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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure 1 (R44) of 12 residents was given the opportunity to be a part of their care planning process in regards to their personal belongings. Findings include: R44's diagnoses include multiple sclerosis, hypertension, anxiety, and is blind in the left eye. The quarterly MDS (minimum data set) with an assessment reference date of 2/16/24 assesses R44's short and long term memory as ok. R44 has modified independence for cognitive skills for daily decision making. R44 is assessed as not having any behavior. R44 is independent with her activities of daily living. The potential of impaired psychosocial well being care plan documents the following approaches: * Provide emotional support and validate concerns/feelings PRN (as needed). Start date of 6/26/24. * Encourage/Facilitate development of peer relationships/participation in activities PRN. Start date of 6/26/24. The at risk for impaired adjustment to new environment care plan documents the following approaches: * Follow community evaluation and monitoring process. Start date of 6/26/24. * Identify current mood and behavioral expressions, monitor for changes. Start date of 6/26/24. * Orient [R44's first name] to community layout, routines, and schedules. Start date of 6/26/24. (continued on next page)

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

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

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

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

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

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

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F 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** 38829 Based on interview and record review the facility did not ensure 1 (R29) of 12 Residents reviewed, notified R29's representative of R29 being transferred to the emergency room for an x-ray on 6/3/24 and the facility did not have consultation with R29's physician when scheduled pain medications were not being administered and the development of R29's stage 1 pressure ulcer to the coccyx. Findings Include: The facility's policy Change in a Resident's Condition or Status for Residents dated 12/2016 and last revised on 2/2022 documents: .Policy Statement Our community shall promptly notify the Resident, his or her health care provider, and representative of changes in the Resident's medical/mental condition and/or status\. Policy Interpretation and Implementation A. The nurse will notify the Resident's Health care provider or physician on call when there has bee a(an): 1. accident or incident involving the resident 2. discovery of injuries of an unknown source 3. adverse reaction to medication 4. significant change in the Resident's physical/emotional/mental condition 5. need to alter the Resident's medical treatment center significantly 6. need to transfer Resident to a hospital/treatment center B. A significant change of condition is a major decline or improvement in the Resident's status that: 1. Will not normally resolve itself without intervention by associate or by implementing standard disease-related clinical interventions 2. Impacts more than one area of the Resident's health status 3. Requires interdisciplinary review and/or revision to the care plan (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Ultimately is based on the judgment of the clinical associate and the guidelines outlined in the Resident Assessment Instrument. C. Prior to notifying the health care provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact SBAR Communication Form. D. Unless otherwise instructed by the Resident, a nurse will notify the Resident's representative, consistent with his or her authority, when: 1. The Resident is involved in any accident or incident that results in an injury including injuries of an unknown source 2. There is a significant change in the Resident's physical/emotional/mental, or psychosocial condition 3. A need to alter treatment significantly 6. It is necessary to transfer the Resident to a hospital/treatment center . R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia and Anxiety Disorder. R29 has an activated Health Care Power of Attorney (HCPOA) effective 9/16/2019. R29 has been receiving hospice service since 4/24/23. Surveyor notes that R29's Quarterly Minimum Data Set (MDS) dated [DATE] was not completed. R29's Annual MDS dated [DATE] documents R29 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R29's MDS also documents that R29 is at risk for developing skin issues and has no current skin issues, osteoporosis is not documented as a current diagnosis, R29 is receiving scheduled pain medications and that a pain interview can be completed but then is documented that R29 is unable to answer any questions. R29's MDS documents R29 has range of motion impairment on both upper and lower extremities on both sides and that R29 is dependent for assistance for eating, hygiene, mobility, and transfers. On 5/2/24, Hospice Registered Nurse (HRN)-S documents that R29 has bruising to the left eye and left breast. HRN-S documents this was not reported to Hospice. HRN-S documents that R29's buttocks and bilateral heels are reddened. HRN-S documents that HRN-S reported these findings to the facility nurse and the Nursing Home Administrator (NHA)-A. Surveyor reviewed the facility progress notes located in R29's medical record and notes there is no documentation that R29's primary physician was consulted with as well as the activated HCPOA was not notified of the bruising and reddened areas on the left eye and left breast. On 5/15/24, facility nurse documents applying a dressing to the right great toe, bruising is noted to the foot and there is bruising to the right upper eye. Facility nurse was instructed to add R29 to the wound doctor list. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24, HRN-S documents that new bruising is noted to R29's right eyelid, new bruising, purple in color is suggestive a new bruise to left eyelid. Bruising to right foot is observed, which was not reported to Hospice. HRN-S finds a significant laceration between R29's big right toe and the second toe. HRN-S is informed by Unit Manager (UM)-J that a nurse found the cut and applied a dressing to it. HRN-S receives permission from activated HCPOA to send R29 to the emergency room (ER). R29 is to receive as needed pain medication prior to cares on scheduled shower days. HRN-S documents that Licensed Practical Nurse (LPN)-M informed HRN-S that LPN-M forgot about R29 because LPN-M got pulled into a meeting by administration. LPN-M informed HRN-S that R29 did not receive R29's scheduled medications. On 5/16/24, it is documented by the facility that R29 returned from the ER and received 2 sutures and surgical glue to the laceration located between the right great toe and second toe. Surveyor notes there is no facility documentation that R29's primary physician was consulted with regarding R29 having new bruising to the right eye, the right foot, and has a cut between the right big toe and second toe which required 2 sutures and surgical glue. There is no documentation that R29's primary physician was notified that R29 did not receive scheduled medications. On 5/22/24, HRN-S documents there is significant bruising to the right foot. An x-ray imagining of the right foot is obtained and an acute fracture in the proximal phalanx of the first digit is found. Surveyor notes there is no documentation by the facility that R29's x-ray results found an acute fracture in the proximal phalanx of the first digit of the right foot and there is no documentation that R29's primary physician was notified of the fracture. On 5/30/24, HRN-S documents that swelling to R29's right knee is evident. HRN-S obtains order from hospice doctor for an x-ray to the femur and tibia and fibula. R29 is to be on complete bedrest until x-ray results. On 6/3/24 at 8:12 AM, x-ray results determine that R29 has an acute impacted fracture at the distal femur. No evidence of osteomyelitis. On 6/3/24, at 10:30 PM, a facility nurse documents that R29 is sent out to ER this evening for x-ray to right leg. Diagnosis of right distal femur fracture and returned with an immoblizer. It is documented in the hospice Interdisciplinary Group Meeting dated 7/3/24 that activated HCPOA is upset with R29 being sent to the ER by R29's self. Surveyor notes there is no facility documentation that R29's activated HCPOA was notified of the transfer. On 6/19/24, HRN-S documents that a new stage 1 pressure ulcer is observed on R29's coccyx. HRN-S documents HRN-S made facility nurse aware. Surveyor notes there is no documentation by the facility that R29's primary physician was consulted with regarding the new stage 1 pressure ulcer to R20's coccyx. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes progress notes written by facility nurses located in R29's medical record document that on the following dates, R29's scheduled morphine was not administered to R29 as a result of nurses' opinions: 6/6/24,6/9/24,6/15/24, 6/16/24, and 6/24/24. On 7/11/24, Registered Nurse (RN)-T documents that the 6:00 AM dose of scheduled morphine was held due to somnolence, signs of no pain. Surveyor notes there is no facility documentation by the facility that R29's primary physician was notified that staff were not administering the scheduled morphine. On 7/17/24, at 12:35 PM, Surveyor interviewed UM-J. UM-J informed Surveyor that UM-J was aware that nurses were not administering scheduled pain medications to R29. UM-J stated that nurses were making their own decisions to not administer, it is not appropriate to not administer, and is not good practice. UM-J had to educate the nursing staff on this issue. UM-J confirmed that R29's primary physician was never consulted with that R29 was not being administered scheduled pain medication. On 7/18/24, at 10:27 AM, Surveyor interviewed R29's primary physician (PP)-U who confirmed that PP-U was not made aware by facility nursing staff that R29 was not receiving R29's scheduled morphine and was not aware that R29 had developed a stage 1 pressure ulcer to the coccyx. PP-U confirmed PP-U should have been notified of these issues. On 7/18/24, at 12:52 PM, Director of Nursing (DON)-B is aware that R29 was not receiving scheduled pain medications and does not know if R29's physician was notified. DON-B informed Surveyor that DON-B thinks the activated HCPOA was notified that R29 was going to theER on [DATE] and will need to look for documentation in a soft file. On 7/18/24, at 3:42 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that there is no documentation that the activated HCPOA was notified of R29 going out for the 6/3/24 x-ray to the ER and that the primary physician was not consulted with regarding the nurses not administering R29's scheduled morphine and of R29's new stage 1 pressure ulcer on R29's coccyx. At this time, no further information was provided by the facility in regards to notification not being completed for R29's injuries of unknown origin, the decision to transfer R29 to the ER for an x-ray, and the deterioration in R29's skin condition as evidenced by R29's stage 1 pressure ulcer on the coccyx. On 7/29/24, at 12:33 PM, Surveyor reviewed additional information provided by the facility after the survey process was completed. Surveyor continues to have concerns that the notification on 6/3/24 was not to R29's activated HCPOA. Surveyor remains with concerns that R29's PP-U was not notified of R29's injuries of unknown injuries, that prescribed pain medications were not being administered, and that R29 developed a stage 1 pressure area.

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

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	525552	A. Building B. Wing	07/22/2024

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

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

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

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

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

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

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

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

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

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

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review, interviews, facility document review, and review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, it was determined that the facility failed to complete a comprehensive annual Minimum Data Set (MDS) assessment for 2 (R18 and R21) of 12 Residents reviewed for RAI regulatory timeframe's. *R18's Annual MDS was due 5/15/24, and was not completed and submitted until 7/18/24, during the recertification survey. *R21's Annual MDS was due 5/8/24, and was not completed and submitted until 7/15/24, during the recertification survey Findings included: A review of the Centers for Medicare & Medicaid Services [CMS] Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, dated October 2019, revealed an annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days). The RAI Manual specified the MDS completion date must be no later than 14 days after the ARD [Assessment Reference Date] (ARD + 14 calendar days). 1.) R18 was admitted to the facility on [DATE] with diagnoses of Toxic Encephalopathy, Type 2 Diabetes Mellitus, Essential Hypertension, Chronic Kidney Disease, Stage 3, Epilepsy, Hemiplegia Following Cerebral Infarction Affecting left Non-Dominant Side, Major Depressive Disorder, and Anxiety Disorder. On 7/17/24, at 11:47 AM, Surveyor reviewed R18's list of completed MDS(s) and noted that R18's most recent Annual MDS was dated 5/15/24 and had not yet been completed and submitted. Surveyor noted with the facility not completing the annual MDS electronically or via paper, 18 did not have a timely annual comprehensive assessment to include the completion of care assessment areas, and review of needed care plans or revisions to care plans based upon a comprehensive assessment. 2) R21 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction Due to Embolism, Metabolic Encephalopathy, Chronic Kidney Disease, Stage 3, Heart Failure, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Dysphagia, Aphasia, and Pyuria. On 7/17/24, at 11:47 AM, Surveyor reviewed R21's list of completed MDS(s) and noted that R21's most recent Annual MDS was dated 5/8/24 was not completed and submitted until 7/15/24. Surveyor noted with the facility not completing the annual MDS electronically or via paper, R21 did not have an annual comprehensive assessment to include the completion of care assessment areas, and review of needed care plans or revisions to care plans based upon a comprehensive assessment. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24, at 1:13 PM, Surveyors interviewed MDS Registered Nurse (RN)-G in regards to Resident MDS(s) not being completed. RN-G stated that RN-G is currently responsible for making sure the Resident MDS(s) are completed. Social Services completes sections C, D, Q; the Dietitian completes section K; and Activities completes F if comprehensive; and RN-G completes the rest of the MDS. RN-G stated then Regional Consultant (RC)-H submits the MDS. RN-G stated that when the facility had no access to electronic medical records (EMR) (5/8/24-6/28/24), RN-G was working at another facility and came back to current facility about a month ago. RN-G stated there are quite a few MDS(s) not done (probably about 30) from May and June. RN-G stated that the goal is to have all the MDS(s) completed and submitted by 7/31/24 because new owners are taking over 8/1/24. RN-G stated that the outstanding MDS(s) could not be transmitted during the time there was no access to the Residents EMR. On 7/18/24, at 3:54 PM, Nursing Home Administrator (NHA)-A informed Surveyors that the Resident MDS(s) should have been put on paper and believes there were some challenges going through the CMS website. Surveyor shared the concern that R18 and R21's Annual MDS(s) were not completed and submitted by the designated time. NHA-A provided no additional information at this time. Surveyor requested the facility's Emergency Preparedness plan for when EMR access is not available. On 7/22/24, at 7:56 AM, Surveyor received the undated EMR Disaster and Downtime Process which documents: .Unanticipated EMR Downtime -In advance routinely make sure that downtime forms are printed, accessible, and current. -During downtime, locate downtime devices and print face sheets, medication and treatment administration records, locate downtime forms, and document on paper. -After, paper documentation becomes part of the legal medical record and recommend scanning into EMR as soon as possible. Surveyor notes it is not documented what to do to complete and submit Resident MDS(s) in the EMR Disaster and Downtime Process instructions. On 7/25/24 the facility submitted additional documentation which was reviewed and did not change the concerns being cited

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure quarterly assessments were completed as required for 6 (R27, R5, R44, R29, R25, & R50) of 12 residents reviewed for MDS (minimum data set). R27, R5, R44, R29, R25, & R50 did not have a quarterly MDS assessment completed within 92 days of their last MDS assessment. Findings include: On 7/17/24, at 1:13 p.m., Surveyor met with RN/MDS (Registered Nurse/Minimum Data Set)-G to inquire about the MDS's. Surveyor asked who completes the MDS. RN/MDS-G explained social service does sections C, D, & Q, the Dietitian does section K and activities does section F if the MDS is a comprehensive assessment. RN/MDS-G indicated she thinks she does all the rest of the sections. Surveyor inquired who submits the completed MDS. RN/MDS-G informed Surveyor Regional Consultant-H. Surveyor asked RN/MDS-G how Regional Consultant-H is aware of the MDS's that need to be submitted. RN/MDS-G informed Surveyor she usually checks or she tells her. Surveyor asked RN/MDS-G about the MDS when the Facility's computer system was not accessible starting 5/8/24 until 6/24/24. RN/MDS-G informed Surveyor she wasn't here and was at another facility. RN/MDS-G explained she is still working on MDS from May and some in June. Surveyor asked RN/MDS-G if she has a plan of when the MDS are going to be completed. RN/MDS-G explained she has her calendar to see who is not done and states she has quite a few that have to be done by July 31st. Surveyor asked RN/MDS-G how she came up with the July 31st date. RN/MDS-G replied that's when the new owners take over, August 1st they take over. Surveyor asked RN/MDS-G if she has any idea how many MDS still need to be completed. RN/MDS-G replied about 30, they are mostly quarterly and discharges. 1.) R27 was admitted to the facility on [DATE]. On 7/16/24, at 2:17 p.m., Surveyor reviewed R27's quarterly MDS with an assessment reference date of 6/19/24. Surveyor noted sections C, D, E, GG, H, I, J, L, M, N, O up to immunizations, & P have not been completed. Surveyor also noted this quarterly MDS has not been submitted. On 7/17/24, at 1:20 p.m., Surveyor asked RN/MDS-G about the status of R27's quarterly MDS with an assessment reference date of 6/19/24. RN/MDS-G informed Surveyor this MDS has not been submitted as a couple sections have been completed but not overall. On 7/22/24, at 12:14 p.m., Surveyor rechecked R27's quarterly MDS with an assessment reference date of 6/19/24 and noted this MDS was completed and submitted on 7/18/24. Although R27's quarterly MDS was completed & submitted on 7/18/24 this is not within the required 92 days from previous assessment. 2.) R5 was admitted to the facility on [DATE]. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24, at 7:34 a.m., Surveyor reviewed R5's quarterly MDS with an assessment reference date of 6/6/24. Surveyor noted section D starting at C. was not completed as well as sections GG, N2001, N2003, & N2005. Surveyor also noted this quarterly MDS has not been submitted. On 7/17/24, at 1:20 p.m., Surveyor asked RN/MDS-G about the status of R5's quarterly MDS with an assessment reference date of 6/6/24. RN/MDS-G informed Surveyor she is waiting for section GG to be completed. On 7/22/24, at 12:15 p.m., Surveyor rechecked R5's quarterly MDS with an assessment reference date of 6/6/24 and noted this quarterly MDS was completed and submitted on 7/17/24. Although R5's quarterly MDS was completed & submitted on 7/17/24 this is not within the required 92 days from previous assessment. 3.) R44 was admitted to the facility on [DATE]. On 7/16/24, at approximately 1:30 p.m., Surveyor reviewed R44's quarterly MDS with an assessment reference date of 5/15/24. Surveyor noted sections E, GG, H, I, M, N, & P have not been completed. Surveyor also noted this quarterly MDS has not been submitted. On 7/17/24, at 1:20 p.m., Surveyor asked RN/MDS-G about the status of R44's quarterly MDS with an assessment reference date of 5/15/24. RN/MDS-G informed Surveyor all sections have been completed except section GG. On 7/22/24, at 12:17 p.m., Surveyor rechecked R44's quarterly MDS with an assessment reference date of 5/15/24 and noted this quarterly MDS was completed and submitted on 7/18/24. Although R44's quarterly MDS was completed & submitted on 7/18/24 this is not within the required 92 days from the previous assessment. On 7/18/24 at approximately 3:54 p.m. NHA (Nursing Home Administrator)-A was informed of R27, R5, & R44 quarterly MDS not being completed or transmitted according to regulations. 49845 4.) On 7/15/24 Surveyor reviewed R50's medical record and Minimum Data Set (MDS) assessments and noted: R50 had an admission MDS with an ARD of 12/5/2023. R50 had a Quarterly MDS with an ARD of 02/09/2024, which was completed and submitted on 03/04/2024. R50 had a Quarterly MDS with an ARD of 05/08/2024, with a submission date of 07/17/2024. Surveyor noted the most recent quarterly MDS was not completed until the recertification survey had started. 38829 5.) R25 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis, Type 1 Diabetes Mellitus, Alcoholic Cirrhosis of Liver with Ascites. Legal Blindness, Acquired Absence of Right Leg Below Knee, Kidney Transplant, Pancreas Transplant, and Depression. On 7/17/24, at 11:47 AM, Surveyor reviewed R25's list of completed MDS(s) and noted that R25's most recent Quarterly MDS was dated 5/22/24 and had not yet been completed and submitted. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia and Anxiety Disorder. On 7/17/24, at 11:47 AM, Surveyor reviewed R29's list of completed MDS(s) and noted that R29's most recent Quarterly MDS was dated 6/26/24 and had not yet been completed and submitted. On 7/18/24, at 3:54 PM, Nursing Home Administrator (NHA)-A informed Surveyors that the Resident MDS(s) should have been put on paper and believes there were some challenges going through the CMS website. Surveyor shared the concern that Quarterly MDS(s) were not completed and submitted by the designated time. Surveyor requested the facility's Emergency Preparedness plan for when EMR access is not available. On 7/22/24, at 7:56 AM, Surveyor received the undated EMR Disaster and Downtime Process which documents: .Unanticipated EMR Downtime -In advance routinely make sure that downtime forms are printed, accessible, and current. -During downtime, locate downtime devices and print face sheets, medication and treatment administration records, locate downtime forms, and document on paper. -After, paper documentation becomes part of the legal medical record and recommend scanning into EMR as soon as possible. Surveyor notes it is not documented what to do to complete and submit Resident MDS(s) in the EMR Disaster and Downtime Process instructions. On 7/22/24, at 9:46 AM, Surveyor reviewed R25 and R29's EMR and notes that R25's Quarterly MDS was completed and submitted on 7/18/22 and R29's Quarterly MDS was completed and submitted on 7/17/24, during the recertification survey. On 7/25/24 the facility submitted additional documentation which was reviewed and did not change the concerns being cited.

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

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

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Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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

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

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

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

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

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

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F 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** 38829 Based on the comprehensive assessment of a fesident, the facility did not ensure that fesidents receive care, consistent with professional standards of practice, to prevent pressure injuries and to ensure residents do not develop pressure injuries unless the individual's clinical condition demonstrates they were unavoidable; and residents with pressure injuries receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 (R29, R5, and R11) of 4 residents reviewed for pressure injuries. *Facility was notified of R29's stage 1 pressure ulcer on the coccyx area on 6/19/24 by hospice. Hospice requested for R29 to be evaluated by the facility wound care doctor. The facility did not assess the area and did not coordinate for the facility wound care doctor to evaluate R29. During the survey process, R29's air mattress was set at 5 for 300 pounds. R29's Treatment Administration Record (TAR) has to check R29's air mattress for setting of 3 for 200 pounds and inflation every shift. On 7/3/24, R29 only weighed 105.3. R29 has had no care plan revisions with the development of the pressure areas. R29 currently has an unstageable pressure ulcer to the coccyx area. *R5 identified with unstageable pressure injury to the left buttock and no turning and repositioning per care plan during the survey process were observed, and treatments were not completed . *R11 had no care plan revision on 6/27/24 for deep tissue injury to the left heel. No treatment was put into place until 6/29/24. During the survey process no heel boots observed in place. No assessment on 7/15/24. Findings Include: The facility's policy Prevention of Pressure Injuries Protocol for Residents dated 12/2016 and last revised on 1/2018 documents: .Preparation A. Review the Resident's care plan to assess for any special needs B. Review current Braden Scale assessment tool General Guidelines A. Pressure injury are usually formed when a Resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation to that area and subsequent destruction of tissue. B. The most common site of a pressure injury is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	C. Pressure can also come from splints, cast, bandages, and wrinkles in the bed linen. If pressure injury are not treated when discovered, they quickly get larger, become very painful for the Resident and often times become infected. D. Pressure injury are often made worse by continual pressure, heat, moisture, irritating substances on the Resident's skin(feces, urine), decline in nutrition and hydration status, acute illness and/or decline in the Resident's physical and/or mental condition. E. Once a pressure injury develops, it can be extremely difficult to heal. Pressure injuries are a serious skin condition for the Resident. F. The community should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. J. Routinely assess and document the condition of the Resident's skin per community wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury to the supervisor. Interventions and Preventive Measures: SKIN E. Routinely assess and document the condition of the Resident's skin per Weekly Skin Integrity form for any signs and symptoms of irritation or breakdown. F. Report any signs of a developing pressure injury to the physician. G. The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate. Assessment A. Risk Assessment. A pressure injury risk assessment will be completed upon admission, and then weekly times 3 weeks, with each additional assessment; quarterly, annually and with significant changes. B. Skin Assessment. Skin will be assessed for the presence of developing pressure injuries on a weekly basis or more frequently if indicated. C. Monitoring: 1. Staff will perform routine skin assessments(with daily care). 2. Nurses are to be notified to inspect skin if skin changes are identified. 3. Nurses will conduct skin assessments at least weekly to identify changes. Identifying Residents at Risk (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A. Extrinsic risk factors for pressure include: 1. Pressure-Resident is not capable of moving without assistance 2. Shear-sliding movement of skin and subcutaneous tissue 3. Maceration-persistently wet 4. Friction-rubbing of one body against another or force that resists relative motion between 2 bodies in contact and/or material elements sliding against each other B. Intrinsic risk factors for pressure ulcers include: 1. Immobility 2. Altered mental status 3. Incontinence 4. Poor nutrition Steps in the Procedure A. Gather assessment tools and documentation and conduct the assessment in the manner most appropriate to the Resident's condition and willingness to participate D. Once inspection of skin is completed proceed to the Admission Assessment or Weekly Skin Integrity tool(depending on whether this is a new admission or an existing Resident) and complete documentation of findings. E. If new skin alteration is noted, initiate a new skin evaluation record related to the type of alteration in skin. F. Proceed to care planning and interventions individualized for the Resident and their particular risk factors Documentation The following information should be recorded in the Resident's medical record utilizing community forms: A. The type of assessment conducted(Admission Assessment, Weekly Skin Integrity tool) B. The date and time and type of skin care provided, if appropriate C. The name and title of the individual who conducted the assessment D. Any change in the Resident's condition, if identified (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 0686 Level of Harm - Actual harm Residents Affected - Few	E. The condition of the Resident's skin if identified. J. The signature and title of the person recording the data. K. Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted. L. Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care if indicated. M. Documentation in medical record addressing family, guardian or Resident notification if new skin alteration noted with change of plan of care if indicated. 1.) R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia and Anxiety Disorder. R29 has an activated Health Care Power of Attorney (HCPOA) effective 9/16/2019. R29 has been receiving hospice service since 4/24/23. R29's Annual MDS dated [DATE] documents R29 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R29's MDS also documents that R29 is at risk for developing skin issues and has no current skin issues, osteoporosis is not documented as a current diagnosis, R29 is receiving scheduled pain medications and that a pain interview can be completed but then is documented that R29 is unable to answer any questions. R29's MDS documents R29 has range of motion impairment on both upper and lower extremities on both sides and that R29 is dependent for assistance for eating, hygiene, mobility, and transfers. R29's Care Area Assessment (CAA) for pressure ulcer/injury dated 4/3/24 documents R29 is on hospice, oriented to self only, confusion, and remote memory conversations. R29 is incontinent and dependent. Staff anticipates R29's needs. Staff will continue to monitor and report any concerns. On 4/29/24, the most recent completed Braden skin assessment places R29 to not be at risk with a score of 15. R29's comprehensive care plan includes R29 is at risk for pressure ulcers and other skin related injuries including to but not limited to Braden scale, decreased mobility and dexterity, contractures, dermal fragility, poor intake, MASD (moisture associated skin damage), systemic lupus erythematous, incontinence with a start date of 4/24/23. The following interventions for R29 are documented: -Braden scale to be completed quarterly-4/24/23 -Include proper peri hygiene and the use of barrier cream after each incontinence episode and as needed-4/24/23 -Observe skin for redness and breakdown during routine care-4/24/23 -Use pressure relieving devices, cushion on wheelchair and offload of heels, and use pillows as indicated-4/24/23 -Follow community skin care protocol-4/24/23 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Treatments, as indicated, see physician order sheet-4/24/23 -Pressure reducing mattress on bed- 4/24/23 -Encourage to float heels in bed-4/24/23 -Specialized mattress on bed. Type: Pressure relief air mattress, check setting (3) and inflation Q (each) shift. Only one barrier between body and mattress-5/10/23 -Offer assistance to bed after lunch-9/27/23 2. R29 has a diagnosis of osteopenia with a history of fractures presented 5/22 and 6/3/24. -Per MD orders as of 6/5/24 as discussed in the care conference, R29 will be on permanent bedrest due to transitioning -Remove immobilizer every shift (qs) for skin assessment 5/22/24 Surveyor notes that R29's facility comprehensive care plan does not have any new interventions added when R29's new open areas were identified to the chest, left buttocks, and coccyx areas. On 7/15/24, Surveyors were provided with a facility skin/wound tracking report for the dates of 6/15/24-7/15/24 and R29 is not listed in the report. The facility provided Surveyor on 7/16/24, 1 skin evaluation form that was completed on 6/12/24 for an open area on the chest. The order reads for small foam dressing every three days or as needed. Surveyor notes there are no documented measurements on the skin evaluation form. The facility was not able to provide Surveyor with weekly skin checks on R29. On 7/16/24, Surveyor was provided R29's current physician orders which documents: -2/8/24-skin prep bilateral heels every shift -3/12/24-left heel: skin prep every AM-1 topical every day for prevention/skin integrity -6/12/24-apply foam dressing left chest area. Change every 3 days and as needed. 1 patch topical every 3 days for skin break down prevention. R29's Treatment Administration Record (TAR) document to check pressure relief mattress, check setting (3) and inflation every shift with a start date of 11/20/22. Surveyor reviewed R29's hospice visit notes which lists a care plan problem of skin integrity. The following is documented: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/2/24-Hospice Registered Nurse (HRN)-S documents R29's buttocks is reddened, barrier cream applied. R29's groin is reddened so anti-fungal powder was applied. Bilateral heels are reddened. Scratch marks noted to R29's left upper thigh. R29 scratches self when incontinent. Scratches are in various healing stages, no open skin noted. 5/21/24-HRN-S documents R29 has the following risk factors for skin breakdown and healing -bony prominences -bowel incontinence -external factors of pressure -inability to change positions -increased susceptibility related to other existing disease process -poor nutrition -urine incontinence 5/23/24-HRN-S documents from care conference meeting that family is concerned R29 is sitting in the Broda chair too long throughout the day. New plan for scheduled wake up, nap, and bedtime routines for R29. Facility to add this to their established care plan. Surveyor notes this routine was not added to R29's Certified Nursing Assistant (CNA) worksheet or R29's comprehensive care plan. 6/3/24-HRN-S documents HRN-S performed peri care and applied barrier cream. R29's buttocks is reddened and blanchable. Education was provided to the CNAs at the facility regarding the importance of repositioning every 2 hours and applying barrier cream to prevent skin breakdown. HRN-S updated facility Registered Nurse (RN)-L. 6/5/24-HRN-S documents skin checks in and around the immobilizer should be performed every 8 hours to prevent skin breakdown. Director of Nursing (DON)-B was updated regarding visit. Written communication sheet handed directly to DON-B. Surveyor notes there is no documentation that the facility was monitoring for skin breakdown every 8 hours around the immobilizer despite a care plan intervention dated 5/22/24 to remove R29's immobilizer each shift for assessment/skin monitoring. 6/19/24-HRN-S documents facility caregivers assisted HRN-S with repositioning. A new stage 1 pressure ulcer is noted on R29's coccyx. HRN-S applied barrier cream. R29's right calf is also reddened from the immobilizer being in place. Facility received hospice written communication note from HRN-S documenting the new stage 1 pressure ulcer to the coccyx and the new reddened area from the immobilizer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6/20/24-HRN-S assisted hospice home health aid with repositioning and cleansing her back and buttocks. A new state 1 pressure ulcer is noted to R29's left buttock and coccyx. HRN-S placed a foam border dressing. R29 has reddened areas of skin on her mid-spine, right calf, chest, and bilateral heels. Foam border dressings were placed on all areas of reddened skin to prevent further skin breakdown. Facility received hospice written communication note from HRN-S documenting that dressings to be changed if soiled or every 3-5 days. Foam border dressing to bilateral heels, coccyx, right calf and chin. Hospice Care Plan Documentation-Wound care to coccyx-wash with soap and water or wound cleanser. Apply skin prep to peri wound skin. Cover with foam border dressing. 2 times a week and as needed. Surveyor notes the facility does not have documentation that a physician order was obtained and added to R29's treatment orders. Surveyor reviewed the hospice Interdisciplinary Group Meeting dated 7/3/24 which HRN-S documents: 6/19/24-R29 cannot reposition self to prevent skin injuries. R29 does have a new stage 1 pressure injury on R29's chest. This is thought to be from R29's chin always resting on R29's chest. A foam border dressing is in place to prevent further breakdown. R29's buttocks and bilateral heels are reddened. Barrier cream and skin prep are in use to prevent further deterioration. 7/3/24-R29 has new stage 1 pressure ulcers to chest and coccyx. R29's chest wound is from chin continuously resting on chest. R29 is unable to hold head up on R29's own. R29's coccyx wound is related to being being bed bound and reduced repositioning. An alternating pressure mattress is in use in R29's room. 7/5/24-HRN-S documents HRN-S called for assistance from the facility to assist with incontinence cares and repositioned. R29 was incontinent of urine and bowel. R29's coccyx wound is deteriorating. The blanch-able reddened areas remain as before to R29's spine and right leg. R29's chest wound remains a stage 1. The skin on R29's chest is very thin and fragile. Facility staff updated. Facility received hospice written communication note from HRN-S documenting the status of the wound areas. On 7/9/24-HRN-S documents: Left Buttocks /Decubitus/Pressure Ulcer- Unstageable Onset: 7/9/24 Assessment: Wound Bed-Moist, Bed Color/Percentage-Red, Pink, Purple Wound Edges-Detached, Indistinct, Macerated Peri Wound Skin-Erythema, Scattered tearing (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Drainage Amount-Moderate Color-Sanguineous/bloody-yellow Odor-Foul Wound Status-declined Left Medial Buttocks Coccyx/Decubitus/Pressure Ulcer- Unstageable Onset: 6/19/24 Assessment: Wound Bed-Moist, Non-granulating Bed Color/Percentage-Red, Pink, Purple Wound Edges-Detached, Indistinct Peri Wound Skin-Erythema, Scattered tearing, Macerated Drainage Amount-Moderate Color-Sanguineous/bloody-yellow Odor-Foul Wound Status-declined Care Plan Documentation-Coccyx wound has increased in size and worsened in stage levels. Wound is currently unstageable. HRN-S documents on 7/9/24 that wound cares completed. R29's coccyx wound continues to have deterioration in size and staging. Foam border dressing placed. Other reddened areas are noted and covered during visit. HRN-S removed R29's heel boots as they were too tight and causing further skin breakdown. HRN-S updated facility nurse and DON-B regarding visit. Facility received hospice written communication note from HRN-S documenting coccyx wound is deteriorating. Stage 2. On 7/11/24-HRN-S documents: Left Buttocks /Decubitus/Pressure Ulcer- Unstageable Onset: 7/9/24 Assessment: Wound Bed-Moist, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Bed Color/Percentage-Red, Beefy Red, Pink, Purple Wound Edges-Detached Peri Wound Skin-Erythema, Scattered tearing Drainage Amount-Small Color-Sanguineous/bloody-yellow Odor-Foul Wound Status-declined Left Medial Buttocks Coccyx/Decubitus/Pressure Ulcer- Unstageable Onset: 6/19/24 Assessment: Wound Bed-Moist, Slough Bed Color/Percentage-Red, Beefy Red, Pink, Purple Wound Edges-Detached, Indistinct Peri Wound Skin-Erythema, Scattered tearing, Excoriated Drainage Amount-Moderate Color-Sanguineous/bloody-yellow Odor-Foul Wound Status-declined Care Plan Documentation-Deterioration has occurred to coccyx wound. HRN-S documents on 7/11/24 that Licensed Practical Nurse (LPN)-M and DON-B were updated regarding visit. HRN-S asked for the facility wound care MD to see R29 on Monday for further wound recommendations and follow-up. DON-B and LPN-M verbalized understanding. Surveyor reviewed R29's nursing progress notes located in R29's medical record from May to present and there is no facility documentation referring to any skin areas of concern for R29. On 5/15/24 there is a nurse's progress note that documents to add R29 to wound MD list for cut under the right great toe per DON-B. The facility has no documentation that R29 was evaluated by the facility wound MD for the cut. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/15/24, at 10:37 AM, Surveyor observed R29's air mattress is set at 5 which indicates 300 pounds. On 7/15/24, at 2:12 PM, Surveyor observed R29's air mattress is set at 5. On 7/16/24, at 7:47 AM, Surveyor observed R29's mattress is set at 5. On 7/17/24, at 7:16 AM, Surveyor observed R29's air mattress remains set at 5. On 7/17/24, at 12:16 PM, Surveyor observed R29's air mattress remains set at 5. On 7/18/24, at 9:26 AM, Surveyor observed R29's air mattress is now set at 1 which is for 100 pounds. On 7/15/24, at 3:31 PM, Surveyor reviewed R29's most recent weight from 7/3/24 which is 105.3. Surveyor reviewed previous weights going back to 11/9/23 which was 117.20. The highest weight recorded for R29 was 120 pounds on 1/8/24. On 7/16/24, at 10:43 AM, Surveyor interviewed HRN-S in regards to R29's pressure wounds. HRN-S stated that R29 has had a stage 1 to the left buttock and coccyx since 6/19/24 and has reminded staff to reposition R29. On 7/9/24, HRN-S states HRN-S marked it as a stage 2 because the wound was decorating. HRN-S stated HRN-S is not wound care certified so HRN-S reviewed it with the hospice wound nurse who stated the wound was unstageable. HRN-S requested from DON-B on 7/11/24 for R29 to be seen by the facility wound care MD. HRN-S stated R29 was supposed to be seen 7/15/24. HRN-S asked Unit Manager (UM)-J why R29 was not evaluated by the facility wound care MD, and UM-J informed HRN-S because state is here. HRN-S saw wound today and it is getting worse. Hospice will be coming back to get measurements. HRN-S confirmed that HRN-S have communicated with the facility about the pressure areas. HRN-S is not aware of the facility getting measurements of the pressure areas. HRN-S has been dating the dressings and sometimes its the original date indicating to HRN-S the treatment has not been getting done. On 7/17/24, at 7:21 AM, Surveyor asked Registered Nurse (RN)-L about R29's pressure area on the coccyx. RN-L stated RN-L has been on vacation, returned to work this weekend and is not aware of any open area on R29's left buttocks and coccyx. RN-L is only aware of the area on the chest. On 7/17/24, at 7:22 AM, Surveyor interviewed UM-J in regards to R29's open area on the left buttocks and coccyx. UM-J confirmed that R29 has an open area to the coccyx and believes R29 receives a daily treatment to the area. On 7/17/24, at 11:42 AM, Surveyor was provided R29's July TAR which documents apply foam dressing to sacrum every 3 days and as needed if soiled effective 7/17/24. On 7/17/24, at 12:16 PM, Surveyors requested to observe R29's pressure areas, however, facility staff never came to get Surveyors. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/18/24, at 4:06 PM, Surveyor again shared the concern with NHA-A that R29's heel, left buttock, and coccyx has not been assessed with measurements by the facility. Surveyor shared that hospice had requested on 7/11/24 for R29 to be seen by the WMD-W and that was not initiated by the facility and the treatment order for the coccyx was not entered until 7/17/24 after Surveyor expressed concern. Surveyor stated that R29's air mattress has not been set at the correct setting during the survey process and R29's primary physician was not updated when the new pressure areas were identified. Surveyor shared the concern that R29's pressure areas have deteriorated. 20483 2.) R5's diagnoses include multiple sclerosis, cirrhosis of the liver, unspecified protein calorie malnutrition, hypertension, anxiety disorder, and depression. [R5's first name] at risk for pressure ulcers and other skin related to but not limited to Braden and other skin related injuries documents the following approaches dated 7/5/23: * Braden scale to be completed. * Encourage proper peri hygiene and the use of barrier cream after each incontinent episode and PRN (as needed). * 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. * Encourage to float heels, W/C (wheelchair) with cushion is dated 7/6/23. Surveyor noted this care plan does not include approaches for repositioning R5. The physician orders dated 9/18/23 documents Hospice Eval (evaluation) and treat. The significant change MDS (minimum data set) with an assessment reference date of 9/29/23 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R5 is assessed as not having any behavior including not refusing cares. R5 is assessed as requiring extensive assistance with two plus person physical assist for bed mobility & transfers, extensive assistance with one person physical assist for toilet use, is occasionally incontinent of urine and always incontinent of bowel. R5 is at risk for pressure injuries and is assessed as not having any pressure injury. R5 is checked for hospice care. The pressure injury CAA (care area assessment) dated 9/30/23 documents see Fall CAA. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Falls CAA dated 10/1/23 documents Resident sig (significant) change new admit to hospice. She is alert with dx (diagnosis) of MS (multiple sclerosis). See attachments tab-general/labs/orders/consults/PT (physical therapy)/OT (occupational therapy)/ST (speech therapy) tabs. See Dx tab. She is innocent sic (incontinent) of both b/b (bowel bladder) see point of care tab-daily. Does use w/c (wheelchair) for mobility. Does not walk at this time. Does take Morphine, oxycodone eliquis and Lasix see EMAR (electronic medication administration record). Has had PRN (as needed) Ativan over look back, See assessments/forms tab-assessments 923-9/29. Has a PHQ9 (patient depression questionnaire) score of 4 and BIMS 15 indicating intact cognition. Resident is alert and able to choose her daily activities. Does not have pressure ulcer, see skin tab. Does have pressure reducing mattress, remedy cream and w/c cushion in place see ETAR (electronic treatment administration record) see skin care plan. Has had no falls over look back. Will proceed to care plans. See ID (interdisciplinary) notes Braden immunizations care plan wts (weights) emar/etars. The nurses note dated 11/8/23, at 17:16 (5:16 p.m.) documents General skin check completed on resident. Resident has a new issue that were identified during the skin check. See site specific note for full details of the new issue(s) identified during the skin check. This nurses note was written by RN-MM. The Braden assessment dated [DATE] has score of 12. If a resident's score is 12 or less consider him/her high risk for pressure ulcer development. The [R5's first name] has impaired skin integrity related to pressure area to left ischium documents the following approaches: * Provide treatment with a start date of 11/8/23. * Provide pain management with dressing changes PRN with a start date of 11/8/23. * Keep skin clean and dry with a start date of 11/8/23. * Provide peri-care after each incontinence episode and apply skin protectant with a start date of 11/8/23. * Educate resident and/or family to the importance of frequent turning/shift and repositioning with a start date of 11/8/23. * Minimize force and friction applied to skin with a start date of 11/8/23. * Registered Dietician consult with a start date of 11/8/23. * Assist/teach to reposition self to reduce pressure (shifting own weight or turning) with a start date of 11/8/23. * Provide supplements to promote healing as ordered by physician with a start date of 11/8/23. * Specialized mattress on bed. Type: Pressure relief air mattress, check setting (2) and inflation Q (every) shift. Only one barrier between body and mattress, CHUX of sic (or) brief not both with a start date of 11/8/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* MD (medical doctor) and hospice updated on skin sweep and status of wounds. Continue with current POC (plan of care). Hospice/MD and [R5's first name] in agreement with a start date of 1/19/24. * Wound rounds with [Wound MD-W's name] (wound MD) POC reviewed, physician orders updated. Hospice and POA (power of attorney) aware with a start date of 2/12/24. * Wound MD assessed with recommendations-MD updated, Tx (treatment) changed to daily and PRN. Resident/Hospice/Family updated on status/POC with a start date of 2/19/24. * Wound MD assessed, wound stable with recommendations to continue current Tx-MD updated, Resident/Hospice updated on status/POC with start dates 2/26/24, 3/4/24, 3/11/24, 3/18/24, 4/1/24, & 4/8/24. Surveyor noted the approach to reposition was not implemented until R5 was identified with an unstageable left upper buttocks pressure injury. R5's left upper buttocks pressure injury assessment dated [DATE] documents the stage as unstageable. The description is eschar & slough. Measurements are 2.4 cm (centimeters) x (times) 1.8 cm x utd (unable to determine. The tissue type is necrotic eschar. Drainage type is serosanguineous, odor is mild, color is green and exudate is light. There is no evidence on the assessment R5's physician was notified of the pressure injury. R5's left upper buttocks pressure injury weekly assessment dated [DATE] documents stage as unstageable. The description is left upper buttocks (ischium/bony prominence) eschar with slough noted to wound base. Measurements are 2.4 cm x 1.6 cm x utd, tissue type is necrotic eschar, MD/hospice updated. Surveyor noted weekly assessment from 11/21/23 to 12/12/23. R5's left upper buttocks pressure injury weekly assessment dated [DATE] documents stage as Stage 3. Description is left upper buttocks (ischium/bony prominence) wound bed red bloody. Measurements are 3.8 cm x 2.8 cm x utd. Drainage is bloody/sanguineous. Tissue type is granulation. R5's left upper buttocks pressure injury weekly assessment dated [DATE] documents stage as Stage 3. Description left upper buttock (ischium/bony prominence) 100% granulation to wound bed resolved. Measurements 3.8 cm x 3 cm x 3 cm. Tissue type is granulation. Drainage is bloody/sanguineous. Undermining throughout wound edges. Surveyor noted weekly assessments dated 12/26/23 to 1/2/24. R5's left up [TRUNCATED]

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

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

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

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

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

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

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

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

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

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

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

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F 0690 Level of Harm - Minimal harm or potential for 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** 47094 Based on observation, interview, and record review the facility did not ensure 1 (R315) of 2 residents reviewed with an indwelling catheter received appropriate treatment and were provided dignity. Surveyor had several observations during survey of R315's catheter bag not covered in a privacy bag and was visible from the hallway. R315's care plan was not revised to indicate if R315 did not mind if R315's catheter bag was visible to others. Findings include: R315 was admitted to the facility on [DATE] and has diagnoses that include encounter for surgical after care (placement of urostomy) following surgery on the digestive system, bowel obstruction, ESBL (extended spectrum beta-lactamase) infection, and weakness. R315's baseline care plan initiated on 7/12/2024 indicated R315 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15. R315 used a wheeled walker and limited assist of 1 staff member for transferring, mobility, and toileting. R315 was admitted with a urostomy and right arm PICC (peripherally inserted central catheter) line to have antibiotics administered through. On 7/15/2024, at 10:57 AM, Surveyor observed R315 lying in bed watching TV. R315 stated R315 was tired and wanted to rest. Surveyor observed R315 had a catheter bag located on the right side of R315's bed with a small amount of hematuria (bloody urine). Surveyor asked R315 regarding the hematuria. R315 stated that R315 just had the urostomy placed and was to be expected and would clear up. R315 stated R315 was on antibiotics for it because R315 developed a major infection. Surveyor noted that R315's catheter bag was visible from the hallway and not in a privacy bag. On 7/16/2024, at 7:50 AM, Surveyor observed R315 sleeping in bed, R315's catheter bag was on the right side of the bed, visible from the hallway, and not in a privacy bag. Surveyor noted a small amount of hematuria in catheter bag. On 7/17/2024, at 7:38 AM, Surveyor observed R315 lying in bed watching TV. Surveyor noted R315's catheter bag on the rights side of the bed, visible from the hallway, and not in a privacy bag. Surveyor noted a small amount of light yellow urine in bag with streaks of red through it. R315 stated R315 noticed urine was looking better. On 7/18/2024, at 9:19 AM, Surveyor shared observations with unit manager (UM)-J and director of nursing (DON)-B regarding R315's catheter bag not in a privacy bag and visible from the hallway. UM-J stated R315's family member wanted the catheter bag uncovered so they were able to see it. Surveyor stated that R315 was R315's own person and if it was ok with R315 the care plan was not revised to indicate that R315 did not want the catheter bag covered. UM-J and DON-B expressed understanding with Surveyors concerns.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on observation, interview, and record review the facility did not ensure the necessary services to provide respiratory care were consistent with professional standards of practice for 1 (R11) of 2 residents reviewed for respiratory care. R11's oxygen tubing was not labeled during survey. On 7/17/2024 R11's oxygen humidification was dry/empty. Findings include: The facility policy, entitled PROCEDURE: Oxygen Administration, last approved 12/2022, documents: Purpose- The purpose of this procedure is to provide guidelines for safe oxygen administration.Steps in the Procedure- . K. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. L. Label and date the humidifier bottle and oxygen tubing. N. Periodically re-check water level l the humidifying jar. R11 was admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus, dementia, Alzheimer's, anxiety disorder, major depressive disorder, heart failure, pulmonary fibrosis, and chronic respiratory failure with hypoxia. R11's quarterly minimum data set (MDS) dated [DATE] indicated R11 had moderately impaired cognition with a Brief Interview of Mental Status (BIMS) score of 12 and the facility assessed R11 needing maximal assistance with 1 staff member for lower body dressing, bathing, and toileting hygiene and supervision for personal hygiene and upper body dressing. R11 was occasionally incontinent of bowel and bladder and wore an adult brief for protection. R11 was on continuous oxygen therapy via nasal cannula and used a wheelchair that R11 was able to propel by using R11's feet. On 7/15/2024, at 11:14 AM Surveyor observed R11 sitting in R11's wheelchair watching TV. R11 had oxygen on and was set at 6L via nasal cannula. R11's tubing was not labeled, and the humidification jar was almost empty and was not dated. Surveyor reviewed R11's current physician orders: - Continuous oxygen at 4 LPM (liters per minute) via NC (nasal cannula). May titrate up to keep O2 sats above 90%- 4 LPM inhalation every shift. Inhale into the lungs continuous for respiratory failure with hypoxia . Every shift. - Change tubing and humidifier bottle weekly . for O2 (oxygen) maintenance. Surveyor reviewed R11's treatment administration record (TAR) for July 2024 and noted staff signed out that R11 tubing, and humidification was last changed on 7/13/2023. R11's next scheduled date for tubing and humidification change is scheduled for 7/20/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/2024, at 7:31 AM, Surveyor observed R11 sitting in her wheelchair in her room and was dressed for the day. R11 had oxygen on and was running at 4 LPM. Surveyor noted the oxygen tubing was not labeled and the humidification jar was dry. Surveyor asked R11 if her nose or mouth felt dry. R11 denied feeling dry. On 7/18/2024, at 7:33 AM, Surveyor shared observations with unit manager (UM)-J of R11's oxygen tubing and humidification not being labeled and R11's humidification was dry/ empty all day on 7/17/2024. Surveyor and UM-J went into R11's room and observed R11 sitting in wheelchair and watching TV. R11's tubing was not labeled and there was now a new humidification jar on the concentrator but was not labeled as to when it was put on. UM-J shared understanding of concerns and agreed that the oxygen tubing and humidification needs to be labeled and checked on frequently especially if R11's oxygen gets turned up. UM-J stated that typically NOC/3rd shift is responsible for changing out the tubing and humidification for oxygen concentrators. On 7/18/2024, at 4:10 PM, Surveyor shared concerns with nursing home administrator (NHA)-A regarding R11's oxygen tubing and humidification not being labeled during survey and R11's humidification was dry/empty all day on 7/17/2024. NHA-A shared understanding of Surveyors concerns.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure that 1 (R29) of 2 Residents reviewed for pain management received pain management consistent with professional standards of practice and Resident choice related to pain management. R29 was admitted to hospice on 4/24/23. R29 did not receive requested and prescribed pain medication as scheduled during a time that R29 had a right great toe fracture and a right distal femur fracture. Findings Include: The facility was unable to provide a policy and procedure in regards to pain management. R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia and Anxiety Disorder. R29 has an activated Health Care Power of Attorney (HCPOA) effective 9/16/2019. R29 has been receiving hospice service since 4/24/23. R29's Annual Minimum Data Set (MDS) dated [DATE] documents R29 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R29's MDS also documents that R29 is at risk for developing skin issues and has no current skin issues, osteoporosis is not documented as a current diagnosis, R29 is receiving scheduled pain medications and that a pain interview can be completed but then is documented that R29 is unable to answer any questions. R29's documents R29 has range of motion impairment on both upper and lower extremities on both sides and that R29 is dependent for assistance for eating, hygiene, mobility, and transfers. Surveyor notes R29 did not trigger a Care Area Assessment (CAA) for pain with the 4/3/24 annual MDS. Surveyor notes this is prior to R29's injuries. R29 has 1 pain assessment dated [DATE] with a score of 1. Surveyor requested additional pain assessments from the facility and notes there are no new pain assessments completed by the facility with the right great toe fracture or the femur fracture that R29 had. R29's comprehensive care plan documents (R29) might have pain due to dementia, anxiety and trunk weakness. (R29) has potential for pain related to DJD (degenerative joint disorder), rash, MASD (moisture associated skin disorder), contractures, history of left and hip and wrist fracture with a start date of 4/23/24. Interventions of importance are as follows with a start date of 4/24/23: -(R29) states that medication makes it better -(R29) states that a lot of moving makes it worse -Administer medications as indicated and monitor for effectiveness -Report uncontrolled pain to provider (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor for non-verbal signs of pain such as grimacing, irritability, moaning, body language, guarding, daily 1 - 50 mg Tramadol tablet every 8 hours as of 2/27/24 for pain was scheduled. R29's current physician orders regarding pain management are as follows: On 6/3/24, Tramadol was discontinued and changed to morphine concentrate 100 mg/5ml(20mg/ml) every 6 hours Lidocaine 4% topical patch 2 times a day effective 4/24/23 Assess pain and document every shift effective 11/16/22 Surveyor reviewed R29's May and June Medication and Treatment Administration Records and notes there is no documentation that the facility was monitoring and documenting R29's pain level every shift. July's Medication and Treatment Administration Record documents R29's pain level every shift. Surveyor notes progress notes written by facility nurses located in R29's medical record document that on the following dates, R29's scheduled morphine was not administered to R29 as a result of nurses' judgement: 6/6/24,6/9/24, 6/15/24, 6/16/24, 6/24/24. On 7/11/24, Registered Nurse (RN)-T documents that the 6:00 AM dose of scheduled morphine was held due to somnolence signs of no pain. Surveyor notes there is no documentation by the facility that R29's primary physician was notified that staff were not administering the scheduled morphine. Hospice Registered Nurse (HRN)-S documents the following in regards to pain management for R29 5/16/24-pain level is at 8. Per hospice plan of care, as needed (PRN) medications to be administered when requested to alleviate pain. HRN-S asked Licensed Practical Nurse (LPN)-M if R29 had received any PRN medications. HRN-S documents that Licensed Practical Nurse (LPN)-M informed HRN-S that LPN-M forgot about R29 because LPN-M got pulled into a meeting by administration. LPN-M informed HRN-S that R29 did not receive R29's scheduled medications nor R29's PRN which is scheduled on shower days. HRN-S informed LPN-M that R29 should receive those medications as soon as possible, especially because R29 is headed into the shower. R29 is very agitated and yelling during transfer. R29 screaming in pain when HRN-S touches foot. 5/21/24 HRN-S attempted to assess R29's feet, but R29 becomes agitated and yells when HRN-S attempts to do so. Pain level is 3. 5/23/24 HRN-S asked for PRN medication to be administered during shower. R29 was screaming in pain. Pain level is 8. HRN-S asked facility caregiver if R29 had received PRN medication prior to HRN-S arrival because it was R29's shower day. Facility caregiver denied administration of medication to [NAME]. HRN-S facility caregiver to administer medication. R29 was very agitated and in pain. Pain level 8. HRN-S asked for facility caregiver to also administer PRN morphine to help control R29's pain. R29 did not tolerate cares as well. R29's medications were discussed with facility staff. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/30/24 Pain level 8 with movement. Range of motion attempted by HRN-S, however, R29 is unable to lift R29's right leg off of the bed which is new. HRN-S attempted to move R29's lower extremity, but R29 yelled out in pain, crying, it hurts. R29 has not received any PRN medication since 5/26/24. 6/3/23 Pain level 8 during repositioning. Facility nurse was asked to administer PRN morphine as R29 was having a lot of pain. 6/5/24 Registered Nurse (RN)-L asked HRN-S if facility should continue to medicate R29 if R29 is sleeping because morphine could hasten R29's death or kill R29. HRN-S educated RN-L that morphine is there for the comfort of R29. HRN-S told RN-L to imagine being repositioned every 2 hours while having a fractured femur and understanding the immense pain that R29 would feel if morphine was not administered. HRN-S also expressed the importance of nursing assessment and nursing judgement. HRN-S educated RN-L to wake R29 during morphine administration and assess R29's pain. If facility nurses feel that R29 is sedated or they have concerns they can always call hospice for instructions or contact their medical provider. Written communication sheet handed directly to Director of Nursing (DON)-B. 6/20/24 During repositioning, R29 complained of pain by stating, ouch. Pain level 4. 7/5/24 Pain level 8 upon arrival, pain level 4 upon departure. R29 is visibly in pain as evidenced by facial grimacing and moaning. R29 is stating, it hurts while grabbing towards right leg. R29 is very agitated. Facility nurse had not administered R29's scheduled pain medications yet. HRN-S instructed facility nurse to administer medications as R29 was very agitated and in pain. 7/11/24 R29 appears agitated and painful. HRN-S spoke with LPN-M regarding R29's medications. LPN-M reported R29 had not gotten R29's medications yet. HRN-S asked for R29's medications to be scheduled so R29 is comfortable and calm during cares. DON-B updated regarding visit. Surveyor notes that HRN-S documents on pain assessments that R29's side effects of pain is severe for physical functioning, social interaction, mood/emotions and interferes with activity or movement. R29 will display facial grimacing and at times is unable to be consoled due to pain. Hospice's Interdisciplinary Group Meeting dated 7/3/24 documents R29's pain has increased since having a fractured femur. Scheduled morphine was added to manage R29's pain. R29 is unable to make R29's needs known. The facility nurses documented in R29's medical record: 6/15/24-scheduled morphine held due to end of life distress 6/16/24-scheduled morphine not given per family request 6/24/24-scheduled morphine held due to no signs/symptoms of pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24, at 10:43 AM, Surveyor interviewed HRN-S in regards to R29. HRN-S stated that prior to R29's injuries, R29 did not have issues with pain. When R29 started sustaining injuries, R29 had pain, would cry out, facial grimacing and reach out to R29's knee and stated, it hurts, it hurts. R29 refused to raise right knee and would scream out in pain. HRN-S stated that R29's demeanor changed as well as physical effects since the femur fracture. Prior to the fracture, R29 had agitation, but after fracture became nice, stopped eating. HRN-S stated the facility had no answers as to why facility nurses were not administering R29's scheduled pain medications. HRN-S stated that R29's injuries with the increased pain caused R29 to have a significant change of condition. HRN-S, based on observations, thought R29 was transitioning, but stated R29 has recently started to bounce back. On 7/17/24, at 3:36 PM, Surveyor interviewed Hospice Supervisor (HS)-V who stated that the facility never called hospice to communicate they were not giving R29's prescribed pain medications. HS-V stated that at the care conference, it was discussed that R29's pain needed to be controlled due to the femur fracture. On 7/18/24, at 10:37 AM, Surveyor interviewed HRN-S again in regards to R29's pain management. HRN-S stated HRN-S has never seen the lidocaine patch on R29 and when HRN-S asked RN-L about it, RN-L responded where am I supposed to put it. On 7/18/24, at 12:52 PM, Director of Nursing (DON)-B is aware that R29 was not receiving scheduled pain medications and does not know if R29's physician was notified. DON-B understands the concern that no new pain assessment was completed by the facility when R29 sustained the right great toe fracture and and the right femur fracture and agreed the expectation would be to have new ones completed. On 7/18/24, at 3:42 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern that there is no documentation that the facility was monitoring R29's pain level every shift in May and June. Surveyor shared there are multiple nursing progress notes that R29's scheduled morphine was not administered to R29, and hospice had to frequently ask for R29's pain medication to be administered and educate facility nurses on the importance to administer R29's pain medication in order to provide comfort and quality of life to R29. No further information was provided by the facility at this time in regards to R29's pain management. On 7/29/24, at 12:33 PM, Surveyor reviewed additional information provided by the facility after the survey process was completed. Surveyor reviewed the pain evaluation provided, however, Surveyor still has concerns. The pain evaluation is not dated. Surveyor continues to have concerns that R29's scheduled pain medication was not administered on several occasions and R29's pain level was not monitored every shift as physician orders documented for the month of May and June.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on record review and interview, the facility did not have evidence that the pharmacist's medication record review of any irregularities were reported to the attending Physician, Medical Director and Director of Nursing and that these reports are acted upon for 5 (R5, R42, R25, R18, & R11) of 5 residents whose drug regimens were reviewed. Findings include: The facility's policy titled, Pharmacy Services - Role of the Consultant Pharmacist last revised 7/2020 under Policy Interpretation and Implementation documents C3. Determines that drug records are in order and that an account of controlled drugs is maintained and periodically reconciled through MRR (Medication Regime Review). If any irregularity is noted during the MRR, the pharmacist is required to notify the attending physician, DON (Director of Nursing), and medical director. The MRR will be conducted monthly. a. Irregularity includes, but is not limited to, the use of any drug that meets the criteria for an unnecessary drug. b. The pharmacist will report on the MRR and will submit recommendations to the physician and DON. c. The DON, or designee will ensure that recommendations are followed through on a timely basis, which does not exceed 30 days. d. Irregularities will be addressed immediately, but not to exceed 24 hours. e. The attending physician will document in the resident's medical record that the irregularity was received and what action was taken to accommodate it. f. Copies of drug/medication regimen review reports, including physician responses, will be maintained as part of the permanent medical records. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) R5 was admitted to the facility on [DATE] with diagnoses which include multiple sclerosis, cirrhosis of the liver, unspecified protein calorie malnutrition, hypertension, anxiety disorder, and depression. The pharmacist note dated 11/21/23 documents In accordance with 42 CFR (Code of Federal Regulations) section 483.45 (c) this resident's medication regimen has been reviewed; please see CPh (Consultant Pharmacist) report for any irregularities and/or recommendations. Surveyor was unable to locate a pharmacist note in R5's medical record during the month of December 2023. The pharmacist note dated 1/17/24 documents In accordance with 42 CFR section 483.45 (c) this resident's medication regimen has been reviewed; please see CPh report for any irregularities and/or recommendations. Surveyor was unable to locate a pharmacist note in R5's medical record during the months of February 2024 & March 2024. The pharmacist note dated 4/12/24 documents In accordance with 42 CFR section 483.45 (c) this resident's medication regimen has been reviewed; please see CPh report for any irregularities and/or recommendations. Surveyor was unable to locate a pharmacist note in R5's medical record during the months of May 2024 & June 2024. On 7/16/24, at 3:21 p.m. during the end of the day meeting, Surveyor asked NHA (Nursing Home Administrator)-A for R5's monthly drug regimen review from 11/21/2023 to present. On 7/17/24, at 12:27 p.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-AA if they are getting monthly medication regime reviews. RN/UM-AA replied we are now and explained she doesn't know if they were being sent to the wrong person. Surveyor asked when they started receiving the monthly medication regime reviews. RN/UM-AA informed Surveyor she doesn't know if she has the exact date. On 7/17/24 at 3:51 p.m. during the end of the day meeting Surveyor informed NHA-A Surveyor has not received R5's monthly medication regime reviews from 11/21/23 to present. On 7/18/24, at 8:05 a.m., Surveyor reviewed R5's monthly medication regime reviews which were left on the table by NHA-A. Surveyor noted the MRR provided for physician/prescriber response are blank and are not signed or dated by the physician. These reports have a print date of 7/17/24. On 7/18/24 at 8:06 a.m. Surveyor informed NHA-A Surveyor is missing March 204 MRR recommendation and Surveyor need to see the MRR recommendations with the documented physician response and are signed by the physician. Surveyor noted the following for the MRR recommendations provided by NHA-A on 7/18/24: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MRR date: 11/20/23 Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam. CMS (Centers for Medicare & Medicaid Services) requires a defined stop date on all PRN (as needed) psychotropic orders used for a psychiatric indication. Please reissue this order with a stop date OR discontinue this order. Thank you. The physician/prescriber response is blank and is not signed or dated. MRR date: 12/21/23 Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam. CMS requires a defined stop date on all PRN (as needed) psychotropic orders used for a psychiatric indication. Please reissue this order with a stop date OR discontinue this order. Thank you. The physician/prescriber response is blank and is not signed or dated. MRR date: 1/15/24 Resident has received escitalopram 20 mg (milligrams) daily for depression since at least 7/2023. Resident also receives PRN Lorazepam. Please consider a gradual dose reduction (GDR) to escitalopram 10mg daily for depression. If a GDR is contraindicated at this time this contraindication may be documented below in lieu of performing a GDR. Thank you. The physician/prescriber response is blank and is not signed or dated. MRR date: 1/15/24 Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam. CMS requires a defined stop date on all PRN (as needed) psychotropic orders used for a psychiatric indication. Please reissue this order with a stop date OR discontinue this order. Thank you. The physician/prescriber response is blank and is not signed or dated. MRR date: 2/14/24 Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam. CMS requires a defined stop date on all PRN (as needed) psychotropic orders used for a psychiatric indication. Please reissue this order with a stop date OR discontinue this order. Thank you. The physician/prescriber response is blank and is not signed or dated. Surveyor was not provided with a MRR recommendation for March 2024 nor is there a pharmacy note in R5's medical record. MRR date: 4/10/24 Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam. CMS requires a defined stop date on all PRN (as needed) psychotropic orders used for a psychiatric indication. Please reissue this order with a stop date OR discontinue this order. Thank you. The physician/prescriber response is blank and is not signed or dated. MRR date: 5/8/24 Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam. CMS requires a defined stop date on all PRN (as needed) psychotropic orders used for a psychiatric indication. Please reissue this order with a stop date OR discontinue this order. Thank you. The physician/prescriber response is blank and is not signed or dated. MRR date: 6/12/24 Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam. CMS requires a defined stop date on all PRN (as needed) psychotropic orders used for a psychiatric indication. Please reissue this order with a stop date OR discontinue this order. Thank you. The physician/prescriber response is blank and is not signed or dated. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24, at 9:49 a.m., Surveyor asked RN/UM-AA if she knows who receives the monthly medication regime review. RN/UM-AA replied I do not and explained she doesn't know if they go to DON (Director of Nursing)-B or NHA-A. On 7/18/24, at 10:14 a.m., Surveyor asked DON-B if she could explain the process of monthly drug regime reviews to Surveyor. DON-B informed Surveyor she started a couple weeks ago with the pharmacy consultant. DON-B explained when they get those reports they are suppose to look at them, give them to the prescribed physician so they can either agree or disagree with what the pharmacist is saying and get those back in a timely manner. DON-B informed Surveyor then they would correct the order and what she does when she gets the report back she makes a pharmacy note. Surveyor asked DON-B if the consultant pharmacist sent her the monthly medication regime reviews. DON-B informed Surveyor he sent her some stuff but wasn't quite everything and she's trying to get caught up with them. DON-B informed Surveyor she's the one that is pretty much doing them and stated just so you know I'm not from here, I just started and I inherited the process. Surveyor informed DON-B Surveyor needs to see R5's monthly MRR recommendation which were addressed by the physician and signed. DON-B replied I sure will get them to you. On 7/18/24, at 4:06 p.m., during the end of the day meeting, NHA-A was informed Surveyor has not received R5's monthly medication regime reviews which were addressed and signed by the physician and has not received a March 2024 medication regime review for R5. On 7/22/24 Surveyor was provided only with one monthly medication regime review for the time period 11/21/23 to June 2024. The MRR date is 6/12/24. The MRR is signed by the physician and documents Medication approved for long term PRN use. Surveyor noted there are fax dates & times of 7/18/24 11:59:31 am, page 7/009 and 7/18/24 2:22:26 PM page 7 of 9. 16584 2.) R42 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE]. R42's diagnosis include congestive heart failure, type 2 diabetes, unstageable pressure ulcer to left heel, dependence on supplemental oxygen, weakness and acquired absence of right leg below knee. R42's plan of care states that R42 has diseases and conditions which are treated with medications. The goal is medication will be overseen and managed by the nursing and Physician team during the stay. Will remain free from any adverse effects due to medication over the next review period. Surveyor conducted a review of R42's medication regimen and reviewed the monthly pharmacy reviews. Surveyor requested to review the monthly reviews from pharmacy on 7/16/24. A copy of the June, 2024 pharmacy review was provided. The review was not signed or dated. Surveyor requested to review April and May, 2024 pharmacy reviews. 07/18/24 08:12 AM Surveyor was provided with copies of the MRR recommendations for R42 for April, May and June 2024 and the following was noted: MRR (medication regimen review), dated 4/10/24, indicates R42 receives clopidogrel but does not receive an agent for gastroprotection. Please consider initiation of pantoprazole 20 mg daily. The form indicates agree but there is no date or signature from the physician/ prescriber. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MRR recommendation, dated 5/8/24,indicates R42 receives clopidogrel but does not receive an agent for gastroprotection. Please consider initiation of pantoprazole 20 mg daily. The form indicates agree but there is no date or signature from the physician/ prescriber. Surveyor conducted a review of R42's physician orders and noted that on 7/4/24, R42 received an order for Pantoprazole 20 mg tablet, delayed release, 20 milligrams by mouth every day for gastro. The facility did not provide additional information as to why the Pantoprazole was not added to R42's medication regimen back in May 2024 when the pharmacist first recommended the addition of the medication. A review of the MRR, dated 6/12/24, indicates that R42 has received rapid-acting insulin with sliding scale instructions for type 2 diabetes for at least 14- days. Other insulin orders and other antidiabetic orders include; Lantus 10 units BID (twice daily). Please consider discontinuation of sliding scale insulin and adjustment of scheduled insulin and/ or antidiabetic agents , as appropriate. If sliding- scale insulin is the only clinically reasonable treatment available for this resident and all clinically reasonable treatment available for this resident and all clinically reasonable alternatives have already been tried, please document this clinical contraindication below. Further review of the form shows that the agree box is checked but the form is not signed or dated by the Physician/ Prescriber. Nursing note dated 7/17/24 at 7:36 p.m. states ; Pharmacy recommendations is to discontinue the sliding scale. After carefully reviewing over the sliding scale orders and results. Resident results have been in range not to receive coverage. MD gave verbal orders to discontinue order. On 7/18/24, Administrator- A provided Surveyor with a copy of the MMR, dated 6/12/24, with the recommendation to discontinue the sliding scale insulin. The copy provided was now signed by the physician on 7/18/24 stating that they agree with the recommendation and will discontinue the sliding scale insulin due to R42 being stable. In addition, Administrator- A provided Surveyor a copy of the MMR, dated 6/12/24, with the recommendation that the facility conduct an AIMS assessment semiannually and 4 weeks after dose changes. The copy was now signed by the physician and dated 7/18/24. As of the time of exit on 7/22/24, no additional information had been provided as to why the physician, did not follow-up on the pharmacy recommendations, in a timely manner. 21855 3.) R18's monthly review on 4/11/24 included recommendations by the pharmacist. The Pharmacist Recommendation Consult documents: (R18) is exhibiting signs/symptoms of depression, per nursing. R18 is currently receiving Sertraline 50 mg daily and Mirtazapine 15 mg (milligram) every HS (bedtime). Please consider evaluation of this condition and, if warranted, consider increasing Sertraline to 100 mg daily. There is no evidence this was reviewed and acted upon promptly by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18's monthly review on 6/13/24 included recommendations by the pharmacist. The Pharmacist Recommendation Consult documents: R18 is exhibiting signs/symptoms of depression, per nursing. R18 is currently receiving Sertraline 100 mg daily and Mirtazapine 15 mg every HS (bedtime). Please consider evaluation of this condition and, if warranted, consider increasing Sertraline to 150 mg daily. There is no evidence this was reviewed and acted upon promptly by the physician. On 7/17/24, at 12:27 p.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-AA if they are getting monthly medication regime reviews. RN/UM-AA replied we are now and explained she doesn't know if they were being sent to the wrong person. Surveyor asked when they started receiving the monthly medication regime reviews. RN/UM-AA informed Surveyor she doesn't know if she has the exact date. On 7/18/24, at 9:49 a.m., Surveyor asked RN/UM-AA if she knows who receives the monthly medication regime review (MMR). RN/UM-AA replied I do not and explained she doesn't know if they go to DON (Director of Nursing)-B or Nursing Home Administrator (NHA)-A. On 7/18/24, at 10:14 a.m., Surveyor asked DON-B if she could explain the process of monthly drug regime reviews to Surveyor. DON-B informed Surveyor she started a couple weeks ago with the pharmacy consultant. DON-B explained when they get those reports they are suppose to look at them, give them to the prescribed physician so they can either agree or disagree with what the pharmacist is saying and get those back in a timely manner. DON-B informed Surveyor then they would correct the order and make a pharmacy note. Surveyor asked DON-B if the consultant pharmacist sent her the monthly medication regime reviews. DON-B informed Surveyor he sent her some stuff but wasn't quite everything and she's trying to get caught up with them. DON-B informed Surveyor she's the one that is pretty much doing them and stated just so you know I'm not from here, I just started and I inherited the process. Surveyor informed DON-B Surveyor needs to see R5's monthly MRR recommendation which were addressed by the physician and signed. DON-B replied I sure will get them to you. On 7/18/24, at 4:00 PM, during the facility exit meeting with NHA-A Surveyor shared the Pharmacy Consult follow-up concerns. NHA-A did not provide any additional information. 4.) R25's monthly review on 2/21/24 included recommendations by the pharmacist. The Pharmacist Recommendation Consult documents: R25 is currently receiving risperidone, which requires AIMS/DISCUS (abnormal involuntary movement scale/dyskinesia identification system:condensed user scale) monitoring. Please ensure monitoring of an AIMS/DISCUS semiannually and 4 weeks after dose changes. There is no evidence this was reviewed and acted upon promptly by the physician. R25's monthly review on 5/8/24 included recommendations by the pharmacist. The Pharmacist Recommendation Consult documents: (R25) has received Mirtazapine 15 mg (milligram) every HS (bedtime) for insomnia since at least 2/2024. R25 also receives Fluoxetine and risperidone. Please consider a gradual dose reduction to Mirtazapine 7.5 mg every HS for insomnia. There is no evidence this was reviewed and acted upon promptly by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24, at 12:27 p.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-AA if they are getting monthly medication regime reviews. RN/UM-AA replied we are now and explained she doesn't know if they were being sent to the wrong person. Surveyor asked when they started receiving the monthly medication regime reviews. RN/UM-AA informed Surveyor she doesn't know if she has the exact date. On 7/18/24, at 9:49 a.m., Surveyor asked RN/UM-AA if she knows who receives the monthly medication regime review. RN/UM-AA replied I do not and explained she doesn't know if they go to DON (Director of Nursing)-B or Nursing Home Administrator (NHA)-A. On 7/18/24, at 10:14 a.m., Surveyor asked DON-B if she could explain the process of monthly drug regime reviews to Surveyor. DON-B informed Surveyor she started a couple weeks ago with the pharmacy consultant. DON-B explained when they get those reports they are suppose to look at them, give them to the prescribed physician so they can either agree or disagree with what the pharmacist is saying and get those back in a timely manner. DON-B informed Surveyor then they would correct the order and make a pharmacy note. Surveyor asked DON-B if the consultant pharmacist sent her the monthly medication regime reviews. DON-B informed Surveyor he sent her some stuff but wasn't quite everything and she's trying to get caught up with them. DON-B informed Surveyor she's the one that is pretty much doing them and stated just so you know I'm not from here, I just started and I inherited the process. Surveyor informed DON-B Surveyor needs to see R5's monthly MRR recommendation which were addressed by the physician and signed. DON-B replied I sure will get them to you. On 7/18/24, at 4:00 PM, during the facility exit meeting with NHA-A Surveyor shared the Pharmacy Consult follow-up concerns. NHA-A did not provide any additional information. 47094 5.) R11 was admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus, dementia, Alzheimer's, anxiety disorder, major depressive disorder, heart failure, pulmonary fibrosis, chronic kidney disease stage 3, heart failure, altered mental status, weakness, abnormalities of gait and balance, and chronic respiratory failure with hypoxia. On 7/16/2024, at 3:07 PM, Surveyor requested from nursing home administrator (NHA)-A to see R11's pharmacy medication reviews from January 2024 - current. On 7/17/2024, Surveyor again requested to see pharmacy medication reviews for R11 from NHA-A for January 2024- current. On 7/18/2024, Surveyor reviewed R11's pharmacy medication reviews and noted there was not a pharmacy review for January 2024 and February, March, April, May, June, and July pharmacy reviews were not signed or dated by a physician indicating the pharmacy reviews were looked at or acted upon. On 7/18/2024, at 10:14 AM, a Surveyor interviewed director of nursing (DON)-B who stated DON-B started looking at the pharmacy reviews a few weeks ago. DON-B stated there is a binder when reports are received from pharmacy and physicians are to review them to, they can indicate if they agree or disagree with the recommendation. DON-B stated DON-B was sent some stuff from the pharmacy and is trying to get caught up. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/2024, at 1:15 PM, Surveyor was handed pharmacy review sheets for May, June, and July 2024 that was signed by the physician but there is no date documented when the physician reviewed the recommendations. Surveyor still has not received January 2024 pharmacy med review and indication that the physician reviewed the pharmacy reviews for February, March, or April 2024. On 7/18/2024, at 4:10 PM, Surveyor shared concern with NHA-A that R11's pharmacy medication reviews for January, February, March, and April 2024 were not reviewed by a physician to indicate if the physician agrees or disagrees with the pharmacy recommendation. No further information was provided at this time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure 1 (R5) of 5 residents did not receive unnecessary psychotropic medications. R5 has an order for Ativan 0.5 mg every eight hours as needed. There is no stop date and no documented rationale from the physician as to why it is appropriate to extend the PRN (as needed) order past 14 days. Findings include: The facility's policy titled, Psychotropic Medication last revised 11/2022 under Policy Interpretation and Implementation documents: N. The need for continued PRN (as needed) orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The specific duration of the PRN order will be indicated in the order. O. PRN orders for psychotropic medications will not be renewed beyond 14 days unless the health care practitioner has evaluated the resident for the appropriateness of that medication. R5 was admitted to the facility on [DATE] with diagnoses which include multiple sclerosis, cirrhosis of the liver, unspecified protein calorie malnutrition, hypertension, anxiety disorder, and depression. On 7/16/24, at 10:43 a.m., Surveyor reviewed R5's physician orders which includes with an order date of 5/6/24 Ativan Tab (tablet) 0.5 mg (milligrams); [Physician-BB's name] .5 mg by mouth every 8 hours as needed. Administer .5 mg every eight hours by mouth for Anxiety. Surveyor noted there is no stop date for R5's PRN Ativan 0.5 mg. On 7/17/24 Surveyor reviewed CP (Consultant Pharmacist)-BB's MRR (Medication Regime Review) for R5 dated 5/8/24, 6/12/24, & 7/10 regarding Resident receives a PRN non-antipsychotic psychotropic medication without a valid stop date: Lorazepam (Ativan). Cross reference F756. Physician-BB's progress note dated 6/22/24 does not address R5's PRN Ativan. On 7/17/24, at 9:37 a.m., Surveyor met with RN/UM (Registered Nurse/Unit Manager)-AA to discuss R5. Surveyor informed RN/UM-AA Surveyor wasn't able to locate a stop date or rationale to continue R5's PRN Ativan. RN/UM-AA informed Surveyor R5 is hospice and those order come from hospice. RN/UM-AA informed Surveyor she may have to touch base with DON (Director of Nursing)-B. Surveyor asked RN/UM-AA if she could get back to Surveyor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24, at 12:24 p.m., RN/UM-AA informed Surveyor regarding R5's PRN Ativan the hospice team are the ones responsible for ordering the medication. Surveyor asked RN/UM-AA if there is a stop date or rational for continuing R5's PRN Ativan. RN/UM-AA replied no not to our knowledge, its a matter of the hospice team providing information which we haven't gotten. We are going to follow up on that. On 7/17/24, at 3:51 p.m., during the end of the day meeting with NHA (Nursing Home Administrator)-A Surveyor informed NHA-A there is no stop date or documented rationale beyond 14 days for R5's PRN Ativan 0.5 mg. On 7/18/24, at 10:20 a.m., Surveyor informed DON-B of the concern of R5's PRN Ativan 0.5 mg does not have a stop date and Surveyor is unable to locate evidence of documented rationale as to why this medication needs to be extended by 14 days. On 7/22/24, at 7:45 a.m., NHA-A provided Surveyor with physician orders for 7/18/24 which documents an order date of 5/6/24 Ativan Tab 0.5 mg - .5 mg by mouth every 8 hours as needed Administer .5 mg every eight hours by mouth for anxiety. [Physician-BB's name]; with a stop date of 11/02/24.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview, observation, and record review, the facility did not assist 1 (R29) of 1 resident reviewed for obtaining routine dental care. R29 has very few teeth, most are black in color and was not offered and did not receive dental services, resulting in being on a mechanically soft altered diet with tube feeding. Findings Include: The facility's policy Dental Services for Residents dated 6/2016 and last revised on 9/2018 documents: .Policy Statement Routine and emergency dental services are available to meet the Resident's oral health services in accordance with the Resident's evaluation and plan of care. Policy Interpretation and Implementation 1. Oral health services are available to meet the Resident's needs. 3. Our community has a contract with a dentist that comes to the community and provides dental services. 4. Dental services are under the supervision of a licensed dentist retained by this community. 8. A complete record of the Resident's dental care and services are maintained in accordance with current regulations. 15. Dental services provided are recorded in the Resident's medical record. 17. Nursing services is responsible for notifying social services of a Resident's need for dental services. 18. Social services personnel will be responsible for assisting the Resident/and/or Resident representative in making dental appointments and transportation arrangements as necessary. R25 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis, Type 1 Diabetes Mellitus, Alcoholic Cirrhosis of Liver with Ascites. Legal Blindness, Acquired Absence of Right Leg Below Knee, Kidney Transplant, Pancreas Transplant, and Depression. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Admission MDS completed on 2/23/24 documents R25 has a Brief Interview for Mental Status(BIMS) score of 11, indicating R25 demonstrates moderately impaired skills for daily decision making. R25's MDS also documents that R25 has an indwelling catheter, is on a mechanically altered diet with a feeding tube, has range of motion impairment on 1 side of lower extremity, requires partial/moderate assistance for mobility and substantial/maximum assistance for transfers. R25's Care Area Assessment (CAA) for nutrition dated 2/28/24 states see nutrition assessment. Surveyor notes there is no care plan in place for R25's dental concerns. On 2/20/24, Dietitian (DIET)-Q documented in the Nutrition Risk Assessment that R25 has chewing difficulty and is on mechanically soft diet with honey thick liquids. DIET-Q also documents that R25 is receiving tube feedings. Nursing reported to DIET-Q that R25 was only consuming pudding. DIET-Q documents that speech will be working with R25 on diet texture. On 7/15/24, at 10:00 AM, R25 was interviewed by Surveyor and R25 stated R25 has not been offered dental services and would like to see a dentist to get R25's teeth removed so R25 can get dentures to eat better. Surveyor observed only 4-5 teeth in R25's mouth and the teeth are black in color. R25 stated most of R25's upper teeth are gone and R25 has difficulty in chewing. R25 stated no one has asked R25 if R25 wanted to be seen by the dentist. On 7/17/24, at 10:25 AM, Surveyor interviewed Social Worker (SW)-O. SW-O stated that a Resident's consent for dental services is received upon admission. Medical Records (MR)-R is the keeper of the list. MR-R puts a Resident on the list to be receive services and reaches out to the specialists. SW-O states that between nursing and SW-O consents are obtained. Surveyor communicated that R25 has not received dental services since admission and has not been approached about seeing the dentist. SW-O indicated that R25 may have refused services and will look for documentation. On 7/17/24, at 10:43 AM, MR-R informed Surveyor that MR-R gets an email of who wants to be seen, lets the specialist know, and does not know if Residents are asked on admission. MR-R has no record of R25 being on the dental list. On 7/17/24, at 10:48 AM, Surveyor interviewed R25 again and asked if R25 wanted to be seen by the dentist. R25 responded, I have to. I want to be seen by a dentist. On 7/17/24, at 10:56 AM, Admission Coordinator (AC)-P informed Surveyor that AC-P is responsible for getting admission paperwork signed, but any individual consents are obtained by SW-O. AC-P obtains a signature authorizing physicians such as a dentist to provide dental care. On 7/17/24, at 3:51 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R25 was offered to receive dental services since admission. Per NHA-A, we offer the services within 6 months. NHA-A stated there was different leadership prior to May. Surveyor shared there is no documentation that the need for dental services has been addressed for R25's quality of life. On 7/18/24, at 3:42 PM, no further documentation was provided that R25 had been offered dental services at admission to address R25's dental concerns. Documentation provided by facility indicates it was first discussed with R25 on 7/17/24, after it was brought to the attention of the facility by Surveyor. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24, at 12:33 PM, Surveyor reviewed additional information provided by the facility after the survey process was completed. Surveyor notes the audit and documentation provided occurred after Surveyor brought it to the attention that R25 was not provided the option of dental services.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on observation, interview, and record review the facility did not provide special assistive eating equipment for 1 of 1 sampled resident (R40) reviewed for assistive devices. R40 did not receive special assistive devices needed for assistance when consuming meals to maintain or improve their ability to eat or drink independently. Findings include: R40 was originally admitted to the facility on [DATE]. R40's medical diagnosis include: Parkinson's Disease, weakness, protein-calorie malnutrition, and Dysphasia. Surveyor reviewed R40's most recent comprehensive Minimum Data Set (MDS), dated [DATE], which documents the following: R40 has a Brief Interview for Mental Status (BIMS) score of 15, which identifies R40 as being cognitively intact. R40 requires partial to moderate assistance with eating. R40 had a recent prolonged hospitalization from [DATE] through 05/10/2024 and was again hospitalized from 5/29/2024 through 06/14/2024. Surveyor reviewed a document titled: nutrition risk assessment, signed on 6/18/2024, and documents R40's diet order m. (mechanical) soft and is on tube feeding as well. Under Registered Dietitian Review, documents special utensils and cups. Surveyor noted a Nursing progress note dated 06/17/2024, which documents, writer worked with res on how she best drinks from a cup i.e by straw or rim of cup. writer observed patient having hard time pulling liquid up from straw, drinking from the rim was better but she needs help holding her cup. On 07/15/24, at 01:25 PM, Surveyor observed R40 had lunch on the bedside table, untouched. R40 informed Surveyor that R40 asked if someone could help her eat and R40 was told no one was available. Surveyor observed R40 to have very shaky hands. R40 stated it's hard to eat when she is this shaky. Surveyor observed R40 unable to pick up foam cup to drink from straw or use metal fork and knife. On 07/16/2024, at 10:12 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-LL who informed Surveyor that R40 is a tube feeder. CNA-LL stated R40 is on a regular diet and needs encouragement with eating. CNA-LL informed Surveyor that when R40 is up in a chair R40 can eat independently. On 07/16/2024, at 11:23 AM, Surveyor interviewed Unit Manager (UM)-AA. UM-AA informed Surveyor that R40 is on a general diet as well as tube feeding at night. UM-AA states R40 will need some assistance, depending on what is being served, something requiring utensils would require more assistance. On 07/16/2024, at 11:35 AM, Surveyor noted R40's meal ticket documents, needs assist. Surveyor interviewed Dietary Aide (DA)-TT who informed Surveyor that R40 is on a regular diet. DA-TT informed Surveyor that the meal tickets will indicate if a resident is on a mechanical soft, puree or regular diet. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024, at 11:50 PM, R40's food tray was placed on the bedside table. Surveyor observed metal utensils, a styrofoam cup with a straw, a hamburger bun with breaded meat and cooked carrots. On 07/17/2024, at 10:58 AM, Surveyor interviewed DON-B who informed Surveyor that a CNA or family member will fill out meal request slips for the week. Surveyor inquired what the process is if a resident requires a special diet or eating utensils. DON-B states Speech Therapy will come and give a form to indicate resident needs and they give the form to kitchen dietary aides. DON-B informed Surveyor that she did not see the dietary assessment note about special utensils for R40 until surveyor pointed it out. On 07/17/2024, at 11:16 AM, Surveyor interviewed Dietician-Q who informed Surveyor that recommendations for special utensils and cups would come from anyone and once a recommendation was made, the expectation is to have those implemented. On 07/17/2024, at 11:40 AM, Surveyor interviewed Speech Therapist (ST)-UU who informed Surveyor that she no longer works at the Facility. ST-UU states that in June ST-UU evaluated R40 and R40 was on a mechanical soft diet and was upgraded to a regular diet a couple weeks after readmission. On 07/18/2024, at 07:57 AM, Surveyor observed R40 up in R40's wheelchair. R40's breakfast tray was on bedside table, LPN-VV assisting R40 with breakfast. Surveyor observed special utensils and cup now provided to R40.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38829 Based on observation, staff interview, and record review, the facility did not ensure food was stored, prepared and served in a sanitary manner. This practice had the potential to affect 47 of 47 Residents residing in the facility. *On 7/15/24 and 7/16/24, Surveyor observed Food Service Associate (FSA)-C not wearing a beard net while preparing plates and trays for Residents in the second floor kitchenette. *On 7/15/24 and 7/16/24, Surveyor observed the facility's low temperature dish machine not reach the minimum required temperature of 120 F and Food Service Aide (FSA)-C, FSA-D, and FSA-E all stated they do not use test strips to test the sanitizer solution concentration (50-100ppm-parts per million sodium solution hypochlorite [chlorine]), thus not ensuring proper sanitation. Findings Include: The facility's policy Sanitation and Infection Prevention/Control; Dish Machine Temperatures Issued 5/95, and Last Revised on 1/24 documents: .:Policies: Dishmachine wash and rinse water should be maintained at temperatures that meet the guidelines established by the Food and Drug Administration. *State or local regulations will apply if stricter. Low Temperature Machine: -Wash Temperature 120 F -Final Rinse Sanitizer Solution Concentration-50-100 ppm(parts per million sodium solution hypochlorite(chlorine) on the dish surface in final rinse(less than 100F) . The facility's policy Sanitation and Infection Prevention/Control; Dish Machine Temperatures Issued 5/95, and Last Revised on 1/24 documents: .Procedures: Supervisor/Food and Nutrition Associate as assigned -Low Temperature Dishmachine-record on Dishmachine Temperature Record form: -Wash temperature during each period of use. -Final rinse sanitizer concentration during each period of use Supervisor (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-If documentation of the temperatures and test strips/max temps results has been assigned to a Food and Nutrition Associate, confirms that it is completed at each meal period. Director -Makes management decision concerning adequacy of sanitation of service ware. If due to inappropriate concentration of sanitizer solution(low temperature machine), implements disposable service ware. Director/Designee -Verifies completion of logs; initials form weekly. The facility's policy Orientation and Education, Uniform Dress Code Issued 5/95 and last Revised on 1/23 documents: .Associates Working with Food -Wear the approved hair restraint when on duty regardless of length or presence of hair. -Restrain all facial hair with a beard net/restraint. On 7/15/24, at 11:05 AM, Surveyor observed Food Service Associate (FSA)-C in the kitchenette on the 2nd floor wearing a hairnet while taking temperatures of the ready to serve food items for lunch, but was not wearing a beard net. FSA-C has an evident beard. On 7/15/24, at 11:29 AM, Surveyor observed FSA-C in the 2nd floor kitchenette, placing the lunch items on Resident plates. FSA-C was wearing a hairnet but was not wearing a beard net. On 7/15/24, at 12:26 PM, Surveyor confirmed with Food Service Supervisor (FSS)-F that the dish washer in the 2nd floor kitchenette was a low temperature dish machine. Surveyor observed FSA-C rinse off the dishes and place in the dish machine. Surveyor observed the wash cycle which started at 113, went down to 111 and back up to 112. FSA-C informed Surveyor that for the dishes to be completely sanitized, the temperature should be at 110. FSA-C did not do a test strip after the cycle. On 7/15/24, at 12:35 PM, Surveyor requested the manufacturer guidelines for the dish machine from FSS-F. On 7/16/24, at 7:50 AM, Surveyor observed FSA-C preparing trays in the 2nd floor kitchenette and is wearing a hair net but not a beard net. On 7/16/24, at 12:45 PM, Surveyor observed FSA-C run the dish machine. Surveyor observed the temperature starting at 121 and went immediately down to 110 and held at that temperature during the whole cycle. Surveyor did not observe FSA-C test the chemicals. Surveyor asked FSA-C, if FSA-C checks the chemicals after washing dishes with each meal. FSA-C stated FSA-C usually does not use the test trips. Surveyor asked if there were test strips in the 2nd floor kitchenette. FSA-C had to dig for the test strips which were located at the back of the drawer. FSA-C completed the test strip and stated it read 200 ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/16/24, at 12:56 PM, Surveyor observed FSA-D unloading the dish machine up in the 3rd floor kitchenette. Surveyor asked if FSA-D and FSA-E who was also present if both FSA-D and FSA-E use the test strips for each meal. Both FSA-D and FSA-E stated they did not use the test strips and were unable to locate test strips in the kitchenette at this time. Surveyor reviewed the dish machine logs for May, June, and July 2024 for both 2nd and 3rd floor kitchenettes. 2nd Floor temperatures recorded for May and June only documents 38 meals where the dish machine reached the minimum of 120 F per policy for 30 days of 3 meals a day. July's recorded temperatures has no minimum temperatures of 120 F recorded for any meal. Surveyor notes the chlorine rinse (50-100 ppm) is recorded as 100 ppm for just about every meal, everyday, every month. 3rd Floor temperatures recorded for May and June only documents 3 meals where the dish machine reached the minimum of 120 F per policy for 30 days of 3 meals a day. July's recorded temperatures has 3 recorded temperatures of minimum temperature of 120F recorded for any meal. Surveyor notes the chlorine rinse (50-100 ppm) is recorded as 100 ppm for just about every meal, everyday, every month. Surveyor notes there is a section on the Dishmachine Temperature Record for the Manager Weekly Review and this section is completely blank for all 3 months. On 7/17/24, at 8:16 AM, FSS-F confirmed that FSA-C should have been wearing a beard net while serving food onto the plates and preparing Resident trays. FSS-F stated that test strips should be done with every meal. Surveyor shared the concern that FSA-C, FSA-D, and FSA-E confirmed they have not been using the test strips and shared the same ppm number is being repeated every day on the dish machine logs. Surveyor also shared that there is no manager weekly review signature on the log, indicating that the temperature and chemical readings were not being audited on a weekly basis as the log indicates should be completed. The manufacturers operation manual for the low temperature dish machine issued 5/15/10 documents the wash and sanitizing rinse should be at a minimum of 140 F. On 6/25/24, the representative tested the dish machines for optimal efficiency. 108F is recorded for the 2nd floor and 121F is recorded for the 3rd floor. On 7/17/24, at 3:42 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A the concern that FSA-C was not wearing a beard net during the survey process and the concern with the dish machines temperature not reaching minimum required temperature per dish machine manufacturers recommendations. Surveyor also shared that Food Service Associates have not been using the test strips to test the chemicals. No further information was provided by the facility at this time in regards to beard nets not being worn and the low temperature of the dish machines and not using the chemical test strips to test the ppm. Surveyor notes that FSS-F conducted a re-education on 7/17/24 with all food service associates on the topics of dish machine temperatures and test strips and hair/beard restraint guidelines. On 7/18/24, at 8:23 AM, Surveyor left a message for the dish machine representative for the facility but did not receive a phone call back during the survey process. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/22/24, at 11:42 AM, FSS-F informed Surveyor that the representative came to the facility late afternoon on 7/16/24 to check the temperature of both dish machines and adjusted to increase the temperature of both dish machines after Surveyor had observed the low temperatures during the wash of dishes on 7/15/24 and 7/16/24. Surveyor notes that 2nd floor dish machine is now at 135 and 3rd floor is now at 137. FSS-F and Surveyor discussed the discrepancy in required minimum temperature for the dish machines. Surveyor pointed out that the low temperature dish machine manual states 140F, but the facility policy is 120F. FSS-F will confirm with the dish machine representative if it should be 140F or 120F. Surveyor notes per regulation it is 120F for wash and 50ppm for the final rinse.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not ensure hospice services were coordinated for 2 (R5 & R29) of 2 residents reviewed for hospice. * Hospice visit notes were not kept in R5's medical record or in R5's hospice binder which was located in the nurses station. * R29's recertification was not complete and there was not list of assigned staff from hospice with contact information. There is not a designated facility liaison with hospice. Findings include: The facility's policy titled, Hospice Program last revised 12/2017 under Policy Interpretation and Implementation documents: D. When a resident participates in the hospice program, a coordinated plan of care between the community, hospice agency and resident/representative will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status. 1.) R5 was admitted to the facility on [DATE] with diagnoses which include multiple sclerosis, cirrhosis of the liver, unspecified protein calorie malnutrition, hypertension, anxiety disorder, and depression. The physician orders dated 9/18/23 documents Hospice Eval (evaluation) and treat. The hospice care plan initiated 9/25/23 documents the following approaches all dated 9/25/23: * Hospice referral and services through [Name] hospice services * Hospice nurse visits as scheduled times per week with PRN visits * Hospice social worker and hospice chaplain visits as scheduled and PRN * Hospice volunteer visits as indicated * Monitor for pain or symptoms of distress or anxiety and notify hospice nurse or physician * Administer medications for comfort as indicated and as ordered. Monitor for effectiveness and observe for side effects and inform physician PRN (as needed) (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Hospice CNA (Certified Nursing Assistant) will visit as scheduled and provide bathing and ADL (activities daily living) (activities daily living) care * Staff will consult with hospice nurse with change of condition or pain management needs * Include family in care and in plan of car and offer support services PRN * Position for comfort in bed or chair as client desires. The significant change MDS (minimum data set) with an assessment reference of 9/29/23 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R5 is assessed as requiring extensive assistance with two plus person physical assist for bed mobility & transfers, does not ambulate and requires extensive assistance with one person physical assist for toileting. R5 is assessed as being occasionally incontinent of urine and always incontinent of bowel. R5 is checked for hospice care. On 7/18/24, at 7:09 a.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-AA if she knows who is the facility's hospice liaison. RN/UM-AA replied I don't know [NHA-A's first name] may have a better idea. On 7/18/24, at 9:22 a.m., Surveyor reviewed R5's hospice binder which was located in the nurses station. Surveyor noted inside R5's hospice binder includes interdisciplinary plan of care revision/physician orders and also has a log of visit description which includes the date, employee name, discipline and visit type. Surveyor was unable to locate hospice visit notes in the hospice binder. Surveyor also reviewed R5's medical record and was unable to locate any hospice visit notes On 7/18/24, at 9:27 a.m., Surveyor asked CNA-DD if she knows when hospice staff comes in for R5. CNA-DD replied I don't know the exact day but when they do come I encourage her to do her cares. On 7/18/24, at 9:29 a.m., Surveyor asked RN (Registered Nurse)-JJ if she knows when hospice staff come in for R5. RN-JJ replied not since [Name] stopped coming, she used to come in Monday, Wednesday and Friday. I didn't see anyone yesterday and I was here until 6:00 p.m. and no one was here home. RN-JJ informed Surveyor there's another case manager but she doesn't know the name. Surveyor asked RN-JJ if she knows who is the facility's hospice liaison. RN-JJ replied I have no clue. On 7/18/24, at 9:40 a.m., Surveyor asked RN/UM-AA if she knows when hospice staff come in for R5. RN/UM-AA informed Surveyor their typical schedule is Monday, Wednesday & Friday. Surveyor asked RN/UM-AA who R5's hospice case manager is. RN/UM-AA informed Surveyor she has it written down and stated she usually works with the nurse, [Name]. Surveyor informed RN/UM-AA Surveyor was informed this hospice nurse is not at the facility any longer. RN/UM-AA indicated she was unaware of this. Surveyor informed RN/UM-AA Surveyor was unable to locate any hospice visit notes for R5 and asked if hospice leaves their notes. RN/UM-AA informed Surveyor this is something they are working with hospice on as they don't always leave their notes. RN/UM-AA informed Surveyor this is something she's been noticing and she has a call out to hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24, at 10:35 a.m., Surveyor asked DON (Director of Nursing)-B if she knows who is the facility's hospice liaison. DON-B replied no ma'am I sure don't. Surveyor asked if hospice leaves their notes. DON-B replied I'm going to be honest with you I saw a note for the first time yesterday with [name of Unit Manager-J]. I don't know if they leave their notes or who they leave them with. Surveyor informed DON-B Surveyor has been unable to locate R5' hospice visit notes. DON-B informed Surveyor they need to know when they came into the building and if they gave a shower. DON-B informed Surveyor she doesn't like the process and will be changing it. On 7/18/24, at 4:06 p.m., during the end of the day meeting NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided to Surveyor regarding R5's hospice visit notes. 38829 2.) R29 was admitted to the facility on [DATE] with diagnoses of Heart Failure, Anemia, Unspecified Dementia and Anxiety Disorder. R29 has an activated Health Care Power of Attorney (HCPOA) effective 9/16/2019. R29 has been receiving hospice service since 4/24/23. R29's Annual MDS dated [DATE] documents R29 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R29's MDS also documents that R29 is at risk for developing skin issues and has no current skin issues, osteoporosis is not documented as a current diagnosis, R29 is receiving scheduled pain medications and that a pain interview can be completed but then is documented that R29 is unable to answer any questions. R29's documents R29 has range of motion impairment on both upper and lower extremities on both sides and that R29 is dependent for assistance for eating, hygiene, mobility, and transfers. Surveyor reviewed R29's current physician orders as of 7/16/24 and notes there is no physician order to evaluate and treat for hospice. On 7/16/24, at 10:27 AM, Surveyor reviewed R29's hospice binder located at the nurse's station. The last recertification of terminal illness in the binder is dated 6/23/23-8/1/23. There is no list of assigned hospice staff with contact information for R29 and no schedule of when hospice staff will be in the facility providing cares to R29. On 7/16/24, at 10:29 AM, Licensed Practical Nurse (LPN)-M states there is no actual schedule of when hospice staff is arriving, and agreed contact information is not available but stated the nurse will text my phone when coming into the facility. On 7/16/24, at 10:43 AM, Surveyor interviewed Hospice Registered Nurse (HRN)-S. HRN-S confirmed HRN-S is R29's primary hospice nurse. HRN-S was not aware a list of hospice staff and contact information and a schedule of hospice caregivers should be easily accessible to facility staff. On 7/17/24, at 12:26 PM, Surveyor interviewed Unit Manager (UM)-J who stated UM-J is not aware of a specific named person in the facility that is the liaison between the facility and hospice. On 7/17/24, at 3:36 PM, Hospice Supervisor (HS)-V informed Surveyor that the facility has never communicated who the liaison is at the facility to communicate issues to in regards to R29. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24, at 10:37 AM, HRN-S was interviewed again by Surveyor who stated some facility nurses want to given verbal report and HRN-S always writes out a communication form on R29 as well. UM-J stated to put the communication form in a box in the nurses station. HRN-S stated the written communication forms were not always getting into R29's hospice binder so HRN-S started placing the written communication forms directly into R29's hospice binder. HRN-S confirmed there have been multiple times where HRN-S has communicated to facility nurses in regards to care issues or changes of care with R29 that has not been addressed by facility nursing staff timely or not at all. On 7/18/24, at 12:52 PM, Director of Nursing (DON)-B stated there is no determined contact person from the facility for hospice to communicate with in regards to R29. On 7/18/24, at 3:42 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that the coordination of care between the facility and hospice for R29 is indicative of a communication failure as well as the facility not designating one specific contact person with clinical background to be the contact person for hospice to communicate with in order to maintain quality of life for R29. No further information was provided by the facility at this time. Surveyor reviewed he Nursing Facility Services Agreement between the facility and the hospice provider for R29. The contract was entered into on 6/10/19 and signed 6/13/19. The following documents: .Article 1 Facility Obligations Facility shall ensure that individuals who have elected, directly or through such individuals' legal representatives, to receive services from hospice and who are accepted by hospice to receive such services are kept comfortable, clean, well groomed and protected from negligent and intentional harm including, but not limited to, accident injury and infection. Facility's primary responsibility is to provide personal care including the following, but not limited to, (iv) assisting in the administration of medicine (vi) supervising and assisting in the use of any durable medical equipment and therapies (viii) providing health monitoring of general conditions (ix) contacting family/legal representatives for purposes unrelated to a hospice terminal condition 1.4 Plan of Care. Facility will work with hospice to develop a written care plan for each hospice patient that is established, maintained, reviewed, and modified. 1.15 Authorized Facility Representatives. Facility shall designate its administrator or another qualified individual, as a liaison to represent facility and to implement the provisions of this agreement. Facility shall also designate a clinically-trained member of the facility's interdisciplinary team to work with hospice representatives to coordinate care provided by facility and hospice to hospice patients. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Article 2 Hospice Obligations 2.6 Provision of Information Hospice shall promote open and frequent communication with facility and shall provide facility with sufficient information to ensure that the provision of services by facility under this agreement is in accordance with hospice patient's plan of care, assessments, treatment planning and care coordination c. Certifications. Physician certifications and recertification of terminal illness d. Contact Information. Names and contact information for hospice personnel involved in providing hospice services e. On-Call System. Instructions on how to access hospice's 24-hour on-call system

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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** 49845 Based on observations, interviews and record review, the facility did not establish and maintain an infection prevention and control program based upon current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all 47 residents. The facility's Water Management Plan (WMP) was not based on current standards of practice and did not: ~Reflect changes in program members. ~Include the Facility's Infection Preventionist (IP). ~revise WMP control measures after the closure of wing 1 ~have a defined flush program for little used outlets. ~have logs to monitor water temperatures. ~ include eye washing stations and ice machines in risk assessment. ~measure and record residual (free) disinfectant (Chlorine) levels. The Facility's Surveillance of the Infection and Control Program did not have: ~ a defined policy and procedure for staff illness. ~ a list of reportable communicable diseases. ~ a system for addressing increase infection rates and the corrective actions taken by the facility. ~urinary tract infections (UTI) separated into catheter associated and non-catheter associated UTIs. ~ have complete COVID outbreak investigation It was observed that the Facility did not: ~wear proper personal protective equipment for a resident on Enhanced Barrier Precautions. ~have a privacy bag over a residents' urinary catheter bag and ensure it was handles in a hygienic manner by not placing on the floor. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Water Management Program 1.) The 6/24/21 CDC Toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings identifies the key elements of a water management program for healthcare facilities to include: 1. Establish a water management program team 2. Describe the building water systems using text and flow diagrams 3. Identify areas where Legionella could grow and spread 4. Decide where control measures should be applied and how to monitor them 5. Establish ways to intervene when control limits are not met 6. Make sure the program is running as designed and is effective 7. Document and communicate all the activities The 6/24/21 CDC Toolkit documents, program team members should possess certain skills that are needed to develop and implement your water management program. The team should also include: -Someone who understands accreditation standards and licensing requirements -Someone with expertise in infection prevention -A clinician with expertise in infectious diseases -Risk and quality management staff The CDC toolkit identifies locations in a buildings water system where Legionella can grow and spread to include but not limited to: ~Hot and cold-water storage tanks ~Water heaters ~Water Filters ~Electronic and manual faucets ~Aerators ~Shower heads and hoses ~Pipes, valves, and fittings (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~Infrequently used equipment including eye wash stations. ~Ice machines ~Hot tubs Control Measures: Determine Locations Where control measures must be applied and maintained to stay in established control limits. The CDC toolkit identifies factors internal to buildings that can lead to Legionella growth to include: ~Water temperature fluctuations: Provides conditions where Legionella grows best (77 -108 Fahrenheit (F)) ~Water pressure changes ~PH (measurement of acidity or alkalinity of a solution on a scale 0 to 14) ~Inadequate disinfectant: Does not kill or inactivate Legionella ~Water stagnation: Encourages biofilm growth and reduces temperature and levels of disinfectant. Common issues that contribute to water stagnation include renovations that lead to 'dead legs' and reduced building occupancy. The Wisconsin State Plumbing Code, Chapter SPS 382.50(3)(b)6, requires a nursing homes hot water system to be installed and maintained to provide bacterial control by one of the following methods: ~Water stored and circulation initiated at a minimum of 140 F and with a return of a minimum of 124 F. This standard is best practice even considering the facility was built prior to May 2003 and grandfathered to meet requirement. ~ 5mg/L residual chlorine. ~Another disinfection system approved by the department. The Facility's policy, titled: Water Management Program to reduce Legionella exposure, with a last approved date of 01/2024, documents in part: B. The community water management plan shall include: 1. Conducting a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria and fungi) could grow and spread in the facility water system. 2. Implementing a water management program that considers the ASHRAE industry standard and the CDC toolkit and includes control measures such as physical controls temperature management disinfectant level control visual inspections and environmental testing for pathogens. 3. Specifying testing protocols and acceptable ranges for control measures and documenting the results of testing and corrective actions taken when control limits are not maintained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the Facility's WMP, dated March 01, 2024, which documents in part: Requirements: this water management plan will conform to the steps below outlining the elements of a water management program. Program team-identify persons responsible for program development and implementation. Control measures-determine locations where control measures must be applied and maintained in order to stay with established control limits. Monitoring/corrective actions- establish procedures for monitoring whether control measures are operating within established limits and, if not, take corrective actions. Confirmation-established procedures to confirm that the program is being implemented as designed (verification) and the program effectively controls the hazardous conditions throughout the building water systems (validation). Documentation-establish documentation and communication procedures for all activities of the program Per the Facility's WMP program team consists of The Executive Director and the Facility Manager. The executive Director listed in the Facility's WMP is the former Executive Director and is no longer employed at the Facility. Surveyor reviewed the Facility's flow diagram of the Facility's water system. Surveyor noted that the Facility's description of cold water distribution documents: cold water is routed to the ice machine, kitchen, laundry, resident faucets in showers along with the domestic hot water system. Surveyor reviewed the process flow diagram and noted the Facility's ice machine(s) is not listed. Surveyor reviewed the Facility's control measure, titled Hot Water Systems documents in part: Risk Factor: Water Heater Control measure: Check flow and return temperatures at hot water heater Frequency: monthly or as required or recommended by Authority Having Jurisdiction (AHJ) or your water treatment professional. Monitoring: supply temperature should be checked at the outlet of the hot water heater and should not be lower than 140 F. The return temperature should also be checked monthly and should not be lower than 122 F. Surveyor reviewed the facility's maintenance task log Titled, Water Systems which documents in part, Water Heaters-Monthly Task One and noted no documented water temperatures from 07/03/2023 to 07/10/2024. Surveyor reviewed the Facility's control measure, titled Hot Water Systems which documents in part: Risk Factor: Water Heater Control measure: check water temperature at the end of each return leg at time of no hot water use. Frequency: monthly or as required or recommended by AHJ or your water treatment professional. Monitoring: ensure temperature is at a minimum of 122 F. Surveyor reviewed the facility's maintenance task log Titled, Water Systems: Water Heaters-Monthly Task Two and noted no documented water temperatures from 07/03/2023 to 07/10/2024. Surveyor reviewed the facility's control measure Titled, Hot Water Systems which documents in part: Risk Factor: Water Heater Control Measure: check temperatures after 30 seconds and 60 seconds of running at all taps to ensure that you are receiving the appropriate temperature and it being achieved in a reasonable amount of time. Frequency: annually or as required or recommended by AHJ or your water treatment professional. Monitoring: ensure the temperature is at a minimum of 122 F (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the facility's maintenance task log Titled, Water Systems: Water Heaters-Monthly Task Two which documents in part: Control Measure Check Temperatures after 30 seconds of running at all taps. Surveyor noted no documented water temperature and no documentation for running of all taps for 60 seconds. Surveyor reviewed the facility's control measure Titled, Hot & Cold Water Systems which documents in part: Risk Factor: Little-Used Outlets Control Measure Flush little used outlets. Flush for several minutes and until temperature stabilizes and is comparable to supply water. Have a flush program defined in the Water Management Plan by the team. Location: Thru out building Frequency: twice weekly where users are at high risk; weekly in all other buildings. Surveyor reviewed the facility's maintenance task log Titled, Little Used Outlets which documents in part: Control Measure Task Flush little-used outlets. Flush for several minutes and until temperature stabilizes and is comparable to supply water. Have a flush program defined in the Water Management Plan by the team. Surveyor noted task was documented as completed one time per week from 03/2024 to current. Surveyor also noted the wing 1 of the facility has been closed since 03/2024, per NHA-A and noted there is no defined flush program in the Facility's WMP. Surveyor reviewed the facility's control measure Titled, Hot & Cold Water Systems which documents in part: Risk Factor: Check for Residual (free) Disinfectant (Chlorine) Levels Control Measure: Measure and record Residual (free) Disinfectant (Chlorine) levels on the incoming city water supply as well as a representative most distal location within the facility. Frequency: Weekly. Surveyor noted, no maintenance task log provided for this control measure. Surveyor received a Maintenance Task log titled: Inspect eyewash stations. Surveyor noted this task is not identified in the facility's WMP. Steps included in the task log are documented as: -verify the flow of water begins in one second or less. -verify the water flow is continuous by activating the unit. -run water for three minutes to flush system impurities. -verify that water flow continues and the water temperature is between 60 F and 100 F. -verify that eye wash station are disinfected weekly. Surveyor noted, from 07/2023 through 07/2024 the task was documented as completed once per month. Additionally, surveyor reviewed the facility's prior WMP, dated 02/28/2023, and noted no notable revisions to the Facility's current WMP. (continued on next page)

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	525552	A. Building B. Wing	07/22/2024

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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	On 07/18/24 at 11:28 AM, Surveyor interviewed Facility Director-X who stated he is in charge of the WMP and the IP is not involved in the WMP. Facility Director-X stated the WMP is revised annually or when there is a change to water lines. Facility Director-X stated wing 1 rooms are shut down. Facility Director-X stated the sinks and toilets are flushed daily. Facility Director-X informed Surveyor that temperatures of water are not logged and are just documented as yes meets the temp range. Facility Director-X stated the Facility does have eyewash stations that are part of maintenance program tasks. Facility Director-X informed Surveyor that a company comes in and cleans ice machines. Facility Director-X was not aware of a chlorine test needing to be performed. Facility Director-X stated the Executive Director listed on the WMP is the former Executive Director and is no longer at the Facility. On 07/18/24 at 10:09 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A states the IP should be listed in the WMP and everyone that is in QAPI (Quality Assurance and Performance Improvement) is part of water management committee. Infection Surveillance 2.) The Facility does not have a policy for staff illness procedures. The Facility's policy, titled: Surveillance for Infections documents in part, Policy Statement The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiological significant infections that have substantial impact on potential resident outcome and that may require transmission based precautions and other preventative interventions. H. The charge nurse will notify the attending health care provider and the Infection Preventionist of suspected infections. 1. The infection preventionist will determine if the infection is reportable. Data Collecting and Recording A. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: 8. Treatment measures and precautions (interventions and steps taken that may reduce risk.) . D. For targeted surveillance using the community-created tools, follow these guidelines: 3. MONTHLY: Summarize monthly data for each nursing unit by site and by pathogen. Surveyor reviewed the Facility's infection surveillance for 04/2024 through 06/2024 and noted no identified increase in infection rates or interventions implemented. Surveyor noted an increase in infection rates from 05/2024 to 06/2024. The surveillance data did not have organism type or urinary tract infections (UTI) separated by catheter associated and non-catheter associated infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/17/24 at 02:02 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated she began working at the Facility in 04/2024 and became the IP in 05/2024. DON-B stated Licensed Practical Nurse (LPN)-Y assists her with the Facility's infection control program (ICP). DON-B informed Surveyor that any resident with a nasogastric tube, wound, foley catheter or multidrug resistant organism (MDRO) would require Enhanced Barrier Precautions (EBP). DON-B stated gloves, gown and mask are required when performing direct cares of a resident on EBP. DON-B stated they meet during morning huddle in the morning and discuss which residents are on EBP or other transmission-based precautions (TBP). DON-B stated she would need to get a list of the reportable communicable diseases and get back to Surveyor with that information. DON-B stated that NHA-A would have information regarding staff testing. Surveyor asked DON-B to explain the Facility's procedure regarding staff illness. DON-B stated the staff would need to let the DON, NHA and managers know if they have signs and symptoms. DON-B stated staff is informed not to come to work if symptomatic. DON-B stated staff would have to see a doctor and get a note to return to work until staff is fever free, symptom free, temperature less than 100 F without medication for 24 hours and no nausea or vomiting. If at work, staff immediately sent home, can test at facility but would still need a doctor note to return. On 07/18/24, at 10:14 AM, Surveyor interviewed NHA-A. Surveyor asked NH-A the procedure for staff illness. NHA-A stated, staff is to call supervisor and give symptoms. NHA-A stated, depending on symptoms, a covid test can be obtained at the Facility. If calling in for other issues staff would need to a release back to work from doctor. Information regarding staff illness is only documented on the schedule for call-ins to keep track of attendance, per NHA-A. NHA-A stated last week Dietician-Q tested positive for COVID, which prompted them to test all residents. NHA-A was not able to provide documentation where this is documented for surveillance purposes. On 07/18/24, at 10:20 AM, Surveyor interviewed LPN-Y. Surveyor observed LPN-Y going through infection control logs. LPN-Y stated she is currently reviewing logs from 04/2024 forward to ensure everything is in there. LPN-Y stated she collects data and inputs information for DON-B regarding the ICP. On 07/18/24, at 02:29 PM, Surveyor interviewed DON-B. Surveyor inquired how DON-B acquires the infection percentage rates. DON-B stated she gets the calculations by in-putting information into infection log in Matrix. DON-B stated she looks at infection rates monthly. DON-B stated if an increase in infection rates is observed, then they will educate staff as well as residents, observe cares, bring it to QAPI and discuss in daily huddles. DON-B stated she is working on putting together, and improving the track and trending/surveillance of the ICP. Surveyor noted an increase in UTI infection rates from 05/2024 to 06/2024. No documentation provided on this increase being addressed or interventions implemented. On 07/22/24, at 11:06 AM, Surveyor reviewed QAPI documentation from 05/2024-06/2024. Surveyor noted no information documented regarding acknowledgment of increase in UTI infections and no documented interventions implemented to address this increase. COVID outbreak 3.) Surveyor reviewed the facility's infection control surveillance and noted the facility documented a COVID outbreak that began on 01/09/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's policy, titled: Outbreak of Communicable Diseases, with a last approved date of 01/2024, documents in part: Policy Interpretation and Implementation . G. The administrator will be responsible for: 1. Telephoning a report to the health department;2. Restricting admissions to the community as indicated or as authorized by the health department medical director; 3. Submitting periodic progress reports to the health department, as requested; 4. Calling emergency meetings of the infection control committee; 5. Discontinuing group activities, as indicated; 6. Limiting visitors if indicated(i.e., influenza in the community); and 7. Forwarding communicable disease report cards to the health department, as required. On 07/22/2024, at 08:33 AM, NHA-A gave Surveyor paperwork from the COVID outbreak that contained all staff/residents COVID testing, and the education provided to staff on hand hygiene & personal protective equipment (PPE). NHA-A states he will have to reach out to the person who did the investigation, and states he provided what he had. On 07/22/24, at 11:19 AM, A summary of the COVID outbreak was provided to Surveyor by NHA-A. Per the facility summary, titled: COVID outbreak 2024, documents the outbreak began on 01/09/2024 with two residents on the second floor. Two residents were treated prophylactically, one with Paxlovid and one with Molnupiravir. All COVID positive staff members and residents were not hospitalized and had no complications related to COVID. All residents on the 2nd floor were tested two times per week and no further cases were reported. All staff members were required to mask throughout the building and test biweekly as well. The Milwaukee County health department was contacted on 01/16/2024 alerting of current COVID outbreak. The last resident came out of isolation on 01/24/2024. Biweekly testing to continue for 14 days since the last resident was removed off isolation with a tentative date to be completed on 02/07/2024. On 01/26/2024 residents on the third floor started experiencing symptoms. The facility continued biweekly testing. On 02/03/2024 all staff members were asymptomatic and were able to return to work. On 02/06/2024 all remaining residents were removed from isolation and asymptomatic. Rooms were terminally cleaned, biweekly testing and building wide masking to continue for at least 14 days from last resident removed from isolation. All staff members were using required PPE to enter COVID positive resident rooms with gown, gloves, goggles and N95. Proper signage and isolation carts were placed outside of designated rooms. Surveyor noted no documentation of Milwaukee County Health Department recommendations, no restriction of admissions, no documentation of emergency meeting with infection control committee (ICC), no documentation of discontinuing/limiting group activities, no documentation of limiting of visitors and no documentation of forwarding communicable disease report cards to the health department as required, per the Facility Policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/22/24, at 2:30 PM, Surveyor spoke with Corporate IP-Z. Corporate IP-Z stated she is the Director of clinical reimbursement but also has IP certificate. Corporate IP-Z stated her role is to support the community in the Facility with MDS (minimum data set) but also with clinical questions as needed. Corporate IP-Z stated she tries to visit the facility weekly to look at the Facility's ICP. Corporate IP-Z stated she was at the Facility on 07/21/2024 to review ICP. Prior to 07/21/2024 she was at the Facility on 06/20/2024 and reviewed the ICP. Corporate IP-Z stated she does not normally work on infection surveillance with DON-B, but instead embrace the Matrix software for rates. Corporate IP-Z stated data is collected by making rounds, talking with staff, observing cares, and then that information is put into data software. Surveyor asked Corporate IP-Z if organisms should be listed on surveillance. Corporate IP-Z stated the team on site is new to using the infection tracking but are aware of the organisms. Surveyor asked Corporate IP-Z about UTI categories being identified by catheter associated infections and non-catheter associated infections. Corporate IP-Z stated it's a small facility, the team knows who has catheters and who does not. Surveyor asked Corporate IP-Z if there is an increase in infection rates would that be documented in QAPI. Corporate IP-Z stated yes, minuets should be taken during QAPI meetings. no further information was provided during time of survey. 20483 Enhanced Barrier Precautions 4.) The facility's policy titled, Enhanced Barrier Precautions last revised 3/24 under Purpose #4 documents Enhanced Barrier Precautions expand the use of PPE (personal protective equipment) and refer to the use of gown and gloves during high-contact resident activities that provide opportunities for transfer of MDRO (multidrug-resistant organism) to staff hands and clothing. Surveyor was provided with the facility's policy titled, Procedure: Handwashing/Hand Hygiene last revised 5/18 which documents how to perform washing hands/hand hygiene but does not address when to perform handwashing/hand hygiene. * R5's diagnoses include multiple sclerosis, cirrhosis of the liver, unspecified protein calorie malnutrition, hypertension, anxiety disorder, and depression. R5 has a Stage 3 pressure injury on the left upper buttocks and is EBP (enhanced barrier precautions). The significant change MDS (minimum data set) with an assessment reference date of 9/29/23 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R5 is assessed as requiring extensive assistance with two plus person physical assist for bed mobility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/16/24, at 11:39 a.m., Surveyor observed CNA (Certified Nursing Assistant)-KK and CNA-LL enter R5's room and place gloves on. Surveyor observed neither CNA-KK or CNA-LL are wearing a gown. CNA-KK & CNA-LL removed pillows from under R5 and then reposition R5 up in bed. CNA-KK asked R5 how's that. R5 then directed CNA-KK & CNA-LL where she wanted the pillows under her including the left & right side, under R5's left shoulder/arm area and under R5's lower legs. CNA-KK placed a second pillow under R5's upper left side. The call light was placed in reach, R5's purse was placed on the bed along the left side and the head of the bed elevated. CNA-LL removed her gloves and left R5's room. Surveyor observed CNA-LL did not perform hand hygiene prior to leaving R5's room. CNA-KK removed her gloves, cleansed her hands and left R5's room. Surveyor noted R5 is on enhanced barrier precaution and CNA-LL & CNA-KK did not wear the appropriate PPE (personal protective equipment). On 7/18/24, at 7:12 a.m., Surveyor observed CNA-DD place a gown on. Surveyor asked CNA-DD for residents on enhanced barrier precautions do you always wear a gown. CNA-DD replied yes. CNA-DD placed a mask on cleansed her hands, placed gloves on, and informed R5 name of RN (Registered Nurse)-JJ wants me to wash you up. CNA-DD wet wash cloths, asked R5 if she wants to change her shirt today, lowered the head of the bed and removed the pillows from under R5. CNA-DD unfastened R5's incontinence product and then washed R5's face. At 7:16 a.m. RN-JJ entered R5's room with treatment supplies. CNA-DD lowered R5's incontinence product, squeezed water on R5's frontal perineal area and washed the frontal area. CNA-DD informed R5 she was going to roll her on her side and R5 was positioned on left side. CNA-DD wiped R5's rectal area to remove BM (bowel movement) stating to R5 I think you need to have a BM my friend. CNA-DD removed the incontinence product, placed the wash cloth inside the product and threw the product away. CNA-DD did not remove her gloves or perform hand hygiene. CNA-DD unfolded the incontinence product and then held onto R5 for RN-JJ. At 7:19 a.m., RN-JJ placed a barrier on R5's bed and placed the treatment supplies on the barrier. RN-JJ placed Santyl on calcium alginate, and dated the dressing. RN-JJ went into the bathroom, removed gloves, and placed the gloves on the barrier. RN-JJ asked R5 if she was ready, removed the dressing from R5's left upper buttocks, removed her gloves, reached into her pocket for hand sanitizer and cleansed her hands. RN-JJ placed gloves on, cleansed the wound bed with normal saline on four by four stating it's looking good , placed the Santyl with calcium alginate on the wound bed and covered with a foam dressing. RN-JJ did not remove her gloves and perform hand hygiene after cleansing R5's pressure injury. RN-JJ removed her gloves, threw the barrier away, removed her gown, washed her hands and left R5's room. At 7:25 a.m. after RN-JJ had completed R5's pressure injury treatment, CNA-DD placed an incontinence product along R5's right side and then positioned R5 from side to side to straighten out and fasten the incontinence product. R5's head of the bed was raised, CNA-DD showed R5 a shirt from her closet, removed the shirt R5 was wearing, applied deodorant and placed the new shirt on. CNA-DD combed R5's hair, placed a clip in her hair, lowered the head of the bed and asked Surveyor if Surveyor could help boost R5. After Surveyor explained Surveyor could not assist, CNA-DD used the pad and positioned R5 up in bed. CNA-DD placed pillows under R5's left & right side, under R5's lower legs and raised the head of the bed. CNA-DD covered R5 with a sheet, placed a towel, call pad, remote & purse on R5's bed. CNA-DD removed her gloves & gown and then cleansed her hands. Surveyor noted this is the first time CNA-DD performed hand hygiene during this observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/18/24, at 9:34 a.m., Surveyor asked RN/UM (Registered Nurse/Unit Manager)-AA when CNAs are doing incontinence cares when should hand hygiene be performed. RN/UM-AA informed Surveyor when switching from dirty to clean explaining when doing bowel care after cleaning should remove their gloves and perform hand hygiene. Surveyor informed RN/UM-AA of the observation with R5 & CNA-DD. Surveyor asked RN/UM-AA when should the nurse perform hand hygiene during a treatment. RN/UM-AA informed Surveyor when the nurse enters the room, after taking the dressing off, after cleansing the wound and at the end of the treatment. Surveyor informed RN/UM-AA of the hand hygiene concerns during R5 pressure injury treatment with RN-JJ. At 9:48 a.m. Surveyor asked RN/UM-AA if a resident is on enhanced barrier precaution should staff have a gown on when repositioning. RN/UM_AA replied yes anytime they are going to come in contact with surface, gown and gloves. RN/UM-AA informed Surveyor she tells staff if they are chatting with a resident it's fine otherwise gown and gloves. Surveyor informed RN/UM-AA of the observation of CNA-KK and CNA-LL not wearing the appropriate PPE with R5. On 7/18/24, at 10:24 a.m., Surveyor informed DON (Director of Nursing)-B of the observation of staff not wearing appropriate PPE when repositioning R5 and hand hygiene concerns. On 7/18/24 at 4:06 p.m. during the end of the day meeting NHA (Nursing Home Administrator)-A was informed of the above. No additional information was provided. 38829 Unhygienic handling of urinary catheter bag 5.) R25 was admitted to the facility on [DATE] with diagnoses of Rhabdomyolysis, Type 1 Diabetes Mellitus, Alcoholic Cirrhosis of Liver with Ascites. Legal Blindness, Acquired Absence of Right Leg Below Knee, Kidney Transplant, Pancreas Transplant, and Depression. R25's Admission MDS completed on 2/23/24 documents R25 has a Brief Interview for Mental Status(BIMS) score of 11, indicating R25 demonstrates moderately impaired skills for daily decision making. R25's MDS also documents that R25 has an indwelling catheter, is on a mechanically altered diet with a feeding tube, has range of motion impairment on 1 side of lower extremity, requires partial/moderate assistance for mobility and substantial/maximum assistance for transfers. The facility's policy Procedure: Catheter Care, Urinary dated 12/2016 and revised 1/2024 documents: .Infection Control 2. Be sure the catheter tubing and drainage bag are kept off the floor. On 7/15/24, at 9:55 AM, Surveyor observed R25's foley catheter bag hanging on the right side of the bed, uncovered, and not facing the doorway. On 7/15/24, at 12:58 PM, Surveyor observed Certified Nursing Assistant (CNA)-I wake R25 up to eat lunch. CNA-I was on the right side of R25's bed and Surveyor observed R25's uncovered foley catheter bag on the floor and CNA-I did not acknowledge the catheter bag on the floor and did not pick up the catheter bag up off the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/15/24, at 2:07 PM, Surveyor observed R25's foley catheter bag not covered, laying on the floor on the right side of R25's bed. On 7/15/24, at 2:24 PM, Surveyor observed R25's foley catheter bag remains on the floor on the right side of R25's bed. On 7/16/24, at 7:37, AM, Surveyor observed R25's foley catheter bag hanging on the right side of R25's bed and is not covered. On 7/16/24, at 11:53 AM, Surveyor observed R25's catheter bag remains hanging on the right side of R25's bed. On 7/17/24, at 7:11 AM, Surveyor observed R25's foley catheter bag is laying on the floor on the right side of R25's bed. On 7/17/24, at 8:09 AM, Surveyor observed CNA-K go into R25's room and was on the right side of R25's bed. Surveyor observed R25's catheter bag remains on the floor on the right side of R25's bed. CNA-K did not pick R25's catheter bag up off the floor. On 7/17/24, at 10:51 AM, Surveyor observed R25's foley catheter bag remains on the floor on the right side of R25's bed. On 7/17/24, at 12:25 PM, Surveyor interviewed Unit Manager (UM)-J who confirmed that foley catheter bags should not be on the floor. UM-J stated some Residents have behaviors and will take the catheter bags off the bed. UM-J stated that R25 will sometimes take the catheter bag off the bed, but not a whole lot. On 7/17/24, at 3:51 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that Surveyor had multiple observations of R25's foley catheter bag laying on the floor and Surveyor had observed CNA(s) go into R25's room and not acknowledge that R25's catheter bag was on the floor which is an infection control issue. No further information was provided by the facility at this time. On 7/18/24, at 10:06 AM, Surveyor shared the concern with Director