to both arms and legs. The assessment documented R13 did not have any pressure injuries. On 12/31/2024, R13 had a treatment [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review and interviews, the facility failed to ensure root cause analysis was conducted and an updated care plan put into place after falls were experienced by three residents (R)13, R14 and R17) out of 33 residents reviewed in the sample. This failure created the potential for these resident to continue to experience falls. Findings include: Review of the facility's policy titled, Accidents ad Incidents - Investigation and Reporting dated 01/2024 indicated, Accidents and incidents involving resident shall be investigated and reporting completed, .federal requirements .The Health Care Administrator, or designee and interdisciplinary team will review the incident at the next scheduled meeting. Review of the facility's policy titled, Falls dated 01/2024 indicated, Fall should be reviewed at the Daily Stand-Up Meeting following the fall for identification of any additional individualized interventions to reduce the risk of falls. 1. Review of R13's Profile Face Sheet dated 03/28/25 and found in the Electronic Medical Record (EMR) under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnoses included chronic kidney disease and type 2 diabetes. Review of R13's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/04/25 and found in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated that R13 experienced falls prior to and after admission to the facility. Review of R13's Falls Care Plan dated 01/21/25 and found in the EMR under the Care Plan tab indicated the resident had a potential for falls and had fallen during her admission to the facility. The care plan goal was for the resident to remain free from falls. Interventions included: keep pathways clear and provide adequate lighting, keep bed at appropriate height, keep personal items within reach, follow therapy recommendations/plan of treatment, place mattress at the resident's bedside, take resident back to room/bed upon residents request or after meals if she is up in the dining room for meals, increase supervision with toileting/transferring during night hours, and provide non skid socks for use when ambulating. There was nothing on the resident's care plan to indicate an update had been made to the plan related to any recent falls. Review of R13's Interdisciplinary Notes dated 03/08/25 indicated, Upon entering resident's room around 0800 [8:00AM] this morning, resident found to be sitting on floor next to bed. Resident stated she was in the bathroom and the floor was slippery and she slipped and then scooted on her butt from the bathroom to the bed. Resident denies hitting head, denies losing consciousness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Nurse Post Fall Assessment and Follow up Document dated 03/08/25 completed by the resident's assigned nurse at the time of the incident indicated the resident was appropriately assessed related to the fall, immediate measures were taken by nursing staff present at the time of the fall to ensure the resident's safety, and notifications were made appropriately to the resident's physician and responsible party related to the fall. The Director of Nursing (DON-B) was unable to provide any documentation to show R13's 03/08/25 fall had been reviewed by the IDT (interdisciplinary team) the next morning's stand-up meeting or that a root cause analysis of the fall had been discussed by the IDT at any time to ensure adequate interventions were put into place to prevent the resident from experiencing further falls. 2. Review of R14's Profile Face Sheet dated 03/28/25 and found in the EMR under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnoses of heart failure and chronic pulmonary embolism. Review of R14's quarterly MDS with an ARD of 03/10/25 and found in the EMR under the MDS tab indicated a BIMS score of six out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated R14 had experienced two or more falls with no injury since his admission to the facility. Review of R14's Falls Care Plan dated 02/17/25 and found in the EMR under the Care Plan tab indicated the resident had a potential for falls. The care plan goal was for the resident to remain free from injury related to falls. Interventions included make sure the resident is wearing non-skid socks, keep pathways clear and provide adequate lighting, keep bed at appropriate height, keep personal items within reach, follow therapy recommendations/plan of treatment, place mattress at the resident's bedside, orient to room and call light, and staff to make sure resident's bedside table is in reach with his water on the table. Nothing could be found on the care plan to indicate any additional interventions had been initiated for the resident related to his 03/12/25 fall. Review of R14's Interdisciplinary Notes dated 03/12/25 revealed R14 had an unwitnessed fall and was found sitting on the floor while coming from the bathroom. The document indicated the resident denied hitting his head during the fall. Review of the facility's Nurse Post Fall Assessment and Follow up Document dated 03/12/25 completed by the resident's assigned nurse at the time of the incident, indicated the resident was appropriately assessed related to the fall, immediate measures were taken by nursing staff present at the time of the fall to ensure the resident's safety, and notifications were made appropriately to the resident's physician and responsible party related to the fall. DON-B was unable to provide any documentation to show R14's 03/12/25 fall had been reviewed by the IDT the next morning's stand-up meeting or that a root cause analysis of the fall had been discussed by the IDT at any time to ensure adequate interventions were put into place to prevent the resident from experiencing further falls. 3. Review of R17's Profile Face Sheet dated 03/28/25 and found in the EMR under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnoses of persistent atrial fibrillation and type 2 diabetes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R17's admission MDS with an ARD of 01/13/25 and found in the EMR under the MDS tab indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated R14 had not experienced any falls immediately prior to or since his admission to the facility as of the time of the assessment. Review of R17's Falls Care Plan dated 01/07/25 and found in the EMR under the Care Plan tab indicated the resident had a potential for falls. The care plan goal was for the resident to remain free from injury related to falls. Interventions included floor mat at bedside while resident in bed and remove when the resident out of bed, keep pathways clear and provide adequate lighting, keep bed at appropriate height, keep personal items within reach, follow therapy recommendations/plan of treatment, and orient to room and call light. The care plan indicated that R17 had a fall on 02/05/25 and was sent out to the local Emergency Department (ED) related to the fall, however there was nothing to indicate any additional interventions had been added to the residents plan of care related to the fall to prevent further falls. Review of R17's Interdisciplinary Notes dated 02/05/25 at 12:26 AM (related to a fall that occurred on the night of 02/04/25) revealed R17 put on his call light and was found by a staff member sitting at the side of his bed with blood everywhere on the resident, the bed, and the floor. The note indicated the resident was asked and stated he did not know what happened, but he remembered turning and falling out of bed, although he was not sure how. The note indicated that the resident was assessed and then sent to the local ED related to the fall. Review of R17's Interdisciplinary Notes dated 02/06/25 revealed R17 had a small wound over his right eyebrow with intact stitches related to the 02/04/25 fall. Review of the facility's Nurse Post Fall Assessment and Follow up Document dated 02/04/25 completed by the resident's assigned nurse at the time of the incident indicated the resident was appropriately assessed related to the fall, immediate measures were taken by nursing staff present at the time of the fall to transfer the resident to the local ED, and notifications were made appropriately to the resident's physician and responsible party related to the fall. DON-B was unable to provide any documentation to show R17's 02/04/25 fall had been reviewed by the IDT the next morning's stand-up meeting or that a root cause analysis of the fall had been discussed by the IDT at any time to ensure adequate interventions were put into place to prevent the resident from experiencing further falls. During an interview with the DON-B on 03/28/25 at 9:30 AM, she confirmed the IDT had never addressed any of the above reference falls and confirmed the residents' plans of care had not been updated to include new interventions related to each fall to prevent each resident from further falls. The DON-B stated her expectation was that every fall experienced by a resident, a root cause analysis for each fall was to be conducted by the IDT and each residents care plan updated with additional interventions related to each fall to prevent further falls.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review, the facility did not ensure 1 (R24) of 1 resident reviewed for a suprapubic catheter received appropriate treatment and services related to catheter care. * R24 has physician orders in place for catheter care and the Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed many dates care was not documented as provided. R24 has been treated for urinary tract infections (UTIs) four times in the last six months, in addition to the prophylactic antibiotic R24 has physician orders to receive twice daily to prevent UTIs. Findings include: The facility procedure titled Catheter Care, Urinary last approved 1/2024, states in part: Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections . Complications A. Observe the resident for complications associated with urinary catheters . 2. Check the urine for unusual appearance . 5. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately . Managing Obstruction . B. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction . Documentation The following information should be recorded in the resident's medical record: A. The date and time that catheter care was given. B. The name and title of the individual(s) giving catheter care . 1.) R24 was originally admitted to the facility on [DATE]. R24's pertinent diagnoses include multiple sclerosis, neuromuscular dysfunction of bladder, paraplegia, and personal history of urinary tract infections. (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 0690 Level of Harm - Actual harm Residents Affected - Few	R24's Significant Change Minimum Data Set (MDS), with an assessment reference date of 1/6/25, documents a Brief Interview for Mental Status (BIMS) score of 09, indicating that R24 has moderate cognitive impairment. The MDS documents that R24 was assessed to have no behaviors exhibited during the look back period. R24 is coded to have an indwelling catheter and is always incontinent of bowel. R24 has a health care Power of Attorney. R24's physician order dated 11/8/24 documents, acetic acid irr (irrigation) soln (solution) 0.25% - 60cc FYI (for your information) every day for irrigate suprapubic catheter to maintain patency . Surveyor noted that from 3/1/25 to 3/20/25 this order was not documented as completed on 3/5/25, 3/7/25, 3/9/25, 3/16/25, and 3/18/25. (5 missed treatments) R24's physician order dated 9/8/23 documents, suprapubic catheter . inserted for neurogenic bladder. Check function and patency Q (every) shift. Update MD (medical doctor) for any concerns . Surveyor noted from 3/1/25 to 3/20/25 this order was not documented as completed on 3/5/25, 3/7/25, 3/8/25, 3/9/25, and 3/14/25 for day shift. The order was not documented as completed on 3/4/25, 3/15/25, and 3/16/25 for evening shift, and on 3/3/25 for the night shift. (9 missed treatments) R24's physician order dated 1/29/21 documents, mx (monitor) for atypical s/s (signs/symptoms) of infection specific for resident-making nonsensical statements, confusion, eyes glossy and right eye becomes lazy. Complete VS (vital signs) and assessment, SBAR (situation, background, assessment, recommendation) and update Optum NP (Nurse Practitioner) immediately - every shift for chronic UTI . Surveyor noted from 3/1/25 to 3/20/25 this order was not documented as completed on 3/5/25, 3/7/25, 3/8/25, 3/9/25, and 3/14/25 for day shift. The order was not documented as completed on 3/4/25, 3/11/25, 3/15/25, and 3/16/25 for evening shift, and on 3/3/25 for the night shift. (10 missed treatments) R24's physician order dated 8/24/22 documents, suprapubic cath (catheter) site - NSW (normal saline wash) pat dry, apply thin layer of house stack Zguard cream FB (followed by) drain sponge and secure with tape daily - every day . Surveyor noted from 3/1/25 to 3/20/25 this order was not documented as completed on 3/5/25, 3/7/25, 3/8/25, 3/9/25, and 3/14/25. (5 missed treatments) R24's physician order dated 9/8/24 documents, suprapubic site-wash with soap and water, pat dry FB drain sponge change - topical every shift change every shift for cath dressing change . Surveyor noted from 3/1/25 to 3/20/25 this order was not documented as completed on 3/5/25, 3/7/25, 3/8/25, 3/9/25, 3/12/25, 3/14/25, 3/16/25, and 3/20/25 for day shift. The order was not documented as completed on 3/4/25, 3/9/25, and 3/11/25 for evening shift, and on 3/3/25 for the night shift. (12 missed treatments) R24's physician order dated 4/2/22 documents, hiprex tab (tablet) 1GM tabs (methenamine Hippurate) - 1 gram by mouth twice a day for UTI prophylaxis. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted from 3/1/25 to 3/20/25 this order was not documented as administered for the 8:00 AM administration time on 3/5/25, 3/7/25, 3/9/25, 3/12/25, and 3/16/25. (5 missed administrations) For the 4:00 PM administration time his order was not documented as completed on 3/4/25 and was marked as medication refused on 3/16/25. (7 missed administrations) Surveyor noted that multiple times over a twenty day span, the medications and treatments for R24's urinary catheter and catheter care are not documented as completed leaving R24 at risk of infection. Surveyor noted that on 3/20/25, R24 was transferred to the hospital due to acute encephalopathy from a UTI (urinary tract infection). Surveyor noted R24 has been prescribed antibiotics 11/7/24, 12/8/24, 12/30/24 (medication changed on 1/4/25,) and 3/15/25 related to UTIs. R24's physician order dated 11/7/24 with stop date of 11/10/24 documents, Rocephin inj (injection) 1 GM - 1 gram intramuscular every day for prophylactic . R24's physician order dated 12/8/24 with a stop date of 12/15/24 documents, cipro tab (tablet) 500mg by mouth twice a day for proph (prophylactic) uti . R24's physician order dated 12/30/24 with a stop date of 1/4/25 documents, cefepime 1 gram solution for injection - 1 gram intravenous every 12 hours for UTI prophylactic . R24's physician order dated 1/4/25 with a stop date of 2/7/25 documents, cefpodoxime 200 mg tablet - 200 mg by mouth every 12 hours for bacteria in the urine . R24's physician order dated 3/15/25 with a stop date for medication of 3/20/25 documents, Rocephin inj 1 GM - 1 gram intramuscular every day . Surveyor noted that on 3/20/25, R24 was transferred to the hospital due to acute encephalopathy from a UTI. On 1/16/25, R24 was seen by an urologist for symptom of urinary retention with visit description of suprapubic catheter dysfunction, subsequent encounter; neurogenic bladder; urinary retention. The visit notes document, .continues with flushes and super pubic tubing changes at the facility . Reports one UTI causing mental status changes, R24's usual sign which was treated and improved back to baseline. I again recommend culture directed antibiotics when symptoms of UTI; they are aware of colonization/chronic bacteria. On 3/31/25 at 3:09 pm, Surveyor interviewed Director of Nursing (DON)-B regarding R24 and was told R24 has had frequent UTIs and that staff always notify the optum nurse and R24's wife when one is suspected. Surveyor asked about the treatments not documented as completed on the TAR and Hiprex doses not documented as administered on the MAR was told by DON-B: we all monitor R24, it doesn't matter what you do, you cannot prevent infection, for R24 it is easy to get infections. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 4/1/25 at 9:29am, Surveyor interviewed Certified Nursing Assistant (CNA)-G about care for R24's suprapubic catheter and was told that staff empty the catheter bag and clean around the insertion site. CNA-G puts a gown and gloves on. CNA-G stated that CNA-G takes multiple washcloths to clean around the site and dry the area and then puts a brief on to cover the area. Surveyor noted this does not correspond with either of the treatment orders for cleaning the site. On 4/1/25 at 2:49pm, Nursing Home Administrator (NHA)-A let Surveyor know that 1/16/25 was the only urology after visit summary available. Per NHA-A, the facility heard back from the urology office and R24 had not been seen before that since 2023. Surveyor noted the multiple antibiotic treatments for R24 and lack of urology involvement from the facility. On 4/1/25 at 3:45pm, Surveyor met with NHA-A and DON-B to discuss the concern of multiple treatments not being signed out in the TAR, missed Hiprex doses, and the multiple UTIs that R24 has experienced. No additional information was provided as to why the facility did not ensure R24 received appropriate treatment and services related to catheter care to prevent acute encephalopathy from a UTI.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 36898 Based on interview, record review, and review of the facility's policy, the facility failed to maintain pharmaceutical services by ensuring medications were available to be administered as ordered by their physician to meet their medical needs for nine of nine residents (R)18, R19, R9, R5, R17, R21, R22, R23 and R24 reviewed for medication availability. This failure placed the residents at risk for unmet pharmacological interventions to maintain or improve their medical conditions. * Failure to ensure the availability of ordered medications for R9, R18, and R19 * Medication administration observed for R23, R22, R21, and R17 with an error rate of 97.05% * R5's physician ordered Imatinib medication unavailable * R24 had a delay in the start of physician ordered ertapenem intravenous antibiotic medication * R22 has medications that are EC (enteric coated) and ER (extended release) that were crushed and R22's levetiracetam was observed being crushed as well. Findings include: Review of the facility's policy titled, Policy Services Overview dated 01/2024 revealed, .The community shall accurately and safely provide or obtain pharmacy services, including the provision of routine and emergency medications and biologicals, and the services of a licensed Pharmacist-P. Each community shall adopt the provider pharmacy policy and procedure manual .6. Help the community assure that medications are requested, received, and administered in a timely manner as ordered by authorized prescribers .8. Collaborate with the associates and practitioners to address and resolve medication needs or problems . Review of the facility's policy titled, Administering Medications revised 12/2024 revealed, .Medications shall be administered in a safe and timely manner, and as prescribed .C. Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines (60 minutes before the due time and 60 minutes after the due time) . 1. Review of R18's undated Profile Face Sheet revealed the resident was admitted to the facility on [DATE] with diagnoses which included acute osteomyelitis of right and left ankle and foot, type 2 diabetes mellitus with foot ulcer and with diabetic neuropathy, lymphedema, gastro-esophageal reflux disease, iron deficiency anemia, seizures, and hyperlipidemia. Review of R18's Interdisciplinary Note dated 02/28/25 at 4:31 PM revealed, Resident admitted from [name of hospital] .with Type 2 Diabetes Mellitus, with infected foot ulcer .Resident has right arm single lumen PICC [peripherally inserted central catheter]. Resident to receive IV/ABT [Intravenous Antibiotic] until 04/07/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R18's Physician Orders revealed the following order,02/28/25 Vancomycin (antibiotic used to treat bacterial infections) 1.5 gram/300 mL [milliliter] in dextrose [glucose] 5% intravenous piggyback-166.7ml intravenous Every Day .for foot wound .Last Dose 03/11/25. 02/28/25 Ertapenem [an antibiotic used to treat certain serious infections] INJ [injection] 1GM [gram] SOLR [solution reconstituted]-100ml Intravenous Every Day for .wound infection .Last Dose 03/27/25. 02/28/25 Allopurinol [medication used to treat gout] Tab 300mg [milligram] TABS-300mg by Mouth Every Day For Gout . 02/28/25 Gabapentin [used to treat seizures and nerve pain] 800 mg Tablet .By Mouth 3 Times per Day for Pain . 03/01/25 Furosemide TAB 40 mg - 1 tab [tablet] by mouth Every Day for Edema . 03/01/25 Rosuvastatin [medication used to treat high cholesterol and triglyceride levels] Tab 40 mg TABS-40mg By Mouth Every Day For Hyperlipidemia . 03/01/25 Pantoprazole 40 MG Tablet, Delayed Release-40 mg By Mouth Every Day for GERD . 03/01/25 Ferrous Sulf [sulfate] EC [enteric coated] TAB 325mg- 1 tab by Mouth Every Day For Anemia . 03/01/25 Eliquis [an anticoagulant] Tab 2.5mg TABS - 2.5 mg By Mouth Twice a Day for DVT [deep vein thrombosis] . 03/01/25 Sertraline [medication used to treat depression and anxiety] Tab 100mg- 1 tab By Mouth Every Day for Anxiety . Review of R18's Medication Administration Record (MAR), dated 03/2025 revealed the resident did not receive her physician ordered medications of: Vancomycin was scheduled at 8:00 AM on 03/01/25, 03/02/25, 03/03/25, and 03/04/25. The MAR included the following notes: 03/01/25 Med [medication] Not Administered. 03/02/25 Med Not Administered. Trough lab on order. 03/03/25 Med Not Administered. Trough not resulted. Lab called multiple times by DON-B [Director of Nursing]-B. Lab stated they are very behind. 03/04/25 Med Not Administered. Per lab and DON-B, still waiting on vanco [vancomycin] trough level and should hold dose of vancomycin. Lab stated results will be in tomorrow morning. Ertapenem scheduled at 6:00 AM on 03/01/25. The MAR included a note dated 03/01/25 of Med Not Administered, medication wasn't delivered. Review of the MAR dated 03/25 indicated on 03/01/25 the medications: Allopurinol, Gabapentin, Furosemide, Rosuvastatin, Pantoprazole, Ferrous Sulfate, Eliquis and Sertraline scheduled at 8:00 AM, had a note that indicated Medication Not Administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R19's undated Profile Face Sheet revealed the resident was admitted to the facility on [DATE] with diagnosis of glaucoma. Review of R19's Physician Orders revealed the following orders: 11/26/24 Dorzolamide-timolol (PF) (medicated eye drops used to treat glaucoma) 2%-0.5% eye drops .2-0.5% Both Eyes Twice a Day For glaucoma . 11/26/24 Latanoprost 0.005% Eye Drops .1 drop Left Eye Hour of Sleep For glaucoma . Review of R19's MAR dated 03/25 revealed the resident did not receive the following medications as ordered: Dorzolamide-timolol scheduled for 4:00 PM on 03/09/25. The MAR included a note dated 03/09/25 of Medication Not Administered. Medication not available. Latanoprost scheduled for HS (hour of sleep) on 03/09/25, 03/23/25 and 03/24/25. The MAR included the following notes: 03/09/25-Med Not Administered. Med not available; 03/23/25 Med Not Administered and 03/24/25 Med Not Administered. During an interview on 03/28/25 at 12:26 PM, the DON-B confirmed R18 did not receive her vancomycin as ordered. The DON-B stated the facility needed a trough lab before the pharmacy would send the medication. The DON-B also stated she was not aware a trough lab could not be ordered and results received immediately. The DON-B stated the hospital came to the facility and drew the lab; however, it took two or three days for the result to come back. The DON-B further stated R18 had been receiving the vancomycin when she was discharged from the hospital and admitted to the facility. The DON-B stated it was important that R18 would have received the vancomycin as ordered by her physician because when there is a delay in treatment, it could take longer for the resident's infection to heal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/25 at 2:55 PM, when asked about the process for the facility ordering medications, the Pharmacist-P-P stated the when a resident was admitted , the facility would enter the resident into their electronic medical record (EMR) system. As the facility entered the resident's physician orders in the system, the orders would automatically transmit to the pharmacy's system. When the orders are transmitted to the pharmacy, the pharmacy technicians will review the orders and do any edits needed for the packaging of the medications. The Pharmacist-P would then verify the information against the physician orders. If completed by 5:00 PM, the medication would leave with the currier and be delivered within a few hours. If the medications were not completed by the 5:00 PM cutoff time, they would be sent out later that night to the facility. The Pharmacist-P stated if somehow the medication missed the second delivery, the facility could contact the pharmacy and either get a code to obtain the medication from the cubex (the facility's emergency medication supply) if the medication was available in the cubex, or the pharmacy would work with a local pharmacy to supply a few doses. Continued interview revealed if the medication was a controlled medication, an order either has to be faxed with a wet signature or completed via electronic script with an electronic signature. The Pharmacist-P stated the cubex was stocked with some controlled medications and the nurse would need to get an order from the physician and then the pharmacy would give them a code to retrieve the medication from the cubex. If the medication is for a resident who was not a new admission, and the medication was routine, the medications were automatically refilled and there should never be a problem with the facility running out of the medication unless the medication was out of refills, or the facility had to waste a medication and then it could cause a medication to run out early. The Pharmacist-P further stated if the facility had a situation where an ordered medication did not arrived from the pharmacy, the facility should contact the pharmacy so they could figure out why it was not delivered, and the pharmacy would then ensure the medication got to the facility. When the Pharmacist-P was asked about R18's vancomycin not being delivered to the facility, the Pharmacist-P stated that for a resident who was admitted and had already been receiving vancomycin, a trough or random level would need to be completed before the pharmacy could send any to ensure the correct dosage was sent and administered to the resident. The Pharmacist-P stated that when vancomycin was administered as ordered or abruptly stopped because the pharmacy is awaiting the trough labs, there is a risk the infection could worsen, and patient would have to be readmitted back to the hospital. During an interview on 03/28/25 at 5:53 PM, the DON-B confirmed the medications not administered for R18 and R19 were due to the medication not being on hand. The DON-B stated it was her expectation that the nurses would have called the pharmacy and then notified the resident's physician to get further direction. The DON-B also stated if the medication needed was available in the cubex, it was her expectation that the nurse would have asked the physician if the medication could be obtained from it and then call the pharmacy and get a code to retrieve the medication. During an interview on 03/28/25 at 6:30 PM, Attending Physician (AP)-M stated it was his expectation when the trough lab did not come back and the vancomycin medication was not sent by the pharmacy, the nursing staff would have notified him. AP-M stated it was important the vancomycin was administered as ordered to promote healing. AP-M also stated if a medication was not received from the pharmacy and a resident was out of the medication, the nursing staff should have notified him and the pharmacy to see what they could do to get medication for the resident. 3. Review of the facility's policy titled, Medication and Treatment Orders dated 01/2024 indicated, Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and time of the order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Profile Face Sheet dated 03/28/25 and found in the electronic medical record (EMR) under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnosis of cellulitis of the right lower limb and chronic pain. Review of R9's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/12/25 and found in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated R9 was receiving opioid pain medication and antibiotics at the time of the assessment. Review of R9's Interdisciplinary Notes dated 03/21/25 3:11 PM in the EMR under the Notes tab indicated, Resident states she is vomiting, but there is nothing in the basin except spit. Review of R9's Interdisciplinary Notes dated 03/25/25 2:48 PM in the EMR under the Notes tab indicated, Several episodes of emesis throughout shift. Doctor notified. Will continue to monitor. Review of R9's physician orders dated 03/01/25 through 03/27/25 and found in the EMR under the Orders tab revealed an order, with an original order date of 02/08/25, for the resident to receive Tramadol (a potent pain-relieving medication) 50 milligrams (mg) every six hours for chronic pain. The Tramadol order indicated an end date of 03/15/25. The document also included an order, with an original order date of 03/21/25, for the resident to receive Keflex (an oral antibiotic medication) 500 mg by mouth four times per day for a urinary tract infection. The Keflex order indicated an end date of 03/28/25. There were no physicians orders found in the EMR to indicate the resident's oral Keflex was to be discontinued on 03/25/25 or that and intravenous (IV) line was to be placed for hydration of the resident and for the administration of IV antibiotics. An order was entered on 03/27/25 to indicate an IV line was to be started and 1000 milliliters of normal saline was to be administered one time on that date. Review of R9's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 03/01/25 through 03/27/25 and found in the EMR under the Orders tab revealed R9 did not receive ordered doses of her scheduled Tramadol on 03/01/25, 03/02/25, 03/03/25, 03/04/25, 03/06/25, 03/07/25, 03/10/25, 03/11/25, 03/12/25, and 03/13/21. Notation next to the administration entries for 03/01/25, 03/04/25, 03/06/25, and 03/10/25 revealed the medication was not administered due it was not available from the pharmacy. Nothing was noted to indicate why the remaining doses listed above were not administered. The MAR indicated the normal saline ordered to be administered to the resident via IV on 03/27/25 was not administered as of the evening shift on that date. During an interview with Licensed Practical Nurse (LPN)-E on 03/25/25 at 12:10 PM while she was administering medications from the facility medication cart, she stated she worked with the facility as an agency nurse and stated she was often not able to administer medications to residents due to the medications were not available from the pharmacy. LPN-E stated the facility had an automated medication contingency machine in which medications were stored to be accessed if medication was not available in a resident's inventory, however she did not have access to this machine. LPN-E stated, There have been medications (recently) I just can't give, and I have to indicate not available in the resident's MAR because they (the medications) just aren't here and available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nursing Unit Manager (UM)-Q on 03/25/25 at 12:37 PM, The UM-Q stated medications were often not available from the pharmacy due to the medications not being ordered in a timely manner by nursing staff. She stated medications were available in the facility's medication contingency machine, however many of the facility's nurses were agency nurses and most did not have access to this machine. UM-Q stated she still did not have access to the contingency medication machine. UM-Q stated controlled medications, such as narcotic pain medication required two nurses to obtain the medication from the machine and so even when there was one nurse in the facility who could access the machine, controlled medication could not always be accessed due to this requirement. UM-Q stated the expectation was at least one nurse should in the building at all times who was able to access the contingency medication machine. UM-Q confirmed this was not always the case and confirmed many medications had been simply documented as unavailable and had not been administered per physician's orders due to these challenges. During an interview with LPN-R on 03/25/25 at 3:35 PM, LPN-R stated she did have access to the contingency medication machine and was able to remove medication from it most of the time if a resident was out of a medication in the medication cart. LPN-R stated that she was not able to access controlled medication, such as narcotic pain medication when a resident ran out of it on the cart since it required two staff members to access the machine and sometimes there were not two nurses in the facility who had access to the machine. LPN-R stated that when medication was not available from the pharmacy and she was not able to access it in the contingency medication machine, she was unable to administer the medication to the resident and would document this in the resident's MAR. During an interview with Licensed Practical Nurse (LPN)-S on 03/25/25 at 4:08 PM, LPN-S stated he did not have access to the facility's automated contingency medication machine. He stated medications were sometimes not available from the pharmacy and then he was usually able to reach the DON-B to help him access the medication. He stated when the DON-B, or someone else with access to the contingency medication machine, was not available, he was not able to give the medication and had to document it as not administered in the resident's record. LPN-S additionally stated a verbal physician's order had been passed on to him from the day shift nurse working on that medication cart, indicating R9's oral antibiotics were to be discontinued due to her vomiting and an IV was to be placed for the resident and IV antibiotics had been ordered. LPN-S stated the day shift nurse was an agency nurse and told him she did not know how to enter the orders into the facility's EMR and so was passing this on to him to do. LPN-S stated he also did not know how to enter the orders into the resident's EMR and that he had been trying to contact the DON-B to assist him with this task and had not been able to reach her. He stated he did not think the DON-B was in the building that day and so he was unsure of how the orders were going to be entered into R9's record. During an observation and interview with R9 on 03/27/25 at 10:13 AM, she stated she had been vomiting for several days and had not been able to hold down her oral antibiotic (Keflex). Observation revealed that R9 did not have an IV in place. R9 stated the Keflex was too large to swallow and caused her to become nauseated when she took it. R 9 confirmed that she had been told an IV line was supposed to be placed on 03/25/25 so that IV antibiotics and fluids could be administered per the IV. R9 stated no one had ever been in to place the IV. R9 stated her oral antibiotics had been offered to her per her originally ordered schedule. R9 stated when she asked staff when the IV was to be started, staff told her they would check on it but would never return with an answer. R9 stated her ordered Tramadol had not been administered on many dates during the month of March due to it not being available from the pharmacy. R9 stated she needed the Tramadol to help control her chronic pain. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON-B on 03/28/25 at 11:45 AM, she confirmed she was not in the facility on 03/24/25 or 03/25/25 until about 4:45 PM. She stated R9's Tramadol was a scheduled pain medication. The DON-B confirmed that R9 did not get her Tramadol as ordered on multiple dates in March 2025, and stated her expectation was the resident's medication would be available in the facility for administration. The DON-B confirmed nursing staff was expected to have access to the contingency medication machine and expected to be able to always access controlled and non-controlled medications from the machine. The DON-B stated all verbal orders received for residents were expected to be documented in the resident's EMR immediately and followed by nursing staff. The DON-B stated R9's IV had been placed the morning of 03/27/25 (two days after the original order was received). The DON-B stated R9's oral antibiotics had been discontinued. The DON-B stated that R9 was to have received normal saline via her IV on the afternoon of 03/27/25. The DON-B confirmed LPN-S told her, R9's physician wanted the resident to have an IV placed after she arrived at the facility on the evening of 03/25/25. The DON-B stated that LPN-S should have known how to enter orders into the EMR, and stated she directed LPN-S to enter the orders into the resident's record after he informed her of the verbal orders on 03/25/25. The DON-B could not explain why the orders had never been entered into R9's EMR. The DON-B stated she called R9's physician on the morning of 03/27/25, obtained a new order for the resident's IV to be placed and normal saline to be administered, and entered the order into the resident's record. She stated she thought the normal saline had been administered via the resident's IV line as ordered but could not be sure. 49011 The facility's Policy and Procedure titled, Administering Medications last revised 12/2024, states in part: Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . C. Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines (60 minutes before the due time and 60 minutes after the due time) . Q. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document on the MAR (Medication Administration Record) or eMAR (electronicMAR) for that drug and dose . R. The individual administering the medication to document on the MAR or eMAR after giving each medication and before administering the next ones . W. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the nurse assessment, has determined that they have the capacity to do so safely . 4.) On 3/27/2025, at 1:12pm, Surveyor observed medications being prepared and administered to R23 by Registered Nurse (RN)-H. The following medications were administered that were scheduled for 8am: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Midodrine 5mg, the dose scheduled at noon was then not signed out on the MAR Omeprazole 20mg Miralax Eliquis 5mg Sertraline 50mg Metformin 500mg Metoprolol Succinate ER (extended release) 25mg Surveyor noted this was over 4 hours beyond the allotted 60 minutes after the due time of the physician ordered administration time resulting in 7 errors. Surveyor reviewed the MAR and noted that RN-H documented R23's acidophilus-pectin as administered. During R23's medication administration observation RN-H stated that the acidophilus-pectin was not in the cart and did not administer the medication. Surveyor noted an order for the medication atorvastatin to be given at 9am that was documented as given by RN-H, but not observed as administered. This resulted in 2 additional errors. On 4/1/25, at 9:37am, Surveyor observed medications being prepared and administered to R22 by Licensed Practical Nurse (LPN)-E. The following medications were administered that were scheduled for 8am: Amlodipine 10mg Levetiracetam 500mg Aspirin EC 81mg Acetaminophen 325mg (2 pills to equal 650mg) Metoprolol ER 25mg Surveyor noted this was over 30 minutes beyond the allotted 60 minutes after the due time of the physician ordered administration time. This resulted in 5 errors. On 4/1/25, at 9:50am, Surveyor observed medications being prepared and administered to R21 by Licensed Practical Nurse (LPN)-E. The following medications were administered that were scheduled for 8am: Alopurinol 100mg Losartan 25mg (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Methenamine Hippurate 1 gram Aspirin Chewable 81mg Escitalopram 20mg And Pantoprazole 40mg was administered that was scheduled for ac (before) breakfast. Surveyor noted this was over 30 minutes (and after breakfast) beyond the allotted 60 minutes after the due time of the physician ordered administration time. This resulted in 6 errors. On 4/1/25, at 11:20am, Surveyor observed medications being prepared and administered to R17 by Licensed Practical Nurse (LPN)-E. The following medications were administered that were scheduled for 8am: Furosemide 20mg Metoprolol ER 25mg The following medications were administered that were scheduled for 9am: Amiodarone 200mg Eliquis 5mg Spironolactone 25mg Entresto 24/26mg Clopidogrel 75mg Jardiance 10mg Famotidine 20mg Duloxetine 60mg Surveyor noted this was over 2 hours for the 8am and over an hour for the 9am beyond the allotted 60 minutes after the due time of the physician ordered administration time. This resulted in 10 errors. Surveyor notes these errors (plus 3 medications being crushed that should not have) resulted in a 97% error rate for medication administration. On 4/1/25, at 3:45pm, Surveyor spoke with Nursing Home Administrator-A and Director of Nursing-B of the concern that medications were administered late and two were signed out on the MAR as administered and were not observed being administered during the medication observation. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided as to why the facility did not ensure medications were administered timely and only documented as administered if given. 5.) R5 was admitted to the facility on [DATE]. R13's pertinent diagnoses include spinal stenosis lumbar region, myeloid leukemia, type 2 diabetes mellitus, and unsteadiness on feet. R5's Admission Minimum Data Set (MDS), with an assessment reference date of 3/22/25, documents a Brief Interview for Mental Status (BIMS) score of 13, indicating that R5 is cognitively intact for decision making. The MDS documents that R5 makes self understood and understands others. The MDS documents that R5 was assessed to have no behaviors exhibited during the look back period. No swallowing disorders were noted. R5 was coded to have an active diagnosis of cancer. R5 is responsible for self. R5's physician order with a start date of 3/19/25 documents Imatinib 400mg tablet by mouth every day. Surveyor reviewed R5's Medication Administration Record (MAR) and saw that Imatinib was documented as med not administered nine times between 3/19/25 to 4/1/25. Surveyor notes five times the medication was documented as given, however, surveyor noted the medication was not unavailable in the facility. Surveyor reviewed R5's progress notes and was unable to locate any documentation why Imatinib was not given. On 3/31/25, at 1:13pm Surveyor interviewed R5 and asked if they had knowledge of the Imatinib medication not being administered to R5 since they admitted . R5 stated that the medication had been delivered to their house instead of the facility and insurance won't cover more pills so the facility has been unable to give the medication. On 3/31/25, at 02:52pm, Surveyor interviewed Director of Nursing (DON-B)-B regarding R5's Imatinib medication. DON-B-B stated that R5 was taking R5's own Imatinib medication. DON-B-B stated they called the pharmacy and told them to send it even though it was costly to the facility, DON-B-B will follow up on why it was not sent. On 4/1/25, at 9:20am, Surveyor interviewed R5 about the Imatinib medication and R5 confirmed they were still not getting it from the facility. R5's son brought R5 the supply sent to R5's house and R5 is taking the medication on their own. Surveyor confirmed R5 is watching the pills the staff gives to them to be sure R5 does not take a double dose should the Imatinib become available. R5 is very aware of the medications R5 takes, R5 told Surveyor each and how it looks. R5's doctor said the Imatinib is very important and R5 has been taking it for four years due to cancer. On 4/1/25, at 3:45pm, Surveyor let Nursing Home Administrator (NHA)-A and DON-B-B know of concern that Imatinib was unavailable for Facility to administer to R5. DON-B-B stated that R5 has been getting the medication since admission because R5's son brought it from R5's home. Surveyor asked if R5 was assessed to administer their own medications and DON-B-B stated that they began that assessment today. Surveyor was unable to locate any documentation that the physician was aware R5 was administering this medication to self or an order that R5 was deemed to have to capacity to do so safely. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why the facility did not ensure that R5 had Imatinib available to be administered by licensed staff. 6.) R24 was originally admitted to the facility on [DATE]. R24's pertinent diagnoses include multiple sclerosis, neuromuscular dysfunction of bladder, paraplegia and personal history of urinary tract infections. R24's Significant Change Minimum Data Set (MDS), with an assessment reference date of 1/6/25, documents a Brief Interview for Mental Status (BIMS) score of 09, indicating that R24 has moderate cognitive impairment. The MDS documents that R24 was assessed to have no behaviors exhibited during the look back period. R24 is coded to have an indwelling catheter and is always incontinent of bowel. R24 has a health care power of attorney. R24's nursing progress note dated 3/28/25, at 5:53am, documents: resident readmitted to facility on 3/26 . antibiotic was reported to arrive on this night shift for administration - did not arrive . Unable to reach pharmacy to confirm arrival . R24's nursing progress note dated 3/28/25, at 2:32pm, documents: Resident had no concerns or complaints. Nurse Manager started resident on IV ABT . Surveyor noted the Medication Administration Record (MAR) records ertapenem on 3/27/25 as med not administered with a physician order start date of 3/27/25 and end date of 3/28/25, no doses are documented as administered. Another record for ertapenem has a start date of 3/29/25 and end date of 4/2/25 and ertapenem is first documented as administered on 3/29/25. R24's nursing progress note, written by Director of Nursing (DON-B)-B, dated 3/29/25, at 8:12pm, documents: .Resident receive first dose on 3/28/25 due to pharmacy delay. MD (medical doctor) was notified. Wife was updated . Surveyor noted discrepancy in R24's medical record for the start date of the ertapenem. On 3/31/25, at 2:52pm, Surveyor interviewed DON-B-B regarding R24's ertapenem being delayed and DON-B-B stated that R24 had an order for ertapenem when R24 returned from the hospital on the 26th to start on the 27th. DON-B-B called the pharmacy and was told the pharmacy did not see an order on their end, the paperwork was missing. DON-B-B then called the hospital to see if they had the medication and was told they did not have it in the correct dose. DON-B-B stated that the pharmacy couldn't provide the medication in a timely manner. It was started on the 28th though, not the 27th as prescribed. On 4/1/25, at 3:45pm, Surveyor informed Nursing Home Administrator-A and DON-B-B of the concern that R24 had a delay to the start of IV antibiotics after a hospital stay and the discrepancy in the charting No further information was provided as to why the facility did not ensure that R24 had ertapenem due to acute encephalopathy from a UTI available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7.) On 4/1/25, at 9:37am, Surveyor was observing medication administration for R22. Licensed Practical Nurse (LPN)-E put each of the medications for R22 into a medication cup, LPN-E proceeded to crush all of the medications. Surveyor noted that levetiracetam, aspirin EC (enteric coated) and metoprolol ER (extended release) were included in the medications that were crushed. Per epilepsy.com levetiracetam is an intermediate release drug and should not be crushed. Per drugs.com extended release and enteric coated medications should not be crushed because it releases all of the drug at once, increasing the effects. On 4/1/25, at 9:37am, Surveyor interviewed LPN-E who stated that LPN-E knows you should not crush levetiracetam, but LPN-E has made several attempts with pharmacy to get the liquid for [TRUNCATED]

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review, observations and interviews, the facility failed to ensure three residents (R10, R5 and R24) out of a total of 33 residents reviewed in the sample was free from a significant medication error. This failure created the potential for residents to experience negative physical and/or psychosocial effects related to the omission of necessary ordered medication. * R5 had a physician order to receive one 400mg Imatinib tablet (Per Mayoclinic.org Imatinib is used to treat different types of cancer or bone marrow conditions. It prevents or stops the growth of cancer cells.) daily. R5 did not receive Imatinib between 3/19/2025 and 4/1/2025, nine were marked as Med not administered and five administrations were signed out even though the Facility did not have the medication in stock. Hence, 14 administrations were unavailable for administration and still not available at the time of Surveyor's exit from the Facility. * R24 returned from the hospital on 3/26/25 with a physician order for sodium chloride 0.9% parental solution 50ml with ertapenem 1 gram reconstitution solution for 4 days (per Mayoclinic.org ertapenem is used to treat infections) documentation on the Medication Administration Record (MAR) begins 3/29/25, 2 days passed without the medication to treat a urinary tract infection with acute encephalopathy. Findings include: Review of the facility's policy titled, Administering Medications Policy dated 12/2024 indicated, .Medications shall be administered in a safe and timely manner, and as prescribed .Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines (60 minutes before the due time and 60 minutes after the due time) .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document on the MAR or eMAR [Medication Administration Record or Electronic Medication Administration Record] for that drug and dose. Review of R10's Profile Face Sheet dated 03/28/25 and found in the Electronic Medical Record (EMR) under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnoses acute and chronic respiratory failure, multiple myeloma, alcoholic cirrhosis of the liver, Congestive Heart Failure (CHF), Benign Prostatic Hyperplasia (BPH), Amyloidosis, and Chronic Obstructive Pulmonary Disease (COPD). Review of R10's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/25 and found in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R10's Physician Orders, dated 03/25/25 and found in the EMR under the Orders tab revealed current orders for the resident to receive Midodrine (a blood pressure medication) five milligram (mg) three times daily for blood pressure control, Calcium (vitamin supplement) 600 mg twice daily, Mucinex (a cough suppressant medication) 1200 mg Extended Release every twelve hours for cough, Finasteride (a medication used to treat BPH) five mg daily, Atorvastatin (a cholesterol controlling medication) 40 mg daily for hyperlipidemia, Bumex (a diuretic medication) one mg daily for blood pressure control, and Acyclovir (an anti-viral medication) 400 mg twice daily for Amyloidosis. Review of R10's Medication Administration Record (MAR) dated 03/01/25 through 03/27/25 and found in the EMR under the Orders tab revealed R10 did not receive any of the above ordered at the 8:00 AM medication administration time of 03/10/25, 03/11/25, 03/15/25, 03/18/25, or 03/25/25. The MAR indicated the medications were not administered due to the resident being out of the facility. There was nothing to indicate any of the medications were given at a different time on any of the above dates. Review of R10's record revealed the resident had regularly scheduled chemotherapy appointments and revealed the resident left the facility at about 7:45 AM for the scheduled appointments, indicating the resident's morning medications needed to be administered prior to leaving for his scheduled appointments. During an observation and interview with Licensed Practical Nurse (LPN-E) on 03/25/25 at 12:10 PM while she was administering medications from the facility medication cart, a medication cup with medications was observed sitting on the top of the cart. LPN-E stated the medication had been poured for R10 that morning but the medication had not been administered since the medication was poured after the resident left for his scheduled appointment. LPN-E indicated R10 had left the facility for his appointment at approximately 7:45 AM, as scheduled and she had not been informed the resident would be leaving the building and would need to receive his medication prior to that time. LPN-E confirmed the medication in the medication cup was R10's Midodrine, Calcium, Mucinex, Finasteride, Atorvastatin, Bumex and Acyclovir and stated the medication would have to be destroyed since R10 had not returned to the facility as of the time of the interview and it was too late to administer any of the medication. LPN-E stated she would indicate on the MAR the resident had not received the medication. During an interview with the Director of Nursing (DON)-B on 03/28/25 at 11:45 AM, she confirmed R10 did not receive his morning dose of ordered medications on the above dates based on review of the resident's MAR. She stated her expectation was medications would be given as ordered and stated if a resident had a known appointment, her expectation was staff would ensure any scheduled medication was administered prior to the resident leaving for the appointment as long as it could be administered within facility timing parameters (one hour before or after the ordered medication administration time). She stated if this was not possible, her expectation was the resident's physician would be contacted to revise the resident's medication orders to accommodate the resident's scheduled appointments. 49011 The Facility Policy and Procedure titled, Administering Medications last revised 12/2024, states in part: Policy Statement (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . C. Medications shall be administered in accordance with the orders and within the allowable time frame per best practice/regulatory guidelines (60 minutes before the due time and 60 minutes after the due time) . Q. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document on the MAR (Medication Administration Record) or eMAR (electronicMAR) for that drug and dose . R. The individual administering the medication to document on the MAR or eMAR after giving each medication and before administering the next ones . W. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the nurse assessment, has determined that they have the capacity to do so safely . 2.) R5 was admitted to the facility on [DATE]. R13's pertinent diagnoses include spinal stenosis lumbar region, myeloid leukemia, type 2 diabetes mellitus, and unsteadiness on feet. R5's Admission Minimum Data Set (MDS), with an assessment reference date of 3/22/25, documents a Brief Interview for Mental Status (BIMS) score of 13, indicating that R5 is cognitively intact for decision making. The MDS documents that R5 makes self understood and understands others. The MDS documents that R5 was assessed to have no behaviors exhibited during the look back period. No swallowing disorders were noted. R5 was coded to have an active diagnosis of cancer. R5's physician order with a start date of 3/19/25 documents Imatinib 400mg tablet by mouth every day. Surveyor reviewed R5's Medication Administration Record (MAR) and saw that Imatinib was documented as med not administered nine times between 3/19/25 to 4/1/25. Surveyor notes five times the medication was documented as given, however, (per interviews to follow) the medication was not unavailable in the facility. Surveyor reviewed R5's progress notes and was unable to locate documentation why Imatinib was not given. On 3/31/25, at 1:13pm, Surveyor interviewed R5 and asked if they had knowledge of the Imatinib medication not being given to them since R5 admitted . R5 stated that the medication had been delivered to R5's house instead of the facility and insurance won't cover more pills so the facility has been unable to give the medication. On 3/31/25, at 02:52pm, Surveyor interviewed Director of Nursing (DON)-B regarding R5's Imatinib medication. DON-B stated that R5 was taking R5's own Imatinib medication. DON-B stated they called the pharmacy and told them to send it even though it was costly to the facility, DON-B will follow up on why it was not sent. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25, at 9:20am, Surveyor interviewed R5 about the Imatinib medication and R5 confirmed they were still not getting it from the facility. R5's son brought R5 the supply sent to R5's house and R5 is taking the medication on their own. Surveyor confirmed R5 is watching the pills the staff gives to them to be sure R5 does not take a double dose should the Imatinib become available. R5 is very aware of the medications R5 takes. R5's doctor said the Imatinib is very important and R5 has been taking it for four years due to cancer. On 4/1/25, at 9:45am, Surveyor interviewed Licensed Practical Nurse (LPN)-E regarding the Imatinib and if LPN-E had given it today. LPN-E stated that the last LPN-E had heard the facility was waiting for approval due to the cost of the medication. On 4/1/25, at 3:45pm, Surveyor let Nursing Home Administrator (NHA)-A and DON-B know of concern that Imatinib was unavailable for facility to administer to R5. DON-B stated that R5 has been getting the medication since admission because R5's son brought it from R5's home. Surveyor asked if R5 was assessed to administer their own medications and DON-B stated that they began that assessment today. Surveyor was unable to locate documentation that the physician was aware R5 was administering this medication to self or an order that R5 was deemed to have to capacity to do so safely. No additional information was provided as to why the facility did not ensure that R5 had Imatinib available to be administered by licensed staff to prevent a significant medication error. 3.) R24 was originally admitted to the facility on [DATE]. R24's pertinent diagnoses include multiple sclerosis, neuromuscular dysfunction of bladder, paraplegia and personal history of urinary tract infections. R24's Significant Change Minimum Data Set (MDS), with an assessment reference date of 1/6/25, documents a Brief Interview for Mental Status (BIMS) score of 09, indicating that R24 has moderate cognitive impairment. The MDS documents that R24 was assessed to have no behaviors exhibited during the look back period. R24 is coded to have an indwelling catheter and is always incontinent of bowel. R24 has a health care power of attorney. R24's nursing progress note dated 3/26/25, at 11:34pm, documents: Pt (patient) returned from St. [NAME] Hospital were R24 was treated with IV [NAME] (intravenous antibiotics) for UTI (urinary tract infection). Pt alert and awake in bed this shift. Pt able to make needs known . Per discharge paperwork Pt has a peripheral IV in right antecubital placed on 3/20/25. R24's nursing progress note dated 3/28/25, at 5:53am, documents: resident readmitted to facility on 3/26 . antibiotic was reported to arrive on this night shift for administration - did not arrive . Unable to reach pharmacy to confirm arrival . R24's nursing progress note dated 3/28/25, at 2:32pm, documents: Resident had no concerns or complaints. Nurse Manager started resident on IV ABT . Surveyor noted the Medication Administration Record (MAR) records ertapenem on 3/27/25 as med not administered with a physician order start date of 3/27/25 and end date of 3/28/25. Another record for ertapenem has a start date of 3/29/25 and end date of 4/2/25 and is first documented as given on 3/29/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's nursing progress note, written by Director of Nursing (DON)-B, dated 3/29/25, at 8:12pm, documents: . Resident receive first dose on 3/28/25 due to pharmacy delay. MD (medical doctor) was notified. Wife was updated . Surveyor noted discrepancy in R24's medical record of the start date of the ertapenem. On 3/31/25, at 2:52pm, Surveyor interviewed DON-B regarding R24's ertapenem being delayed and DON-B stated that R24 had an order for ertapenem when R24 returned from the hospital on the 26th to start on the 27th. DON-B called the pharmacy and was told the pharmacy did not see an order on their end, the paperwork was missing. DON-B then called the hospital to see if they had the medication and was told they did not have it in the correct dose. DON-B stated that the pharmacy couldn't provide the medication in a timely manner. It was started on the 28th though, not the 27th as prescribed. On 4/1/25, at 3:45pm, Surveyor informed Nursing Home Administrator-A and DON-B of the concern that R24 had a delay to the start of IV antibiotics after a hospital stay and the discrepancy in charting of the actual start of the medication. No additional information was provided as to why the facility did not ensure that R24 had ertapenem due to acute encephalopathy from a UTI available to prevent this significant medication error.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 18947 Based on observation, interview, and policy review, the facility failed to ensure medications were secured properly for three of three medication carts (first, second and third floor medication carts). This failure placed residents' medication to be at risk for diversion and/or at risk to be taken by cognitively impaired residents. Findings include: Review of the facility's policy titled, Administering Medications revised 12/2024 revealed, .O. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or other passing by . 1. During an observation of the third floor on 03/25/25 at 4:30 PM, the medication cart was observed to be unlocked and unattended at the nurses station. No nursing staff was observed in the area. During an interview with Licensed Practical Nurse (LPN)-S on 03/25/25 at 4:35 PM, he confirmed he was responsible for the unlocked medication cart and stated he had just gone down the hall to administer medication to a resident. He stated the cart should have been locked while unattended. 2. During an observation of the first floor on 03/26/25 at 8:55 AM, the medication cart was observed to be unlocked and unattended in the charting room on the unit. The charting room door was open, and no staff could be located on the floor. 3. During an observation of the second floor on 03/26/25 at 11:47 AM, the medication cart was observed to be unlocked and unattended. No nursing staff was observed in the area. During an interview with LPN-T on 03/26/25 at 11:55 AM, she confirmed she was responsible for the unlocked medication cart and stated she thought she had locked it when she walked away to go into the nursing office to do some charting. LPN-T stated the cart should have been locked while unattended. 4. During an observation of the first floor on 03/26/25 at 2:50 PM, the medication room across from the nurses' station revealed the medication room's door was in a fully opened position. Inside the medication room, visible from the hallway was an unlocked and unattended medication cart accessible to residents and unauthorized people. The medication room was vacant with no staff and there were no nursing staff members at the nurses' station or in the vicinity of the medication room. Continuous observation revealed on 03/26/25 at 2:54 PM, LPN-R returned to the medication room. When interviewed at this time about the unlocked and unattended medication cart, LPN-R stated she should not have left the medication cart unlocked when she left the medication room. When asked why the medication cart should not be left unlocked, LPN-R stated because residents and others could assess the medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON)-B on 03/28/25 at 12:57 PM, she stated it was not acceptable for nursing staff to leave a medication cart unlocked and unattended. 36898 Based on observation, interview, policy review, the facility failed to ensure medications were secured properly for three of three units (Unit One, Unit Two, and Unit Three). This failure placed residents' medication to be at risk for diversion and/or at risk to be obtained by cognitively impaired residents. Findings include: Review of the facility's policy titled, Administering Medications revised 12/2024 revealed, .O. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or other passing by . Observation on 03/26/25 at 2:50 PM of the Unit One medication room across from the nurses' station revealed the medication room's door was in a fully opened position. Inside the medication room, visible from the hallway was an unlocked and unattended medication cart accessible to residents and unauthorized people. The medication room was vacant with no staff and there were no nursing staff members at the nurses' station or in the vicinity of the medication room. Continuous observation revealed on 03/26/25 at 2:54 PM, Licensed Practical Nurse (LPN)-R returned to the medication room. When asked about the unlocked and unattended medication cart, LPN-R stated she should not have left the medication cart unlocked when she left the medication room. When asked why the medication cart should not be left unlocked, the LPN-R stated because residents and others could assess the medications.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to ensure a trough level result was received timely from their laboratory for one of one resident reviewed for laboratory results (Resident (R) 18.) R18's physician ordered a laboratory trough level be obtained for R18 for the resident to be able to continue antibiotic infusions; however, there was a delay in the laboratory results and the resident missed four antibiotic infusions. This failure placed the resident at risk of the infection worsening. Findings include: Review of the facility's policy titled, Laboratory, Radiology, and other Diagnostic Test Results dated 01/2024 revealed, .The resident's Attending Physician will be notified of the results of laboratory Policy Interpretation and Implementation .A. Results of laboratory .tests shall be reported in writing to the resident's Attending Physician or to the community. B. Should the test results be provided to the community; the Attending Physician shall be promptly notified of the results. C. The Director of Nursing Services, or Charge Nurse receiving the test results, shall be responsible for notifying the Physician of such test results . Review of R18's undated Profile Face Sheet revealed the resident was admitted to the facility on [DATE] with diagnosis of acute osteomyelitis of right and left ankle and foot. Review of R18's Interdisciplinary Note dated 02/28/25 at 4:31 PM and provided by the facility revealed Resident admitted from [name of hospital] .with infected foot ulcer .Resident has right arm single lumen PICC [peripherally inserted central catheter]. Resident to receive IV/ABT [Intravenous Antibiotic] until 04/07/25. Review of R18's Physician Order dated 02/28/25 revealed, Vancomycin (antibiotic used to treat bacterial infections) 1.5 gram/300 mL [milliliter] in dextrose [glucose] 5% intravenous piggyback-166.7ml intravenous Every Day .for foot wound .Last Dose 03/11/25. Review of R18's Physician Order dated 03/02/25 revealed, Vancomycin trough-For medication mgmt. [management] . Review of R18's Medication Administration Record (MAR) dated 03/2025 revealed the resident was not administered her vancomycin from 03/01/25 through 03/04/25, which indicated she missed four IV/ATB infusions. Review of R18's MAR dated 03/2025 revealed the following documented note regarding the vancomycin medication not being administered: 03/02/25 Med Not Administered. Trough lab on order. 03/03/25 Med Not Administered. Trough not resulted. Lab called multiple times by DON-B [Director of Nursing]. Lab stated they are very behind. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/04/25 Med Not Administered. Per lab and DON-B-B, still waiting on vanco [vancomycin] trough level and should hold dose of vancomycin. Lab stated results will be in tomorrow morning. Review of R18's Interdisciplinary Note dated 03/03/25 revealed IV/ABT Rt. [right] foot infection. PICC intact to RUE [right upper extremity] .Vanco trough drawn this AM awaiting results . Review of R18's Interdisciplinary Note dated 03/03/25 revealed .Vanco trough drawn this morning, still no results. DON-B-B called lab and they stated they would fax results soon, writer still waiting on results . Review of R18's Interdisciplinary Note dated 03/04/25 revealed Vancomycin held per labs recommendation as the vanco trough has yet to results [sic]. Per lab trough will be resulted tomorrow. Review of R18's [Laboratory Name] Patient Report dated 03/05/25 revealed the lab ordered was Vancomycin Trough, Serum. The report also revealed the collection date was 03/03/25, the date received was 03/03/25, and the date reported (results) was 03/05/25. During an interview on 03/28/25 at 12:26 PM, the DON-B confirmed R18 did not receive her vancomycin as ordered. The DON-B stated the facility needed a trough lab before the pharmacy would send the medication. The DON-B also stated the hospital came to the facility and drew the lab; however, it took two or three days for the result to come back. The DON-B stated the resident could not receive the vancomycin until the lab results of the trough level came back. During an interview on 03/28/25 at 2:55 PM, the Pharmacist-P stated the pharmacy could not send R18's vancomycin until the trough lab results came back. During a subsequent interview on 03/28/25 at 5:53 PM, the DON-B stated it was her expectation R18's lab result would have been received back by the next day after it was collected. During an interview on 03/28/25 at 6:30 PM, Attending Physician (AP)-M stated it was his expectation the laboratory would have had the vancomycin results sooner to the pharmacy and the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policies, record review, observations, and interviews, the facility failed to ensure transmission based precaution (TBP) and/or Enhanced Barrier Precaution (EBP) procedures were consistently followed by staff for six residents (Resident (R)23, R6, R25, R36, R34, and R27); the facility failed to ensure infection prevention procedures related to the cleaning/sanitizing of glucometers were followed for eight residents (R4, R5, R3, R18, R15, R16, R19 and R20) out of a total of 33 residents reviewed in the sample; and the facility failed to ensure the facility's overall program for infection tracking and trending/data analysis procedures were consistently followed. These failures created the potential for increased risk of infection for all residents residing in the facility. Findings include: Review of the facility's policy titled, Infection Prevention and Control dated 08/2024 indicated, Prevention of Infection: Important factors of infection prevention include: a. identifying possible infections or potential complications of existing infections; d. Implementing appropriate transmission-based precautions when necessary and placing a visual indicator to identify residents on such precaution, H. instituting measures to avoid complications or dissemination .Surveillance: Pertinent data is evaluated by the IP (Infection Preventionist), or designee .The information obtained from infection control surveillance activities is compared with that from other facilities and with acknowledged standards, and used to assess the effectiveness of established infection prevention and control practices .Data Analysis: Data is analyzed by absolute number of case reported, as well as by infection rate, which is calculated by: a Categorizing infection by 1. Organism, 2. Whether they are facility or community acquired, 3. Physical location, 4. Prescribing provider. B. Recording the absolute number of infections; c. To adjust for differences in bed capacity or occupancy on each neighborhood (unit), and to provide a uniform basis for comparison, infection rates are calculated as the number of infections per 1000 patient days, for the entire facility. Review of the facility's procedure titled, Obtaining a Fingerstick Glucose Level dated 01/2024 indicated The following equipment and supplies will be necessary when performing the procedure (Blood Glucose Checks): A. Disinfected blood glucose meter (glucometer) .Place the equipment on a clean field .Always ensure the blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Review of the facility's policy titled, Transmission-Based Precautions dated 08/2024 indicated, Transmission based precautions (TBP), also referred to as isolation precautions are added to Standard Precautions when needed to manage specific, highly transmissible, or epidemiologically important pathogens based on the mode of transmission. TBP should be implemented for residents known or suspected to be infected with an infectious agent requiring additional control measures based on the mode of transmission. The facility's policy related to Enhanced Barrier Precautions (EBP) was requested on 03/28/25 at 10:00 AM from the Director of Nursing (DON)-B, however, the policy was not received prior to survey exit on 03/28/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Observations conducted of the facility's First Floor Unit on 03/25/25 between 10:45 AM and 11:02 AM and between 3:15 PM and 3:35 PM and on 03/26/25 between 8:45 AM and 9:00 AM revealed the following: Infection control supply carts containing Personal Protective Equipment (PPE), such as gowns, gloves, and face masks, were observed outside of R35 and R6's rooms. There was no signage on either resident's door to indicate what type of precautions the residents were currently on. Observations conducted of the facility's Second Floor Unit on 03/25/25 between 11:05 AM and 11:30 AM and 3:40 PM and 3:55 PM and on 03/26/25 between 9:03 AM and 9:10 AM revealed the following: Infection control supply carts containing PPE were observed outside of R25 and R36's rooms. There was no signage on either resident's door to indicate what type of precautions the residents were currently on. Observations conducted of the facility's Third Floor Unit on 03/25/25 between 11:36 AM and 12:10 PM and between 4:00 PM and 4:15 PM and on 03/26/25 between 9:10 AM and 9:20 AM revealed the following: Infection control supply carts containing PPE were observed outside of R34 and R27's rooms. There was no signage on either resident's door to indicate what type of precautions the residents were currently on. Subsequent observations of all three floors in the facility on 03/06/25 at 11:15 AM revealed signage was placed on each of the above indicated doors to indicate the residents were on EBP. The DON-B determined R6 was not on any precautions. During an interview with Registered Nurse (RN)-U 03/25/25 at 11:00 AM,. RN-U stated she was unsure why residents were on precautions or for what reason. She stated she would look at signage on the resident's door for direction regarding what type of isolation/precautions measures to use and what PPE to wear while in a resident's room if they were on precautions. RN-U confirmed the information might also be in each resident's clinical record, however she stated she had trouble accessing the records to obtain that information and had not tried. During an interview with Certified Nursing Assistant (CNA)-O on 03/25/25 at 11:20 AM, she stated she did not know why the residents had isolation supply carts outside of their rooms. During an interview with CNA-F and CNA-N on 03/25/25 at 11:25 AM, both staff members confirmed they didn't know why the residents were on precautions. They stated they did not know why the residents had isolation supply carts outside of their rooms. During an interview with CNA-V on 03/25/25 at 11:36 AM, she stated she did not know why the residents had isolation supply carts outside of their rooms. During an interview with CNA-W on 03/25/25 at 11:41 AM, she stated she did not know why the residents had isolation supply carts outside of their rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Licensed Practical Nurse (LPN)-R on 03/25/25 at 3:35 PM, she indicated she didn't know why the residents were on precautions. She stated she did not know why the residents had isolation supply carts outside of their rooms. During an interview with the Therapy Manager-X on 03/25/25 at 3:47 PM, she confirmed she did not know why residents had isolation supply carts outside of their rooms. During an interview with CNA-Y on 03/26/25 at 9:00 AM, she stated she thought all of the resident with isolation carts outside of their rooms were on EBP. During an interview with Dietary Aide (DA)-Z on 03/26/25 at 9:07 AM, she stated she thought the isolation supply carts on the third floor were put there if patients were sick with certain infections. She stated she thought the carts outside of the indicated rooms on the third floor were just there for general supplies. During an interview with RN-D on 03/26/25 at 9:16 AM, she stated she thought all of the residents with isolation carts outside of their rooms were on EBP. During an interview with the DON-B/Infection Preventionist (IP1) on 03/26/25 at 12:40 PM, she confirmed signage was expected to be placed on each residents door if they were on any type of precautions to indicate what PPE was required while caring for the resident while in the resident's room. She stated staff should also have access to the type of precautions a resident had been placed on in each resident's Electronic Medical Record (EMR) but confirmed the EMR was difficult to navigate. The DON-B stated staff was expected to receive information regarding what type of precautions they were supposed to follow, if any, for each resident during report at the beginning of each shift, as well. She stated her expectation was when a resident requiring EBP or TBP, she expected staff to follow the precautions when in the resident's room caring for the resident. During an interview with the DON-B on 03/28/25 at 9:45 AM, she confirmed all of the above indicated residents were on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the facility's policy titled, Transmission-Based Precautions, revised 05/2023 revealed, Policy: It shall be the policy of this community to establish Standard/Transmission-Based Precautions as part of Infection Prevention and Control Program. Purpose: To provide guidance for identification and care of residents with communicable infections, in the least restrictive means possible. Types of Precautions: Transmission-Based Precautions (TBP) .also referred to as Isolation Precautions .are added to Standard Precautions when needed to manage specific, highly transmissible, or epidemiologically important pathogens based on the mode of transmission. TBP should be implemented for residents known or suspected to be infected with an infectious agent requiring additional control measures based on the mode of transmission. Some diseases require a combination of types of TBP. The Centers for Disease Control Isolation Guidance is used to guide appropriate type and duration of precautions .Types of Transmission-Based Precautions are: a. Contact .Contact Precautions 1. Indications- used for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact with the resident or the resident's environment. This includes touching environmental surfaces or handling resident care items .2. b. Gloves- Wear gloves upon entering the resident's room. c. Gown- Wear a gown upon entering the resident's room. d. Mask and protective eyewear-Wear a mask or protective eyewear if potential exists for exposure to infections body material.DURATION OF PRECAUTIONS: 1. Residents will remain on transmission based precautions until the Attending Physician or the IP determines precautions may be discontinued. The IP has the authority to implement and discontinue Transmission-Based Precautions as indicated. The IP shall consult the Attending Physician and/or Medical Director .as needed. 3 . Review of R6's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/20/25 revealed the resident was admitted to the facility on [DATE] from a short-term acute hospital. Observation on 03/26/25 at 11:20 AM, revealed a PPE cart outside of R6's room. On the outside of the resident's door was signage of STOP CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During an interview on 03/26/25 at 11:15 AM, when asked why R6 was on contact precautions, LPN-AA stated he did not know. When asked if he could look in the resident's EMR to find out, LPN-AA stated he did not know how to use the facility's EMR as it was his first shift in the facility in over a year. During an interview on 03/26/25 at 11:21 AM, when asked about the contact precaution signage on R6's door, the Housekeeping Director (HD-BB) stated today was the first time she had seen the signage, and she did not know why the resident was on the precautions. Observation and interview on 03/26/25 at 11:30 AM, revealed DA-CC entered R6's room to deliver fluids DA-CC donned a pair of gloves, however, did not doff his gloves and perform any hand hygiene prior to or after exiting R6's room. When asked about the signage and not donning a gown prior to entering R6's room, DA-CC stated the TBP signs throughout the facility only applied to nursing staff, because he never would come into contact with any residents. When asked had the facility provided him training on infection control including TBP, DA-CC stated he had not received any type of training from the facility on the signage or infection control. (continued on next page)

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	525552	A. Building B. Wing	04/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/26/25 at 11:55 AM, when asked why R6 was on contact precautions, the IP-DD stated she was on TBP due to bedbugs. IP-DD stated the resident wound be on contact precautions until the facility had a dog come in and clear the room. During an interview on 03/26/25 at 1:27 PM, Licensed Practical Nurse (LPN)-L stated R6 was admitted to the facility with bedbugs; however, the resident really was not on any type of TBP. LPN-L stated some staff still chose to wear a gown even though they do not have to. The LPN-L also stated there should not be any signage on the resident's door which indicated contact precautions. LPN-L stated she did not see any signage on R6's door this morning. Observation on 03/26/25 at 1:35 PM with LPN-L revealed she confirmed there was signage on R6's door which indicated Contact Precautions. During an interview on 03/27/25 at 10:34 AM, the Infection Preventionist (IP)-DD stated he just heard about R6 having bed bugs this week and he placed the contact precaution signage on the resident's door. The IP-DD stated he assumed LPN-L would have taken all the appropriate precautions and placed the resident on contact precautions. The IP-DD stated if R6 had bedbugs, it was a high risk for the spread of bedbugs in a nursing home setting. The IP-DD stated R6's clothing should not have been laundered with the other residents' clothing. The IP-DD also stated that when DA-CC entered the room with TBP signage on the outside of the door, DA-CC should have donned gown prior to entering the rooms. When asked if he had completed any training since being employed at the facility as the IP-DD, he stated he done some online modules, but did not give any specifics. 3. Review of the EvenCare G3 Blood Glucose Monitoring System User's Guide, indicated, .Cleaning and Disinfection Procedures for the Meter. The EVENCARE G3 Meter should be cleaned and disinfected between each patient . The following products have been approved for cleaning and disinfecting the EVENCARE G3 Meter: Dispatch(R) Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number: 56392-8), Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol (EPA Registration Number: 59894-10), Clorox Healthcare(R) Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12), Medline Micro-Kill (Trademark) Bleach Germicidal Bleach Wipes (EPA Registration Number: 37549-1) .Other EPA registered wipes may be used for disinfecting the EVENCARE G3 system, however, these wipes have not been validated and could affect the performance of your meter . Note: These disinfectants were validated separately; therefore, only one disinfectant should be used on the device for the life of the device, as the effect of using more than one disinfectant interchangeable has not been evaluated .Materials needed: .A validated disinfecting wipe. Step 3. Inspect for blood, debris, dust, or lint anywhere on the meter. Blood and bodily fluids must be thoroughly cleaned from the surface of the meter. Step 4. To clean the meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter including both the front and back surfaces until visibly clean. Avoid wetting the meter test strip port. Step 5. To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Other EPA registered wipes may be used for disinfecting the EVENCARE G3 system, however, these wipes have not been validated and could affect the performance of the meter. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet. Avoid wetting the meter test strip port. Wipe meter dry, or allow to air dry .NOTE: Glucose meters used in a clinical setting for testing multiple persons must be cleaned and disinfected between patients . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the CaviWipes1 Technical [sic] Bulletin [EPA Registration Number: 46781-13] provided by the facility revealed .CaviWipes1, a multi-purpose disinfectant/decontaminant wipe, can be used on hard, nonporous surfaces. CaviWipes1 contains durable, nonwoven, nonabrasive wipes presaturated with CaviCide1. When used as directed, fragrance-free CaviWipes1 will effectively clean and disinfect surfaces and can help reduce the risk of cross-contamination .Efficacy . Bacteria. Staphylococcus aureus, Pseudomonas aeruginosa, Salmonella enterica, Carbapenem-Resistant Klebsiella pneumoniae, ESBL Escherichia coli [ESBL E. coli], Methicillin Resistant Staphylococcus aureus (MRSA), Methicillin Resistant Staphylococcus epidermidis (MRSE), Multi-drug resistant [MDR] Acinetobacter baumannii, Vancomycin Intermediate Staphylococcus aureus, Vancomycin Resistant Enterococcus faecalis (VRE), Burkholderia cepacian, Enterobacter cloacae, Klebsiella pneumoniae. Contact time tested 1 minute .Test Results. PASS. Virus- Hepatitis B Virus, Hepatitis C Virus, Influenza A Virus, Herpes Simplex Virus Type 1, Herpes Simplex Virus Type 2, Human Immunodeficiency Virus Type 1 (HIV-1), Human Coronavirus, Adenovirus Type 2. Contact time tested . 1 minute. Review of the Clorox Disinfecting Wipes, Bleach Free Cleaning Wipes-Crisp Lemon-75 Count [EPA Registration Number: 5813-79] smart label data sheet provided by the facility revealed, Usage Instructions . To disinfect and deodorize hard, nonporous surfaces: Wipe surface; use enough wipes for treated surface to remain visibly wet for 4 minutes. Let surface dry .General Information. Features and Benefits . DISINFECTING WIPES: Clorox Disinfecting Wipes are proven to kill COVID-19 Virus in 30 seconds; cleans and kills 99.9% of viruses and bacteria with powerful, triple-layered wipe; packaging may vary . Review of R4's Profile Face Sheet dated 03/28/25 and found in the EMR under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnosis of type 2 diabetes. Review of the R4's EMR revealed nothing to indicate the resident was infected with any type of blood borne pathogen. Review of R4's physicians orders dated 03/25/25 and found in the EMR under the Orders tab indicated orders for the resident to receive blood sugar checks four times daily (before meals and at bedtime). Review of R5's Profile Face Sheet dated 03/28/25 and found in the EMR under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnosis of type 2 diabetes. Review of the R5's EMR revealed nothing to indicate the resident was infected with any type of blood borne pathogen. Review of R5's physicians orders dated 03/18/25 and found in the EMR under the Orders tab indicated orders for the resident to receive blood sugar checks three times per day before meals. Review of R3's Profile Face Sheet dated 03/28/25 and found in the EMR under the Information tab indicated the resident was admitted to the facility on [DATE] with diagnosis of type 2 diabetes. Review of the R3's EMR revealed nothing to indicate the resident was infected with any type of blood borne pathogen. Review of R3's physicians orders dated 01/21/25 and found in the EMR under the Orders tab indicated orders for the resident to receive blood sugar checks four times per day (before meals and at bedtime). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/25/25 at 4:08PM, revealed LPN-S obtained the glucometer machine from the medication cart and without sanitizing the glucometer proceeded to obtain the residents blood glucose level. The glucometer was placed on the resident's overbed table in his room during the procedure without a clean barrier placed between the glucometer and the surface of the table. After LPN-S completed the blood sugar test, he placed the glucometer back into the medication cart without sanitizing the glucometer. During an interview with LPN-S on 03/25/25 at 4:25 PM, he stated he probably should have sanitized the glucometer with a bleach wipe before and after obtaining R3's blood sugar, but he stated there were no such wipes available in his medication cart and he did not know where to go to find them. LPN-S confirmed he obtained two additional residents' (R4 and R5) blood sugars immediately prior to obtaining R3's blood sugar and did not sanitize the glucometer before or after obtaining the blood sugars for any of the three residents. Review of R18's undated Profile Face Sheet revealed the resident was admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus. Review of R18's Physician Orders revealed an order dated 02/08/25 for Blood glucose check ac [before] meals and HS [hour of sleep] . Observation on 03/26/25 at 11:37 AM, LPN-AA obtained a glucometer out of the top drawer of the medication cart, obtained a Clorox Disinfecting Wipe wiped the front and back of the glucometer and then wrapped the glucometer with the Clorox wipe and set the wrapped glucometer on top of the medication cart. At 11:39 AM (two minutes), LPN-AA unwrapped the glucometer, entered R18's room, pricked the resident's left middle finger, put the glucometer with the test strip to the resident's blood. However, the glucometer turned off and would not turn back on. LPN-AA went to the medication cart, opened the top drawer of the medication cart, retrieved a glucometer from a clear plastic back labeled 109. At 11:42 AM, LPN-AA obtained a Clorox wipe, wiped the front and back of the glucometer and then wrapped the glucometer with the wipe. At 11:44 AM, LPN-AA unwrapped the glucometer, and with the glucometer still wet, he entered R18's room, pricked her middle finger again and obtained the resident's blood sugar (BS) reading. LPN-AA then obtained a Clorox Disinfecting Wipe, wiped down the glucometer, and then wrapped the glucometer in the Clorox wipe and laid it on top of the medication cart. Review of R18's Medication Administration Record (MAR) dated 03/2025 revealed LPN-AA documented R18's BS scheduled for 11:30 AM with a result of 188. During an interview on 03/26/25 at 3:00 PM, LPN-AA confirmed he used Clorox Disinfecting Wipes to clean and disinfect the glucometers. LPNs stated he had always been told to wrap the glucometer for one minute, and it would be clean and disinfected. LPN-AA stated it was okay to use a glucometer while it was wet. LPN-AA stated this was his first day working in the facility in over a year and he had not received any type of training on the facility's policies and procedures. Review of R15's undated Profile Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE] with the diagnosis of Type 2 diabetes mellitus. Review of R15's Physician Orders, provided by the facility revealed an order dated 10/31/24 of Blood glucose checks ac [before] meals . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R15's MAR dated 03/2025 and provided by the facility revealed LPN-E documented obtaining R15's blood glucose on 03/27/25 before the dinner meal. During an observation 03/26/25 at 4:38 PM, LPN-E gathered the other supplies, and laid them directly on the medication cart. LPN-E picked up the glucometer without any cleaning or disinfecting of the glucometer and proceeded to the R15's room. LPN-E placed the glucometer and the other supplies on the resident's over the bed table with no barrier or cleaning of the over the bed table. LPN-E obtained the BS reading, gathered the used supplies, exited the room, and laid the used glucometer back on top of the medication cart. LPN-E did not clean the glucometer before or after the use of the glucometer. Review of R16's undated Profile Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus. Review of R16's Physician Orders revealed an order dated 08/13/24 for Blood glucose check ac meals and HS . During an observation on 03/26/25 at 4:42 PM, LPN-E picked up the second glucometer lying directly on top of the medication cart, entered the R16's room, laid the glucometer and the supplies directly on the seat of the resident's rolling walker without a barrier or cleaning of the rolling walker seat. LPN-E donned a pair of gloves without performing hand hygiene. LPN-E pricked the resident's finger, put the glucometer with the test strip to the blood and obtained the blood sugar reading. The LPN-E then doffed her gloves, went to the medication cart, and laid the used glucometer on top of the medication cart. Review of R16's MAR dated 03/2025 revealed LPN-E documented R16's BS scheduled for 4:30 PM with a result of 288. During an observation and interview on 03/27/25 at 4:50 PM, LPN-E confirmed she did not clean either of the two glucometers before or after using the glucometers to obtain R15 and R16's BS. LPN-E stated normally she would use Cavi wipes to wipe down the glucometers; however, there were no type of cleaning agents on or in her medication cart to clean the glucometers. Observation of LPN-E opening all drawers of the medication cart revealed no type of cleaning agent(s) where on or in the medication cart. When asked where she could get the cleaning agent to clean the glucometers, LPN-E stated, I have no clue where to find them. When asked if she had received any type of training on the facility's policies or procedures, she stated she had not received any training. LPN-E stated she had completed a total of four residents' BS for the dinner meal (R15, R16, R19, and R20) and she did not clean the glucometers before, after, or in between obtaining the residents' blood sugars. When asked about not having a barrier down or cleaning the surface before laying the glucometers and other supplies on R15's bedside table and R16's rolling walker, LPN-E stated she had never heard of doing that. Review of R19's undated Profile Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE] with the diagnosis of Type 1 diabetes mellitus. Review of R19's Physician Orders, provided by the facility revealed an order dated 11/26/24 of Blood glucose checks ac [before] meals . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R19's MAR, dated 03/2025 and provided by the facility revealed LPN-E documented obtaining R19's blood glucose on 03/27/25 before the dinner meal. Review of R20's undated Profile Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE] with the diagnosis of type 2 diabetes mellitus. Review of R20s Physician Orders provided by the facility revealed an order dated 12/23/24 of Blood glucose checks ac [before] meals . Review of R20's MAR dated 03/2025 and provided by the facility revealed LPN-E documented obtaining R10's blood glucose on 03/27/25 before the dinner meal. During an interview on 03/27/25 at 10:34 AM, the IP-DD stated LPN-AA should not have used another resident's glucometer. When it was explained that LPN-AA used Clorox disinfecting wipes to clean the glucometers, the IP-DD stated when LPN-AA cleaned the glucometers with the Clorox wipes, he should have ensured the glucometer was left wet for three minutes. The IP-DD stated the facility had ample supply of glucometers and LPN-AA should have went and got a new one for R18. The IP-DD also stated LPN-AA should have read the back of the Clorox wipes to determine the wet time, and he should have allowed the glucometer to air dry before using it. The IP-DD stated her expectation was that LPN-E would have cleaned the glucometers before use and in between each resident's use, and if there was no cleaning agent available on her cart, then she should have gone and found the appropriate cleaning agent to clean the glucometers. The IP-DD stated LPN-E should have placed a barrier down if she was going to lay the glucometer down. When asked what his concerns were about the glucometers not being cleaned correctly or not being cleaned at all in between residents, the IP-DD stated there would be a concern of transmitting a bacterial infection or if a diabetic resident who receives finger stick had a blood borne pathogen it could be transmitted. The IP-DD stated educating the facility staff was difficult because of so many different agency staff. The IP-DD stated they (agency staff) may come to work one shift at the facility and then not work another shift for a month. During an interview with the DON-B on 03/28/25 at 11:30 AM, she stated her expectation was that the blood glucometers were to be sanitized before and after obtaining blood sugars for each resident to ensure no cross contamination or spread of infection in the facility. 4. Review of the facility's overall Infection Control and Prevention Program Documentation dated 01/01/25 through 03/27/25 and found in the facility's Infection Control Binders, revealed no documentation to indicate tracking and trending of infections or analysis of infection data had been done. During an interview with the DON-B on 03/28/25 at 9:30 AM, she confirmed she had been responsible for infection control in the facility for the past several months. The DON-B confirmed there was not a comprehensive process in place to analyze infection data and track and trend infections. She stated her expectation was this process should be in place and should be comprehensive. During an interview with IP-DD on 03/28/25 at 9:30 AM, he confirmed that he had identified the lack of infection tracking and data analysis. 36898