STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shell Lake Health Care Center	802 E Cty Hwy B Shell Lake, WI 54871

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility failed to implement written policies and procedures when staff did not report an incident of caregiver neglect to the administrator immediately for 1 of 3 residents (R) reviewed for abuse and neglect. (R20) Findings include: R20 was admitted to the facility on [DATE] with diagnoses including, in part, cerebral palsy, unsteadiness on feet, absence epileptic syndrome, and lichen simplex chronicus. R20's Minimum Data Set (MDS) assessment, dated 01/03/24, identified that R20 had a Brief Interview for Mental Status (BIMS) score of 00. This indicated R20 had significant cognitive impairment and was unable to perform an accurate BIMS. The MDS assessment also identified R20 required extensive assistance of two people for bed mobility and toileting and was dependent on two people for transfers. R20's care plan included: -Mobility plan: I transfer with the assistance of two and Hoyer lift, 03/12/24. On 06/19/24 at 10:34 AM, Surveyor interviewed Certified Nurse Assistant (CNA) G who indicated that CNA M had transferred R20 by CNA M's self in February and dropped R20 on the floor. CNA G indicated that CNA M had tripped over R20's non-functional leg and dropped R20 on the floor. CNA G indicated that R20 suffered a swollen hip due to the fall but that no one reported the fall to the appropriate personnel. Surveyor asked CNA G if CNA G reported this incident to the administration, and CNA G indicated that CNA G did let DON B know about CNA M dropping R20 on the floor. CNA G indicated that CNA M keeps transferring residents alone who are ordered to be assisted by 2 or mechanical Hoyer lifts instead of receiving assistance with resident transfers. On 06/20/24 at 7:41 AM, Surveyor interviewed CNA M with another Surveyor present and asked to explain the process with R20 and the fall that occurred in February. CNA M indicated that CNA M did drop R20 during a stand pivot transfer in February. CNA M indicated CNA M does not remember the exact day in February that R20 fell but that it was on the day shift. CNA M indicated that CNA M was transferring R20 with a walker and gait belt. R20's foot went dead, CNA tripped on leg and then CNA M and R20 both fell to the ground. CNA M indicated that CNA M reported this to Registered Nurse (RN) L right away. CNA M indicated that RN L came in and assessed R20. CNA M indicated that R20 did not receive any injuries that CNA M was aware of and then therapy came and assessed R20. CNA M indicated that therapy deemed R20 to be a transfer with a Hoyer lift only. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER: Shell Lake Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 802 E Cty Hwy B, Shell Lake, WI 54871	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/24 at 7:52 AM, Surveyor interviewed RN L and asked if RN L was aware of R20's fall in February. RN L indicated that RN L was aware of R20's fall. Surveyor asked RN L if RN L remembers what RN L's process was for post-fall assessment and reporting the fall. RN L indicated that RN L received notice from CNA M that R20 had fallen in R20's room during CNA M transferring R20. RN L was unaware of who helped CNA M transfer R20 as R20 was assist of 2 transfers at that time. On 06/20/24 at 10:01 AM, Surveyor interviewed Physical Therapy Assistant (PTA) N and asked what R20's transfer status was in February 2024. PTA N indicated that R20 has always been an assist of 2 pivot transfer when feeling strong or assist of 2 with mechanical Hoyer lift. On 06/20/24 at 10:53 AM, Surveyor interviewed DON B and asked if staff had reported CNA M transferred R20 alone when R20 needed assist of 2 for R20's fall in February. DON B indicated that DON B was not aware of R20 falling due to improper transfer technique. The only incident that was known was CNA M indicated that CNA M injured CNA M's foot by tripping over the wheelchair pedal in R20's room in February. DON B indicated that if a resident has fallen, staff need to report the fall right away to the charge nurse, charge nurse assesses the resident, provides proper interventions and investigate the root cause. This would determine if caregiver neglect occurred with the transfer. DON B indicated there was no documentation of R20 falling in February, the CNA misconduct was not reported to administration.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews and record reviews, the facility failed to provide the necessary services for 2 of 6 sampled and supplemental sampled residents (R9, R4) to maintain good grooming, toileting and personal hygiene. This is evidenced by: The facility policy and procedure titled General Care For All Residents includes the following directives to staff: - The resident shall be kept clean and dry - Staff will respond to call lights timely Example 1 R9 has medical diagnoses that include but are not limited to, diabetes mellitus type 2, a recent cerebral infarction (3/6/24), unspecified depression and dementia. According to the most recent MDSA (Minimum Data Set Assessment), which was a Significant Change in Status Assessment with an Assessment Reference Date of 3/18/24, R9 has impaired short-term and long-term memory and severely impaired daily decision making abilities. R9 has no behavioral or mood indices. Also according to this assessment, R9 required partial to moderate assistance of staff for moving from sitting to lying and lying to sitting positions to the side of the bed and is dependent on staff for toileting hygiene, upper and lower body dressing and personal hygiene. R9 is transferred with the use of a full body mechanical lift with the assistance of two staff and is frequently incontinent of bladder function and always incontinent of bowel function. Surveyor reviewed the Comprehensive Care Plan (CCP) completed for R9 and noted the following: 1. Activities of Daily Living (initiated 4/17/23 and last revised 4/30/24): Interventions included: - I need staff assist of 1 with dressing. (4/17/23) - I need the assist of two with the Hoyer (3/12/24) - I need partial assist from staff with grooming. (4/17/23) 2. I am both continent and incontinent of bowel and bladder (initiated 4/25/23 and last revised 4/30/24) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions for this problem included: - Scheduled toileting: every 2 hours and PRN (as needed) - Staff assist of 2 with hoyer to assist me with transferring on and off toilet/commode. Also noted, staff no longer place R9 on a toilet to allow for normal evacuation of the bladder and bowel. Instead, observations have shown that R9 is a check and change, in which R9 is placed onto the bed and the soiled incontinent brief is changed and perineal cleansing is completed. This was not updated on the CCP. 3. I have impaired mobility . (initiated 4/25/23 and last revised 6/3/24): Interventions for this problem included: - Anticipate needs, such as toileting. - I need assist of 1 with turning and repositioning in bed. - I use a Broda chair to get to destinations. I am dependent on staff with chair mobility 4. I am at risk for falls . (initiated 4/25/23 and last revised 4/30/24): Interventions included: - Anticipate and meet my needs (4/25/23) - Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance (4/25/23) - Assist to eh bathroom every two hours and as needed (6/16/23) 5. The resident had a cerebral vascular accident (3/12/24) Interventions include: - Monitor and document bowel and bladder function. If incontinent, monitor and document for appropriate bowel and bladder training program and implement. A bowel and bladder training program has not yet been attempted for R9. On 6/19/24, Surveyor made the following observation of R9: - At 7:18 AM, R9 was up in the Broda chair in her room. R9 was sitting on the mechanical lift sling and a small blanket covered R9's lap. R9 was positioned at 90 degree angles from back to hips, from hips to legs and from knees to ankles. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 7:58 AM, R9 was taken to the Main Dining Room (MDR) and placed at a table in preparation for the morning meal. R9 was served her meal at 8:02 AM by Nursing Student (NS) K, who sat beside R9 and fed her the meal. - At 9:10 AM, R9 completed the meal and was propelled to a small television/bird aviary room by NS K. R9 remained here until 10:38 AM, at which time Activity Director (AD) E approached and offered an activity of exercise. R9 affirmed a desire to attend and AD E propelled R9 to the MDR for a small group activity. Surveyor remained throughout this activity to observe R9's participation level and the assistance provided by activity staff. R9 remained in the MDR activity until 11:03 AM. There were no offers yet attempted by staff to assist R9 to the toilet or change the incontinent brief. - At 11:03 AM, AD E propelled R9 to the small activity room for nail care. R9 remained in this activity until 11:40 AM. - At 11:40 AM, Licensed Practical Nurse (LPN) H propelled R9 to her room in order to screen the resident's blood sugar. No attempts to toilet R9 were offered. At 11:43 AM, Surveyor interviewed Certified Nursing Assistant (CNA) C regarding R9's needs with toileting and repositioning. CNA C was one of two staff responsible for R9's care on this day. CNA C stated that R9 was incontinent of bowel and bladder and required total care. CNA C stated R9 is unable to do any activities of daily living on her own and is dependent on staff and required repositioning and toileting every two hours. Surveyor then asked CNA C why R9 was not offered or attempts were made to assist R9 to the toilet yet on this morning. CNA C stated, I am trying, things have been happening down here, extra alarms are going off, I'm just busy. All I can say is that I am trying. CNA C mentioned to the Surveyor that she informed her nurse (LPN H) that they were behind in cares and needed help. Surveyor then interviewed LPN H at 11:48 AM and asked who was responsible to ensure resident's care was being provided according to the written care plan. LPN H stated, It's us, the nurses. I'm sorry. I have been trying to get them to not schedule two new ones (aides) together, but it happens. Surveyor asked LPN H if the CNAs have mentioned anything to her that staff were falling behind in providing cares. LPN H stated that she has been trying to assist the CNAs but, . when I go in to help, the other CNA comes in. No toileting or repositioning was yet completed for R9, even with Surveyor's questioning. - At 11:57 AM, CNA C and CNA D entered R9's room to assist the resident onto the bed with the use of the full body mechanical lift. The resident was assisted onto the bed at 11:59 AM, at which time, staff removed the incontinent brief. The brief was wet with urine and feces. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This was 4 hours 41 minutes in which R9 was not offered or assisted with toileting. R9's buttocks was red and wrinkled from the wetness of the urine and feces. Surveyor then asked CNA C and CNA D what the normal staffing was for this hall, in which R9 resides. Both staff indicated there is normally two on this hall and two on the adjacent hall with one additional staff assigned to float between the two halls. Surveyor asked what was different today, in which they could not complete cares as assigned. Both staff indicated they have been on staff for only one month. The two staff also stated there was a call in today and a new staff (CNA J) assigned on the adjacent hall, which was only her third day working. Surveyor then asked who is responsible for staffing the floors to ensure residents are receiving the care they need. Both indicated that Director of Nursing (DON) B completed the staffing schedules. At 12:15 PM, Surveyor interviewed DON B and asked how she decided on the staffing for this date, with three new CNAs and only one seasoned CNA working. DON B stated that CNA C has over [AGE] years experience as a CNA and she assigned CNA D to work with CNA C, as she needed a strong CNA to guide CNA D, who did not have any experience as a caregiver and required much direction. DON B further stated there are two CNAs assigned to each hall with one additional CNA as a float between the two halls. DON B assigned CNA J to work with CNA G on a less difficult hall, as CNA J is an orientee for the third day. DON B indicated the staffing on this day is normal. DON B further stated that it was the responsibility of the nurses on the hall to ensure residents are receiving care according to their written care plans. DON B also stated that no staff approached her to inform her that the CNAs were behind on cares. Surveyor then asked DON B what the repositioning and toileting needs for R9 were. DON B stated that R9 was to be toileted every two hours. 44863 The facility policy titled General Care of Residents, revised on 06/2018, stated in part . 9. Call Lights a. Staff will respond to call lights timely. b. If responding to a call light and you are assisting another resident, inform the resident you are assisting another resident and will return shortly and turn off call light. c. If other departmental staff answers call lights, let the resident know that you will tell the nursing staff and turn off the call light. R4 was admitted to the facility on [DATE]. Diagnoses included heart failure, cellulitis of upper limb, chronic kidney disease, chronic obstructive pulmonary disease, and shoulder pain. R4 was admitted with a stage 1 pressure injury to right buttock. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Minimum Data Set (MDS) assessment, dated 06/06/24, confirmed R4 scored 10/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R4's MDS assessment reported R4 is frequently incontinent of urine and always incontinent of bowel. R4 required substantial assistance with toileting, showering, and dressing, and was dependent on staff for transfers with mechanical hoyer lift. R4's care plan included: -Toileting plan: I am on a toileting schedule. Take me upon rising, before meals, after meals, bedtime, and as needed during the night, 05/31/24. The following occurred on 06/19/24 during a continuous observation from 10:22 AM-11:41 AM, for 79 minutes: -10:22 AM, Surveyor observed R4 in his room, sitting in a Broda chair. Surveyor observed R4's call light was on and R4 was calling out stating he needed to use the bathroom. -Between 10:22 AM and 10:35 AM, Surveyor observed physical therapy staff walk past R4's room twice. Surveyor observed Director of Nursing (DON) B walk past R4's room twice. Surveyor observed Certified Nursing Assistant (CNA) G walk past R4's room twice. -10:41 AM, Surveyor observed Licensed Practical Nurse (LPN) I walk past R4's room. -10:44 AM, Surveyor observed LPN H walk past R4's room. -10:46 AM, Surveyor observed CNA J enter R4's room. R4 stated to CNA J he needed to use the bathroom. CNA J told R4 she would let someone know and she would be back. CNA J left R4's call light on. Surveyor observed CNA J tell CNA G R4 needed to use the bathroom. -10:47 AM, Surveyor observed ADON F walk past R4's room. -10:50 AM, Surveyor observed CNA C and CNA D walk past R4's room. -10:52 AM, Surveyor observed CNA G and CNA J walk past R4's room. -10:54 AM, Surveyor interviewed CNA G. CNA G reported she was not assigned to R4's hall. CNA G stated she is working on the other hallway training CNA J. CNA G stated she assists on R4's hallway as she can as it is a heavy hall, but not all staff assist with answering resident call lights in unassigned areas. CNA G stated, With charting, no, I am not able to complete all of my workload. Surveyor observed CNA G and CNA J walk towards R4's room, where R4's call light was on. Surveyor observed CNA G and CNA J exit the hallway through a door immediately adjacent to R4's room. CNA G stated, We are finally going on break. Surveyor observed R4's call light continued to be on. -10:58 AM, Surveyor observed ADON F walk past R4's room. -11:03 AM, Surveyor observed DON B walk past R4's room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11:05 AM, Surveyor observed LPN I entered R4's room. R4 stated he needed to use the bathroom. LPN I turned off R4's call light and stated to R4 she would tell the staff. -11:17 AM, Surveyor observed R4's call light was off. Surveyor interviewed R4, R4 stated he needed to use the bathroom, and no one had helped him. Surveyor encouraged R4 to use his call light to request staff assistance. R4 did engage his call light and stated, It doesn't do any good anyway. -11:21 AM, Surveyor observed DON B enter R4's room. R4 stated he needed to use the bathroom. DON B turned off R4's call light and told R4 she would let staff know. Surveyor observed DON B tell CNA C and CNA D R4 needed to use the bathroom. -11:27 AM, Surveyor interviewed LPN I. LPN I stated she told CNA C R4 needed to use the bathroom, after she answered R4's call light at 11:05 AM. -11:34 AM, Surveyor observed R4 was calling out from his room. Surveyor interviewed R4, R4 stated he still needed to use the bathroom. Surveyor encouraged R4 to use his call light to ask for assistance. R4 engaged his call light. -11:35 AM, Surveyor observed DON B enter R4's room. R4 stated he needed to use the bathroom. DON B left R4's call light on, exited his room, and updated CNA C and CNA D R4 needed to use the bathroom. -11:41 AM, Surveyor observed CNA D and CNA G assist R4 with mechanical lift transfer to his bed. Surveyor observed CNA D and CNA G assist R4 with incontinence care of both bowel and bladder. On 06/20/24 at 1:42 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A reported the facility considers resident acuity when developing staffing patterns. NHA A reported staffing is discussed each morning during the facility's morning meeting, and stated, We move things around based on what is discussed in morning meeting, admissions, discharges, change in condition. Surveyor reported to NHA A the observation of R4 requesting to use the bathroom and not receiving assistance for 79 minutes. NHA A did not make any statements related to the incident.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 17661

Based on observations, interviews and record reviews, the facility failed to ensure 3 of 3 residents reviewed for high risk of pressure injury (PI) development (R9, R5 and R27), received the necessary treatment and services to promote healing of existing skin impairments or prevent new pressure injuries from developing.

- R9 has an active pressure related deep tissue injury to the right heel. R9 remains a high risk for the development of additional PIs related to immobility and bowel and bladder incontinence. An observation of 4 hours 41 minutes was conducted in which repositioning was not offered. Once staff did assist R9 onto the bed for incontinence care, R9's buttocks was red and wrinkled from no pressure redistribution and the incontinence of urine and feces.

- R5 is a high risk for PI and has a current PI on the scapula. R5 was not offered or attempts made to reposition R5 off the scapula for over 4 hours.

- R27 is a high risk for the development of PIs and has a current PI on the right heel, in which the resident was to wear a Podus boot at all times while in bed. Observations were made in which the Podus boot was not applied to R27.

This is evidenced by:

Facility policies and procedures for Skin Integrity, Pressure Ulcer Staging and Wound Care Protocol and General Care For All Residents were reviewed. Neither policy gives clear direction to staff on repositioning guidelines for residents either at high risk for the development of PIs or for those with current PIs.

There was a section in the Pressure Ulcer Staging and Wound Care Protocol for all wounds that the care plan will be initiated. Also, for any deep tissue injuries to the heel, staff are to place pressure relief boots on at all times.

According to the National Pressure Injury Advisory Panel (NPIAP) 2019, page 115, . Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. The underlying cause and formation of pressure injuries is multifaceted; however, by definition, pressure injuries cannot form without loading, or pressure, on tissue. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues and, ultimately, in tissue damage .

According to Wound Care Education Institute (2018), for immobile or bed bound individuals, a full change in position should be conducted a minimum of every two hours. Some individuals require more frequent repositioning due to their high risk status.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to RESNA (Rehabilitation Engineering & Assistive Technology Society of North America) 2015, Position on the Application of Tilt, Recline, and Elevating Leg Rests for Wheel chairs, a lift from a seated position requires at least 2 minutes in order for tissue to return to off-loading levels. (If not, it is only a microshift). RESNA continues to recommend the following for tilt, recline and elevating chairs, such as the Broda: - Tilt, when used alone, must be greater than about 25 to achieve pressure relief and/or tissue perfusion at the ischial tuberosities. - Recline, when used alone, can increase shear but may provide reduction in pressure at the ischial tuberosities at angles greater than 90-100 . - The greatest reductions in pressure are seen when tilt and recline are used together, either at tilt of 35 with recline 100 or tilt of 15-25 with recline of 120 . Example 1 R9 has medical diagnoses that include but are not limited to, diabetes mellitus type 2, a recent cerebral infarction (3/6/24), heart failure, arteriosclerotic heart disease of the native coronary artery, paroxysmal atrial fibrillation, unspecified depression and dementia. According to the most recent MDSA (Minimum Data Set Assessment), which was a Significant Change in Status Assessment with an Assessment Reference Date of 3/18/24, R9 has impaired short-term and long-term memory and severely impaired daily decision making abilities. R9 has no behavioral or mood indices Also according to this assessment, R9 required partial to moderate assistance of staff for moving from sitting to lying and lying to sitting positions to the side of the bed and is dependent on staff for toileting hygiene, upper and lower body dressing, mobility and personal hygiene. R9 is transferred with the use of a full body mechanical lift with the assistance of two staff and is frequently incontinent of bladder function and always incontinent of bowel function. Surveyor reviewed the Comprehensive Care Plan (CCP) completed for R9 and noted the following: 1. Activities of Daily Living (initiated 4/17/23 and last revised 4/30/24): Interventions included: - I need staff assist of 1 with dressing. (4/17/23) - I need the assist of two with the Hoyer (3/12/24) - I need partial assist from staff with grooming. (4/17/23) 2. I am both continent and incontinent of bowel and bladder (initiated 4/25/23 and last revised 4/30/24) Interventions for this problem included: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Scheduled toileting: every 2 hours and PRN (as needed) - Staff assist of 2 with hoyer to assist me with transferring on and off toilet/commode. 3. I have impaired mobility . (initiated 4/25/23 and last revised 6/3/24): Interventions for this problem included: - Anticipate needs, such as toileting. - I need assist of 1 with turning and repositioning in bed. - I use a Broda chair to get to destinations. I am dependent on staff with chair mobility 4. has potential for pressure ulcer development r/t (related to) Immobility, bowel incontinence, bladder incontinence, has SDTI (Suspected deep tissue injury) to right heel. (start 4/25/23; revised 6/3/24) Interventions for this problem include: - Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. - Follow facility policies/protocols for the prevention/treatment of skin breakdown. - Heel lift boots on at all times - Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. - The resident needs assistance of 1 staff to turn/reposition at least every 2 hours, more often as needed or requested. - The resident requires alternating air mattress overlay to bed, Broda chair for pressure reduction when up. Surveyor then reviewed the Braden Scale For Predicting Pressure Sore Risk assessments completed for R9 and noted R9 was scored the following: - 5/5/2024-14 - 6/2/2024-14 - 6/6/2024 -13 - 6/13/2024-13 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shell Lake Health Care Center	802 E Cty Hwy B Shell Lake, WI 54871

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note: Scoring for Braden assessments are as follows: - 15-18 indicates individual is at risk for the development of a PI; - scores of 13-14 indicates a moderate risk; - scores of 10-12 indicates a high risk; and - scores of 9 or less indicates a very high risk. Further review of R9's medical record was completed and noted R9 developed an unstageable PI to the right heel on 6/2/24. Interventions were put into place to apply Podus boots at all times and to reposition at least every two hours. Prosource supplements were added as a dietary intervention to promote healing. On 6/19/24, Surveyor made the following observation of R9: - At 7:18 AM, R9 was up in the Broda chair in her room. R9 was seated at 90 degrees from hips to legs and at a straight 90 degrees from hips to back. R9's legs were also at a straight 90 degrees from knees to ankles. R9 was sitting on the mechanical lift sling and a small blanket covered R9's lap. - At 7:58 AM, R9 was taken to the Main Dining Room (MDR) and placed at a table in preparation for the morning meal. R9 was served her meal at 8:02 AM by nursing student (NS) K, who sat beside R9 and fed her the meal. - At 9:10 AM, R9 completed the meal and was propelled to a small television/bird aviary room by NS K. - At 9:59 AM, Certified Nursing Assistant (CNA) G approached R9 and moved the Broda chair closer to the television. CNA G then slightly reclined R9's back in the chair, approximately 25-30 degrees. Note: According to RESNA guidelines, this was a microshift as tilting of the seat was not completed to redistribute pressure, only a slight reclining of the back of the chair. R9 remained here until 10:38 AM, at which time Activity Director (AD) E approached and offered an activity of exercise. R9 affirmed a desire to attend and AD E propelled R9 to the MDR for a small group activity. AD E straightened R9's back in the chair to a 90 degree angle from the hips. Again, no tilting of the seat was completed and no pressure redistribution. Surveyor remained throughout this activity to observe R9's participation level and the assistance provided by activity staff. R9 remained in the MDR activity until 11:03 AM. There were no offers yet attempted by staff to assist R9 for repositioning or offloading. - At 11:03 AM, AD E propelled R9 to the small activity room for nail care. R9 remained in this activity until 11:40 AM. - At 11:40 AM, Licensed Practical Nurse (LPN) H propelled R9 to her room in order to screen the resident's blood sugar. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No attempts to toilet or reposition R9 were offered. At 11:43 AM, Surveyor approached CNA C and interviewed regarding R9's needs with toileting and repositioning. CNA C was one of two staff responsible for R9's care on this day. CNA C stated that R9 was incontinent of bowel and bladder and required total care. CNA C stated R9 is unable to do any activities of daily living on her own and is dependent on staff and required repositioning and toileting every two hours. Surveyor then asked CNA C why R9 was not offered, or attempts were made to assist R9 to the toilet or to reposition yet on this morning. CNA C stated, I am trying, things have been happening down here, extra alarms are going off, I'm just busy. All I can say is that I am trying. CNA C mentioned to the Surveyor that she informed her nurse (LPN H) that they were behind in cares and needed help. Surveyor then approached LPN H at 11:48 AM and asked who was responsible to ensure resident's care was being provided according to the written care plan. LPN H stated, It's us, the nurses. I'm sorry. I have been trying to get them to not schedule two new ones (aides) together, but it happens. Surveyor asked LPN H if the CNAs have mentioned anything to her that staff were falling behind in providing cares. LPN H stated that she has been informed and was trying to assist the CNAs but, . when I go in to help, the other CNA comes in. No toileting or repositioning was yet completed for R9, even with Surveyor's questioning. - At 11:57 AM, CNA C and CNA D entered R9's room to assist the resident onto the bed with the use of the full body mechanical lift. The resident was assisted onto the bed at 11:59 AM, at which time, staff removed the incontinent brief. The brief was wet with urine and soiled with feces. This was 4 hours 41 minutes in which R9 was not offered or assisted with repositioning. R9's buttocks was red and wrinkled from the combination of pressure, wetness of the urine and soilage of the feces. Surveyor then asked CNA C and CNA D what the normal staffing was for this hall, in which R9 resides. Both staff indicated there is normally two on this hall and two on the adjacent hall with one additional staff assigned to float between the two halls. Surveyor then asked DON B what the repositioning needs for R9 were to prevent pressure injuries. DON B stated that R9 was to be repositioned every two hours. 48793 Example 2 R5 was admitted to the facility on [DATE] with diagnoses including, in part, scoliosis, spastic quadriplegic cerebral palsy, pressure ulcer of the right upper back, dysphagia, and fistula of the intestine. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Minimum Data Set (MDS) assessment, dated 06/05/24, identified that R5 had a Brief Interview for Mental Status (BIMS) score of 00. This indicated R5 had significant cognitive impairment and was unable to perform an accurate BIMS. The MDS assessment also identified R5 required extensive assistance of two people for bed mobility, and toileting and was dependent on two people for transfers. R5's care plan included: -Mobility plan: I need the assistance of one or two to turn, reposition, and boost in bed, 01/08/24. -Pressure area to Right shoulder plan: Up in chair at 10 am for 1 hour. The following occurred on 06/19/24 during a continuous observation from 9:01 AM-1:05 PM, for 4 hours and 4 minutes. -On 06/19/24 at 9:01 AM, Surveyor observed CNA G enter R5's room. Surveyor observed podus foot protectors on, but the knee pad was located down at the end of R5's bed near R5's feet. CNA G rolled R5 to the right side and washed the peri area. CNA G rolled new chuck and brief under R5. CNA G rolled R5 back to the left side. CNA G cleaned peri area thoroughly and dried it, then applied powder to the area. CNA G attached brief and then boosted R5 up in bed. CNA G turned R5 onto R5's back and placed a pillow semi-under R5's left shoulder. Surveyor observed R5 supine on the back with pressure to the right scapula. CNA G applied covers to R5 and raised the head of the bed. -On 06/19/24 at 11:24 AM, Surveyor observed R5 in a supine position with the right scapula pressing into the bed. On 06/19/24 at 1:05 PM, Surveyor observed Registered Nurse (RN) F and CNA G enter R5's room. Surveyor observed podus foot protectors on, but the knee pad was still down at the end of the bed near R5's feet. CNA G changed R5 and rolled from side to side to change. Surveyor interviewed CNA G on why knee pad was down at the end of R5's feet. CNA G indicated that someone did not place the knee pads between the knees and left the knee pad at the bottom of R5's feet. CNA G then grabbed knee pad and placed in between R5's knees. CNA G placed R5 on the back and placed a pillow semi-under R5's left shoulder. Surveyor observed R5 placed on a supine position on back with pressure to the right scapula. -On 06/19/24 at 1:12 PM, Surveyor interviewed CNA G and asked if CNA G had been in R5's room to reposition or perform incontinent care since the morning at 9:01 AM. CNA G indicated that CNA G has not been in there since CNA G and Surveyor were in R5's room at 9:01 AM on 06/19/24 and then when CNA G went in with RN F to complete wound dressing change. CNA G indicated that CNA G is doing CNA G's best and trying to perform tasks that are needed. CNA G indicated that it is hard when I am alone on a heavy hall and have an orientee who is not fully trained to know what to do with all the residents. On 06/20/24 at 12:52 PM, Surveyor interviewed RN F and asked about the repositioning and roho cushion on R5's bed. RN F indicated that R5 should still be repositioned every two hours as the roho cushion is just an additive measure to help further decrease pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/24 at 1:02 PM, Surveyor interviewed DON B and asked about the expectation of repositioning R5. DON B indicated that staff should reposition R5 at least every two hours. DON B indicated that R5 should be repositioned and off-loaded for at least a couple minutes at a time every 2 hours. DON B indicated that CNA G should have repositioned and performed incontinent care to R5 at least every two hours. Example 3 R27 was admitted to the facility on [DATE] with diagnoses including, in part, infection and inflammatory reaction due to unspecified internal joint prosthesis, urinary tract infection, obstructive and reflux uropathy, type 2 diabetes, unspecified dementia, and pyogenic arthritis. R27's MDS assessment, dated 03/27/24, identified that R27 had a BIMS score of 09. This indicated that R27 had significant cognitive impairment. The MDS assessment also identified R27 required extensive assistance of one to two people for bed mobility, and toileting and was dependent on one person for stand pivot transfers. R27's care plan included: -Mobility plan: I need the assistance of 1 to turn, reposition and boost in bed, 04/30/24. -ADL plan: Before getting out of bed, don podus boot and knee brace to right lower extremity, 02/16/24. -When in bed resident to use blue puffy boots to right lower extremity, 02/16/24. -Potential for pressure ulcer development plan: Immobilizer to the right leg when up, remove every shift to check skin, 04/30/24. -The resident requires an air/float mattress to the bed and, a pressure reduction cushion to a wheel chair. Podus boot to right foot at all times, 02/05/24. R27's physician orders include: - Inspect right heel daily for any breakdown and monitor. - Right heel- Clean with NS, apply Mepilex for prevention of recurrence of pressure ulcer. Monitor heel for any sx recurrence every day shift. On 06/18/24 at 9:55 AM, Surveyor observed R27 lying in bed on R27's back with bilateral heels lying directly on the bed. Surveyor did not observe Podus boot on the right foot. R27's Podus boots were lying in the chair across the room. On 06/18/24 at 12:25 PM, Surveyor observed R27 lying in bed on R27's back with bilateral heels lying directly on the bed. Surveyor did not observe podus boot on the right foot. R27's Podus boots were lying in the chair across the room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/19/24 at 11:01 AM, Surveyor observed R27 sitting in R27's wheelchair with R27's right foot on the pedal of R27's wheelchair. R27's right foot had a gripper sock on, but Surveyor did not observe Podus boot on the right foot. On 06/19/24 at 11:24 AM, Surveyor interviewed Licensed Practical Nurse (LPN) I and asked if R27 is supposed to have Podus boot on R27's right foot. LPN I reviewed physician orders and indicated that R27 is to have Podus boot on at all times. On 06/19/24 at 12:57 PM, Surveyor observed R27's feet bilateral lying flat on the floor while R27 was sleeping in R27's wheelchair. Surveyor did not observe Podus boot on the right foot. Podus boots were across the room lying on a chair. On 06/19/24 at 1:51 PM, Surveyor observed R27 lying in bed with bilateral heels flat on the bed without Podus boots on. Surveyor observed Podus boots in the chair across the room. On 06/19/24 at 1:55 PM, Surveyor interviewed CNA G and asked if R27 was supposed to have Podus boots on while R27 was in bed to protect the heels. CNA G indicated that R27 is supposed to have Podus boots on while in bed and R27 does not at this time. Surveyor observed CNA G enter R27's room and place Podus boots on R27 while in bed. On 06/20/24 at 12:01 PM, DON B handed Surveyor progress notes for skin assessments. Surveyor reviewed that R27's right heel wound healed back in March and then reopened 05/30/24. On 06/20/24 at 1:02 PM, Surveyor interviewed DON B and asked the expectations of R27 wearing Podus boots for heal protection to the right foot. DON B indicated that R27 should have Podus boots in place but sometimes R27 refuses. DON B asked Surveyor if R27 refused Podus boots during Surveyor's observations. Surveyor indicated that Podus boots were not offered to R27 during Surveyor's observations of R27's care. Surveyor indicated to DON B that the Podus boots were located across the room in a chair the whole day. DON B indicated that CNA G should have placed Podus boots on R27 while R27 was in bed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, 2 of 3 residents (R20 and R27) at risk for falls did not receive adequate supervision and assistance devices to prevent accidents. R20 required the assistance of 2 staff for transfers. CNA M transferred R20 with one person and R20 fell . R27 was at risk for falls. R27's fall interventions included wearing a knee immobilizer to the right knee during all transfers for stability. CNA G was observed transferring R27 from the wheelchair to the bed without using R27's knee immobilizer. Findings include: Example 1: R20 was admitted to the facility on [DATE] with diagnoses including, in part, cerebral palsy, unsteadiness on feet, absence epileptic syndrome, and lichen simplex chronicus. R20's Minimum Data Set (MDS) assessment, dated 01/03/24, identified that R20 had a Brief Interview for Mental Status (BIMS) score of 00. This indicated R20 had significant cognitive impairment and was unable to perform an accurate BIMS. The MDS assessment also identified R20 required extensive assistance of two people for bed mobility and toileting and was dependent on two people for transfers. R20's care plan included: -Mobility plan: I transfer with the assistance of two and Hoyer lift, 03/12/24. On 06/19/24 at 10:34 AM, Surveyor interviewed Certified Nurse Assistant (CNA) G who indicated that CNA M had transferred R20 by CNA M's self in February and dropped R20 on the floor. CNA G indicated that CNA M had tripped over R20's non-functional leg and dropped R20 on the floor. CNA G indicated that R20 suffered a swollen hip due to the fall but that no one reported the fall to the appropriate personnel. Surveyor asked CNA G if CNA G reported this incident to the administration, and CNA G indicated that CNA G did let Director of Nursing (DON) B know about CNA M dropping R20 on the floor. CNA G indicated that CNA M keeps transferring residents alone who are ordered to be assisted by 2 or mechanical Hoyer lifts instead of receiving assistance with resident transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/24 at 7:41 AM, Surveyor interviewed CNA M with another Surveyor present and asked to explain the process with R20 and the fall that occurred in February. CNA M indicated that CNA M did drop R20 during a stand pivot transfer in February. CNA M indicated CNA M does not remember the exact day in February that R20 fell but that it was on the day shift. CNA M indicated that CNA M was transferring R20 with a walker and gait belt. R20's foot went dead, CNA tripped on leg and then CNA M and R20 both fell to the ground. CNA M indicated that CNA M reported this to Registered Nurse (RN) L right away. CNA M indicated that RN L came in and assessed R20. CNA M indicated that R20 did not receive any injuries that CNA M was aware of and then therapy came and assessed R20. CNA M indicated that therapy deemed R20 to be a transfer with a Hoyer lift only. On 06/20/24 at 7:52 AM, Surveyor interviewed RN L and asked if RN L was aware of R20's fall in February. RN L indicated that RN L was aware of R20's fall. Surveyor asked RN L if RN L remembers what RN L's process was for post-fall assessment and reporting the fall. RN L indicated that RN L received notice from CNA M that R20 had fallen in R20's room during CNA M transferring R20. RN L was unaware of who helped CNA M transfer R20 as R20 was assist of 2 transfers at that time. RN L assessed R20 from head to toe and gathered vitals every 15 minutes for the first half hour, then vitals every 30 minutes for the next 4 hours, and then an hour for the next 24 hours. RN L indicated that all vitals and neuros post-fall are documented on a paper flowsheet located in R20's hard chart. RN L indicated that physician notification was completed and should be in R20's Electronic Health Record (EHR). Surveyor asked RN L to show Surveyor documentation in R20's EHR about the fall incident in February, vitals, neuros, and contact of the physician notification. RN L indicated that RN L could not find any of the documentation in R20's EHR. RN L indicated that RN L thinks RN L had documented it but maybe RN L did not after all. On 06/20/24 at 10:01 AM, Surveyor interviewed Physical Therapy Assistant (PTA) N and asked what R20's transfer status was in February 2024. PTA N indicated that R20 has always been an assist of 2 pivot transfer when feeling strong or assist of 2 with mechanical Hoyer lift. PTA N indicated that R20 has never been an assist of 1 due to the instability of R20's non-functional leg. Surveyor asked if PTA N remembers R20 falling in February and PTA N indicated that PTA N is unaware of a fall in February. On 06/20/24 at 10:53 AM, Surveyor interviewed DON B and asked about any knowledge of R20's fall in February. DON B indicated there was no fall. Surveyor explained to DON B that through several interviews R20 had suffered a fall with minor injury to the right hip. DON B indicated that DON B was not aware of R20 falling and the only incident that was known was CNA M indicated that CNA M injured CNA M's foot by tripping over the wheelchair pedal in R20's room in February. DON B indicated that if a resident has fallen, staff need to report the fall right away to the charge nurse, charge nurse assesses the resident, provides proper interventions to keep the resident safe, documents the fall as an incident, and reports the incident to DON B and the physician. Surveyor asked DON B to find any documentation in R20's EHR about the fall in February. DON B indicated there was no documentation of R20 falling in February. Example 2: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27 was admitted to the facility on [DATE] with diagnoses including, in part, infection and inflammatory reaction due to unspecified internal joint prosthesis, urinary tract infection, obstructive and reflux uropathy, type 2 diabetes, unspecified dementia, and pyogenic arthritis. R27's Minimum Data Set (MDS) assessment, dated 03/27/24, identified that R27 had a Brief Interview for Mental Status (BIMS) score of 09. This indicated that R27 had significant cognitive impairment. The MDS assessment also identified R27 required extensive assistance of one to two people for bed mobility, and toileting and was dependent on one person for stand pivot transfers. R27's care plan included: -Mobility plan: Assist of 1 person pivot transfer with a two-wheeled walker or the transfer pole, use a gait belt, and hold onto it for safety. Needs locking knee brace on right leg for transfers, 04/15/24. -ADL plan: Please put a locking knee brace on the right knee when getting up in the morning, 04/15/24. -Before getting out of bed, don podus boot and knee brace to right lower extremity, 02/16/24. -When in bed resident to use blue puffy boots to right lower extremity, 02/16/24. -Potential for pressure ulcer development plan: Immobilizer to right leg when up, remove every shift to check skin, 04/30/24. -The resident requires air/float mattress to bed, pressure reduction cushion to wheel chair. Podus boot to right foot at all times, 02/05/24. On 06/19/24 at 2:07 PM, Surveyor observed CNA G transfer R27 from the wheelchair to bed without an immobilizer brace on the right leg. On 06/19/24 at 2:14 PM, Surveyor interviewed CNA G and asked if R27 was supposed to have an immobilizer brace on the right leg when transferring to and from bed or wheelchair. CNA G indicated that R27 should have an immobilizer brace on the right leg any time R27 is transferring and ambulating. CNA G indicated CNA G did not place the brace on as CNA G usually puts it on in the a.m. when R27 gets up, but he was sent to the hospital overnight and didn't get back till mid-morning. On 06/19/24 at 2:45 PM, Surveyor interviewed Licensed Practical Nurse (LPN) I and reviewed R27's medical record for transfer status. LPN I indicated that R27 should have an immobilizer brace on the right leg when up and ambulating. On 06/20/24 at 10:01 AM, Surveyor interviewed PTA N and asked what R27's transfer status was. PTA N indicated that R27 is an assist of 1 pivot transfer. PTA N indicated that R27 is to wear an immobilizer brace to the right leg with any transfers and when up for the day for stability post knee surgery to prevent injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/24 at 1:02 PM, Surveyor interviewed DON B and asked the expectation of R27 to wear R27's immobilizer brace to the right knee. DON B indicated that R27 is to always wear the brace once out of bed and transfer to a wheelchair or bathroom. Surveyor indicated observations of CNA G transferring R27 from a wheelchair to a bed without an immobilizer. DON B indicated that CNA G should have transferred R27 with the right immobilizer brace for stability.

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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** 46693 Based on observation, interview and record review, the facility did not ensure each resident receives necessary respiratory care and services that is in accordance with professional standards of practice for 1 of 1 resident (R) reviewed for respiratory care. (R6) The facility did not clean oxygen filter, change nasal cannula tubing, and ensure R6 received oxygen at the ordered rate according to physician orders. This is evidenced by: R6 was admitted to the facility on [DATE] and has diagnoses that include acute and chronic COPD, congestive heart failure, stroke, stage 5 kidney disease, and is receiving hospice services. On 06/18/24 and 06/19/24, Surveyor observed R6 using oxygen via nasal cannula continuously via a black oxygen concentrator set at 2 liters per minute. Surveyor interviewed R6 on 06/18/24 at 10:17 AM. At that time, R6 stated he had trouble breathing and has been on oxygen continuous for years but does take it off when smoking. R6's medical record reveals physician orders as follows: -Start date: 04/12/24 Oxygen at 3 liters per minute via nasal cannula as needed for shortness of breath -Start date: 12/20/23 Change and label oxygen tubing as needed when Oxygen is in use -Start date: 12/20/23 TAN MACHINE-Clean O2 filter with warm water, dry with towel, and replace BLUE MACHINE-Clean the air intake vents on the back of the machine as needed when oxygen is in use. (R6 is currently using a black oxygen concentrator. Facility did not provide the manufacturer instructions or policy and procedure for oxygen/respiratory care as requested.) On 06/19/24, Surveyor was unable to locate any information within R6's medical record as to when R6's nasal cannula was changed and oxygen concentrator filter was washed. On 06/19/24 at 1:42 PM, Surveyor interviewed Licensed Practical Nurse (LPN) H about the amount of oxygen R6 is to be receiving. LPN H stated, I think R6 is on 2 liters per minute, then looked up the order that read Oxygen at 3l/min via NC as needed. LPN H clarified that R6 has been using oxygen continuously. Surveyor asked if LPN H could tell when R6's tubing was changed and oxygen filters were washed. LPN H reviewed the medical record and stated, No one is signing it out, so I am not sure, I can do this after I finish passing medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Shell Lake Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 802 E Cty Hwy B Shell Lake, WI 54871	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor saw Director of Nursing (DON) B in hallway and asked DON B to come to R6's room. DON B confirmed R6's oxygen flow rate was at 2 liter per minute instead of the correct order for 3 liters per minute. Surveyor asked how often the tubing is changed and filters are rinsed. DON B stated they are done weekly on the night shift and could not find a date on the nasal canula tubing. Surveyor then removed the filter on the back of the oxygen concentrator and there was visible dust, light beige in color, on the black filter. DON B stated the concentrator is from hospice and R6 only had it about 2 weeks. DON B stated she will address these issues.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, staff and resident interview, and record review, the facility did not have sufficient nursing staff to ensure the highest practicable physical, mental, and psychosocial well-being. This occurred for 3 of 12 residents reviewed (R4, R9, R2) This is evidenced by: The Facility Assessment staffing plan updated on 01/2023, indicated licensed nurses providing direct care; 5 (average 40-50 hours), and nurse aides: 12 (average 90-96 hours). Review of facility schedules and daily postings confirmed staff hours aligned with Facility Assessment. Surveyor observations of call light times, mechanical lift transfers, toileting, and hygiene assistance indicated the facility was not adequately staffed to meet resident needs. The facility provided additional information related to resident needs during the survey period from 06/18/24-06/20/24, confirming 33 residents are dependent on staff for needs related to activities of daily living, 15 residents are dependent on staff for mechanical lift transfers. Staff interviews confirmed the facility required two trained staff to assist with mechanical lift transfers. The facility policy titled General Care of Residents, revised on 06/2018, stated in part . 9. Call Lights a. Staff will respond to call lights timely. b. If responding to a call light and you are assisting another resident, inform the resident you are assisting another resident and will return shortly and turn off call light. c. If other departmental staff answers call lights, let the resident know that you will tell the nursing staff and turn off the call light. Example 1 R4 was admitted to the facility on [DATE]. Diagnoses included heart failure, cellulitis of upper limb, chronic kidney disease, chronic obstructive pulmonary disease, and shoulder pain. R4 was admitted with a stage 1 pressure injury to right buttock. Minimum Data Set (MDS) assessment, dated 06/06/24, confirmed R4 scored 10/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R4's MDS assessment reported R4 is frequently incontinent of urine and always incontinent of bowel. R4 required substantial assistance with toileting, showering, and dressing, and was dependent on staff for transfers with mechanical hoyer lift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's care plan included: -Toileting plan: I am on a toileting schedule. Take me upon rising, before meals, after meals, bedtime, and as needed during the night, 05/31/24. The following occurred on 06/19/24 during a continuous observation from 10:22 AM-11:41 AM, for 79 minutes. Surveyor observed nine facility staff members (Director of Nursing, Assistant Director of Nursing, Physical Therapist, two licensed nursing staff, and four Certified Nursing Assistants), walk past R4's room while his call light was on, or turn off R4's call light without ensuring R4 received assistance. -10:22 AM, Surveyor observed R4 in his room, sitting in a Broda chair. Surveyor observed R4's call light was on and R4 was calling out stating he needed to use the bathroom. -10:54 AM, Surveyor interviewed CNA G. CNA G reported she was not assigned to R4's hall. CNA G stated she is working on the other hallway training CNA J. CNA G stated she assists on R4's hallway as she can as it is a heavy hall, but not all staff assist with answering resident call lights in unassigned areas. CNA G stated, With charting, no, I am not able to complete all of my workload. Surveyor observed CNA G and CNA J walk towards R4's room, where R4's call light was on. Surveyor observed CNA G and CNA J exit the hallway through a door immediately adjacent to R4's room. CNA G stated, We are finally going on break. Surveyor observed R4's call light continued to be on. -11:05 AM, Surveyor observed LPN I entered R4's room. R4 stated he needed to use the bathroom. LPN I turned off R4's call light and stated to R4 she would tell the staff. -11:17 AM, Surveyor observed R4's call light was off. Surveyor interviewed R4, R4 stated he needed to use the bathroom, and no one had helped him. Surveyor encouraged R4 to use his call light to request staff assistance. R4 did engage his call light and stated, It doesn't do any good anyway. -11:41 AM, Surveyor observed CNA D and CNA G assist R4 with mechanical lift transfer to his bed. Surveyor observed CNA D and CNA G assist R4 with incontinence care of both bowel and bladder. On 06/20/24 at 1:42 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A reported the facility considers resident acuity when developing staffing patterns. NHA A reported staffing is discussed each morning during the facility's morning meeting, and stated, We move things around based on what is discussed in morning meeting, admissions, discharges, change in condition. Surveyor reported to NHA A the observation of R4 requesting to use the bathroom and not receiving assistance for 79 minutes. NHA A did not make any statements related to the incident. 17661 Example 2 R9 has an active pressure related deep tissue injury to the right heel. R9 remains a high risk for the development of additional PIs related to comorbidities as well as immobility and bowel and bladder incontinence. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24, a continuous observation of 4 hours 41 minutes was conducted (7:18 AM - 11:59 AM) in which toileting and repositioning was not offered. Once staff did assist R9 onto the bed for incontinence care, R9's buttocks was red and wrinkled from no pressure redistribution and the incontinence of urine and feces. Interviews were conducted with staff in which they indicated staffing was insufficient on that day, with three new and one seasoned Certified Nursing Assistant working the two halls in which residents reside. Please refer to F677 and F686 for details. 48793 Example 3 R2 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, heart failure, anemia, and hypertension. Minimum Data Set (MDS) assessment dated [DATE] confirmed R2 scored 03/15 during Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. R2's MDS assessment reported R2 is frequently incontinent of urine and always incontinent of bowel. R2 required substantial assistance with toileting, showering, and dressing, and was dependent on staff for transfers. The follow occurred on 06/19/24 during a continuous observation from 1:05 PM-2:14 PM, for 1 hour and 9 minutes. Surveyor observed four facility staff members (Director of Nursing, two licensed nursing staff, and Activities Director) walk by R2's call light. On 06/19/24 at 1:05 PM, Surveyor observed R2's call light on when ambulating down the hallway. Surveyor observed CNA G walk past R2's call light and enter another resident room. On 06/19/24 at 1:06 PM, Surveyor entered into R2's room and asked how R2 was. R2 indicated that R2 had to use the bathroom badly and wanted to get into bed as R2 was tired. On 06/19/24 at 1:25 PM, Surveyor observed R2's call light still on. Surveyor observed CNA J walk by R2's room. On 06/19/24 at 1:41 PM, Surveyor observed R2's call light still on. Surveyor observed Activities Director E walk by R2's room. On 06/19/24 at 1:59 PM, Surveyor observed R2's call light still on. Surveyor observed DON B enter R2's room and ask R2 what R2's needs were. R2 indicated that R2 had to use the bathroom and get into bed. DON B turned the call light off and indicated that DON B would let a staff member know that R2 needed assistance in R2's room. Surveyor observed DON B exit R2's room and walk down the hallway. On 06/19/24 at 2:02 PM, Surveyor observed R2's call light go on again. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/19/24 at 2:14 PM, Surveyor observed CNA G entering R2's room. Surveyor interviewed CNA G and asked if DON B had informed CNA G that R2 needed assistance. CNA G indicated no DON B did not let CNA G know of R2's need. CNA G indicated that CNA G now had time to answer R2's call light.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46693 Based on observation, interview and record review, the facility did not provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections. The facility did not ensure proper infection control practices were followed during and after resident care. This occurred for 1 of 1 resident (R)1. Findings include: R1 was admitted to the facility on [DATE] with diagnoses that include dementia, cerebral palsy, stroke, type 2 diabetes, epilepsy, and left sided paralysis. R1's Minimum Data Set (MDS), dated [DATE], indicates R1 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. R1's care plan identifies that R1 is unable to walk and requires 2 assist for bed mobility, transfers, and toileting. R1 uses a broda chair and a hoyer lift. On 06/19/24 at 7:36 AM, Surveyor observed Certified Nursing Assistant (CNA) C and CNA D provide pericare for R1. CNA D provided the peri care, doffed gloves and did not sanitize hands and proceeded to grab hoyer sling, placed under R1, pushed curtain back, grabbed hoyer, attached sling, raised R1 up, placed R1 in a broda chair, donned gloves again, then grabbed R1's dentures. Surveyor stopped CNA D due to failure to sanitize hands after removing gloves following pericare. Surveyor asked CNA D if she forgot anything. CNA D stated she was not sure. Surveyor stated that CNA D should have sanitized her hands after doffing gloves from doing pericare and applying new gloves to then provide R1 denture care. CNA C discarded the soiled water from the wash basin in the sink with R1's denture cup present. Surveyor asked CNA C if it is common practice to discard the soiled water in the sink. CNA C stated she did not know that was a rule and apologized. On 06/19/24 at 8:50 AM, Surveyor interviewed DON B and was asked what the expectation would be for hand hygiene following doffing gloves and where dirty wash basin water should be discarded after use. DON B replied that hand hygiene should be completed every time after doffing gloves and basins should be emptied in the toilet.