STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525565	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not allow the resident representative the right to exercise their rights as delegated to the representative for 1 (R7) of 2 residents reviewed with an activated power of attorney. R7's power of attorney was not present for the admission of R7 into the facility and did not sign any admission consents or contracts. R7 had been deemed incapacitated by a physician and a psychologist prior to admission. R7 signed all admission consents and contracts while assessed to be incapacitated. Findings include: The facility policy and procedure titled Resident Representative and revised 2/2021 documents: The facility treats the decisions of the resident representative as the decisions of the resident to the extent delegated by the resident or to the extent required by the court, in accordance with applicable law. Policy Interpretation and Implementation . 2. If the resident is determined to be incompetent under the laws of the state by a court of competent jurisdiction, the rights of the resident will devolve to and will be exercised by the resident representative appointed to act on the resident's behalf. a. The court-appointed resident representative will exercise the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with state law. b. In the case of a resident representative whose decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. c. The resident's wishes and preferences are considered in the exercise of rights by the representative. d. To the extent practicable, the resident is provided with opportunities to participate in the care planning process. 3. The term resident representative is defined as: . b. A person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; . (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. a. The facility will treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or authorized by the resident (in accordance with applicable laws). b. If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility will report such concerns when and in the manner required under state law. c. The facility will not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident (in accordance with applicable laws). 6. Documentation designating that the representative has been delegated the necessary authority to exercise the resident's rights for decision-making issues is obtained by the director of nursing or a designee. a. To the degree permitted by state law, the facility staff respects the delegated resident representative's decisions regarding the resident's wishes and preferences so long as the resident representative is acting within the scope of authority contemplated by the agreement authorizing the person to act as the resident's representative. b. Whether or not the resident has been judged incompetent by a court of law, if it is determined that the resident understands the risks, benefits, and alternatives to a proposed health care decision and expresses a preference, the resident's wishes are considered to the degree practicable. 7. The resident may exercise his or her rights not delegated to a resident representative, including the right to revoke a delegation of rights (accept as limited by state law). 8. The director of nursing (or designee) is responsible for making reasonable efforts to obtain updates or changes that are made by the resident, including the resident's revocation of delegated rights, to ensure that the resident's preferences are being upheld. R7 was admitted to the facility on [DATE] with diagnoses of wedge compression fracture of T11-T12 vertebra, cancer of the lung, malnutrition, Parkinsonism, congestive heart failure, atrial fibrillation, emphysema, and peripheral vascular disease. R7's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R7 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and had a fall prior to admission. The Cognitive Care Area Assessment documented R7 had a current BIMS of 15, an activated Power of Attorney (POA) in place, and had some forgetfulness noted. R7 had completed a POA for Healthcare document on 3/27/2018 designating Family Member (FM)-Z as the primary POA and FM-AA as secondary POA if R7 should become incapacitated. The document was signed by R7, two witnesses, FM-Z as the healthcare agent, and FM-AA as the alternate healthcare agent. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7 was hospitalized from 6/9/2024 to 6/14/2024 with a T12 compression fracture and on 6/11/2024 was found to be incapacitated by a physician and a psychologist therefore activating the POA, and making FM-Z R7's responsible party. The hospital Social Worker documented on 6/12/2024 in a progress note that the activated POA was contacted to discuss discharge arrangements from the hospital. FM-Z returned the call on 6/13/2024 and the Social Worker documented FM-Z was given a list of subacute rehab referrals; FM-Z approved of referrals to the facilities provided. The hospital Discharge Summary dated 6/14/2024 documents the physician had an in-depth conversation with FM-Z regarding R7's medications, a final plan about the several medical issues, and the Do Not Resuscitate wishes R7 had expressed with the admitting physician. The Hospital Face Sheet documented FM-Z was the active substitute decision maker. The hospital documentation was provided to the facility prior to and upon R7's discharge from the hospital to the facility. R7's Admission Sheet completed by the facility prior to R7 being admitted documented R7 would be admitted on [DATE] and had an activated POA for healthcare. On 6/14/2024 at 12:25 PM, R7's progress notes written by Admissions-R documented R7's POA was activated at the hospital and documented R7's POA as FM-Z. At 8:02 PM in the progress notes, Admissions-R documented Admissions-R sat with R7 and went over the admission packet and paperwork. Admissions-R documented R7 signed: payor source verification, informed consent for telemedicine, Medicare coverage, consent to treat, transportation policy, authorization for disclosure of contact information, influenza vaccine, pneumonia vaccine, TB risk assessment, and Advanced Directives; discharge planning was started. The following forms were signed on 6/14/2024 by R7 and scanned into R7's medical record: -Skilled Nursing Facility Services Agreement -Advanced Directives (for code status) -Resident Social History -Responsible Person Agreement -Resident Rights -Resident Responsibilities -Resident Grievance/Concern Procedures -HIPAA Notice of Privacy Practices -Privacy Act Statement - Health Care Records -TB Skin Test -Consent to Administer Influenza Vaccine -Pneumococcal and Prevnar Vaccine Administration Assessment and Consent Form (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Authorization for Disclosure of Contact Information -Consent to Treat -Informed Consent for Your Telemedicine Visit -Wisconsin Tuberculosis (TB) Risk Assessment and Symptom Evaluation -Medicare Coverage -Transportation Policy No documentation was found indicating that FM-Z was contacted or provided admission paperwork. FM-Z's signature was not found on any documentation in R7's medical record. On 6/18/2024 at 10:00 AM, in R7's progress notes, Social Worker (SW)-I documented a Care Conference was held with the IDT, R7, and FM-Z. At 11:38 AM in the progress notes, SW-I documented FM-Z sent an email about concern for R7 wanting to go home and FM-Z wanted to meet with SW-I to discuss Assisted Living Facilities (ALFs). SW-I documented R7 was very against going to an ALF and wanted to return home. SW-I documented SW-I informed FM-Z that SW-I was more than happy to speak with FM-Z about this but also informed FM-Z that regardless of if the POA was active or not, they cannot force R7 to go to an ALF. FM-Z was provided with Ombudsman-T's number in case FM-Z had concerns regarding the rights as Active POA. On 6/18/2024 at 2:04 PM in the progress notes, Director of Rehab (DoR)-U documented a care plan meeting was held that day with the IDT, R7 and FM-Z on the phone. Therapy goals were discussed, and discharge planning was completed with R7 reporting that R7's goal was to return home. Home physical therapy (PT), occupational therapy (OT), and Home Health Aide (HHA) was recommended upon discharge. On 6/22/2024 at 2:07 PM in the progress notes, nursing documented FM-BB arrived to take R7 home and was informed R7 was not able to go home because the physician and insurance had not released R7. FM-BB stated FM-BB was going to take R7 home and they could not keep R7 at the facility like a prisoner. Nursing staff explained to FM-BB that FM-Z did not want R7 to leave the facility. FM-Z was contacted via the phone and FM-Z talked to R7 to explain the situation to R7. FM-BB had removed some of R7's belongings and put them in the car. The police were notified and spoke to FM-BB who then brought back R7's belongings. On 6/23/2024 at 3:21 AM in the progress notes, nursing documented at approximately 10:00 PM on 6/22/2024, R7 came out of the room fully dressed with a walker and a suitcase. R7 stated FM-BB was going to pick R7 up and R7 wanted to wait. Nursing documented nursing explained that FM-Z would not allow that to happen and reminded R7 of the incident that happened earlier that day. R7 went to sit on the couch in front of the TV and then went back to R7's room to watch TV. Frequent checks were made for safety and to decrease the risk of elopement. No other situations occurred throughout the night. Safety measures were in place and the call light was within reach. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/2024 at 2:57 PM in the progress notes, SW-I documented SW-I had a long conversation with R7 about R7's wants. R7 did not want to go to an ALF while FM-Z was insisting R7 had to. R7 stated R7 barely had any contact with FM-Z and FM-AA until R7's POA was activated. R7 stated FM-Z wants R7 to go into an ALF so FM-Z can live in R7's house rent free. R7 could not recall when FM-Z was picked to be R7's POA and does not want FM-Z to be the POA. SW-I documented SW-I had spoken to Ombudsman-T about this and Ombudsman-T told SW-I that R7 had the right to revoke the POA whether R7 was activated or not. R7 felt FM-Z was abusing their POA power and would like FM-BB to be the POA since FM-BB might start living with R7 as R7's caretaker. On 6/24/2024, R7 signed a Revocation of Power of Attorney for Health Care form removing both FM-Z as the primary POA and FM-AA as alternate POA. R7 no longer had a designated decision maker. On 6/25/2024 at 10:09 AM in the progress notes, SW-I documented SW-I spoke with an APS SW about R7. Per the APS SW, APS had been working with FM-Z for years to have R7's Primary Care Physician (PCP)-X sign to make R7 incapacitated but PCP-X would not sign it and now R7's POA had been activated in the hospital. SW-I documented the APS SW seemed very biased towards FM-Z and made it known that SW-I should have been in full contact with FM-Z regardless of what R7 wanted. R7 wanted to go home and made allegations that FM-Z was wanting to live in R7's house rent free and had been stealing money out of R7's account. SW-I documented the APS SW said that SW-I revoked the POA and R7 is activated so R7 cannot sign a different POA document and the facility must file for guardianship. SW-I documented SW-I needed clarification on this as Ombudsman-T made it sound like R7 could still sign a new POA document if two witnesses were present. SW-I documented R7 was very distraught by this whole process and said R7 needed someone to advocate for R7 and be on R7's side as R7's family was always making decisions about R7 that R7 does not want. SW-I documented the APS SW claimed that the house was in R7's name and that FM-BB stands to gain it after R7 passes. R7 does not want to sell the house and per the APS SW, FM-Z and FM-AA are trying to sell it so R7 can go to an ALF. R7 was very against an ALF and wants to go home where R7 is comfortable. The APS SW said that FM-BB was not living with R7 but R7 and FM-BB said that FM-BB was. On 6/25/2024 at 1:59 PM in the progress notes, SW-I documented PCP-X was going to assess R7 the next day. On 6/25/2024 at 3:58 PM in the progress notes, Business Office Manager (BOM)-V documented BOM-V met with R7 to discuss the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN). BOM-V documented BOM-V explained R7 was covered through 6/27/2024 and would discharge on 6/28/2024. R7 said FM-BB would be taking R7 home around 11:00 AM on Friday (6/28/2024). BOM-V documented a voicemail was left for FM-AA as well to inform FM-AA of the insurance update. The NOMNC and SNFABN paperwork was signed by R7 on 6/25/2024. No other family members witnessed or were a part of the conversation regarding the end of coverage. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2024 at 11:47 AM in the progress notes, SW-Y documented SW-Y spoke with R7's POA, FM-AA. Surveyor noted R7 did not have a designated POA at this time due to the revocation and FM-AA was revoked as the alternate POA. SW-Y explained to FM-AA that FM-Z was revoked from being the POA which bumped FM-AA up to R7's primary POA. SW-Y documented R7 was to be discharged on Friday. FM-AA stated that FM-AA was not okay with that and R7 needed to be in an ALF or nursing home. SW-Y informed FM-AA that the facility had suggested an ALF several times to R7 and R7 refused. FM-AA then questioned what the point of being a POA was if FM-AA had no say in what goes on with R7's care. SW-Y informed FM-AA that per Ombudsman-T, the state agency for resident rights, R7 gets to make the call of what R7 wants to do and that we cannot deny R7 that right, with or without a POA. SW-Y told FM-AA that R7 would be discharged with home health to make the transition back home a little easier. FM-AA stated FM-AA understood and requested that SW-Y call FM-Z to explain to FM-Z what is going on. SW-Y told FM-AA SW-Y could not do that as FM-Z was no longer R7's POA. FM-AA did not agree with R7's decision to go back home but stated if FM-AA has no say, then it is what it is and that FM-AA would be there on Friday. On 6/26/2024 at 1:00 PM in the progress notes, SW-Z documented FM-BB called and explained that R7 was calling FM-BB saying that R7 can go home on Friday. Since FM-BB was not the POA, FM-BB stated FM-BB would prefer FM-AA, the Active POA, to pick up R7. Surveyor noted R7 did not have a designated POA at this time due to the status of incapacitation. FM-BB stated that FM-BB does not want to be in the middle of R7 and FM-AA. FM-BB stated once R7 returns home, FM-BB would be there to assist R7, such as going to the store, the doctors, etc., however FM-BB does not want to stay there since FM-BB is not the active POA and does not want to get caught up in the mess. SW-Y informed FM-BB that R7 was being taken care of and that R7 would receive the support R7 needs along with receiving home health upon discharge. On 6/26/2024 at 5:22 PM in the progress notes, SW-I documented APS SW-S visited with R7 and then came to speak with SW-I. R7 had revoked both FM-Z and FM-AA as POAs but from the hospital was still deemed incapacitated and does not currently have a decision maker. APS SW-S felt that since both sides of the family were fighting over R7 and R7's house that the best option at that point would be to file for guardianship so the courts could handle the family dynamic and it can be decided/finalized. APS SW-S said SW-I would need a letter from PCP-X stating incapacity. SW-I spoke with PCP-X's nurse who said that PCP-X would like to look over the documents again before writing the letter but will get it to SW-I by Friday. PCP-X's office also noted how R7's family has been fighting over R7 for a while and the family will call PCP-X's office over it. SW-I went to speak with R7 to update R7 and R7 was upset but also said R7 understood what had to happen now. On 6/26/2024 at 5:37 PM in the progress notes, SW-I documented SW-I spoke to FM-AA and FM-BB as per APS SW-S suggested as they would be the candidates for guardianship. SW-I did not document what the conversation entailed. On 6/28/2024, PCP-X faxed a letter to the facility documenting R7 had undergone a psychological evaluation with a Neuropsychologist where R7 was found to have a neurocognitive disorder. PCP-X agreed that R7 was unable to make rational decisions with regard to R7's healthcare or fully understand R7's medical condition and need for care. PCP-X was the third medical professional to deem R7 incapacitated. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/5/2024 at 2:01 PM, BOM-V stated BOM-V provided R7 with the NOMNC and SNFABN paperwork on 6/25/2024. BOM-V stated BOM-V saw R7 had revoked the POA, so BOM-V had R7 sign the NOMNC and SNFABN and then notified FM-AA and FM-BB of the NOMNC and SNFABN because BOM-V did not know what to do with no resident representative or POA in place. BOM-V stated BOM-V wanted to cover all the bases and notify anyone that would need to know. In an interview on 11/6/2024 at 8:09 AM, APS SW-S stated R7 was admitted to the facility with an activated POA and R7 wanted to discharge home. APS SW-S stated the activated POA, FM-Z, did not feel it was safe for R7 to go home. APS SW-S stated FM-Z had a lot of concerns such as R7 had no food or medications at home. APS SW-S stated FM-Z wanted R7 to enroll in Medicaid and R7 was told R7 would lose the house so if there was no POA, R7 could keep the house. APS SW-S stated R7 thought if R7 revoked the healthcare POA, both primary and secondary, R7 would be able to go home. APS SW-S stated with R7 revoking the POA, maybe the facility thought that would be an easy discharge. APS SW-S stated PCP-X determined R7 was still incapacitated so APS SW-S recommended the facility seek guardianship for R7. APS SW-S stated APS SW-S and the APS supervisor talked to their legal counsel about the process needed to have a decision maker for R7 since R7 revoked the POA and APS SW-S told the facility to consult with their attorneys to have the courts involved. APS SW-S stated the facility documented in R7's chart that the family could create a new POA per PCP-X which was not true. APS SW-S stated PCP-X was confused about revoking R7's POA when R7 was incapacitated. APS SW-S stated R7 did not have a decision maker on discharge. In an interview on 11/6/2024 at 9:31 AM, ANHA-D stated Admissions-R no longer is employed at the facility and was aware R7 was incapacitated at the time of admission requiring the POA to sign the admission paperwork. ANHA-D stated ANHA-D was not sure what happened at that time, but ANHA-D would have called the hospital to get the advanced directives. ANHA-D stated SW-I informed ANHA-D and Nursing Home Administrator (NHA)-A that R7 did not want FM-Z or FM-AA as R7's POA anymore because FM-Z and FM-AA were going to sell R7's house and take the money. ANHA-D stated R7 was angry at FM-Z and FM-AA. ANHA-D stated SW-I contacted Ombudsman-T and was told R7 could revoke the POA. ANHA-D stated SW-I ran with that and had R7 revoke the POA. ANHA-D stated now that R7's POA was revoked, ANHA-D did not know what the next step was but knew something needed to be done. Surveyor asked ANHA-D if the facility filed for guardianship. ANHA-D stated they did not do anything to obtain guardianship that ANHA-D was aware of. ANHA-D stated there was a conversation with corporate but could not recall the details of the conversation. In an interview on 11/6/2024 at 10:22 AM, Surveyor asked SW-I once R7 revoked FM-Z as the POA, what was done to get a decision maker for R7. SW-I stated SW-I made Corporate aware and SW-I had nothing more to do with it. Surveyor asked SW-I what Corporate's directive to SW-I was. SW-I stated SW-I kept Ombudsman-T involved and from what SW-I knew, nothing was done legally. SW-I stated APS is responsible for that in the state SW-I was from and was not sure what the protocol is for this state. SW-I stated Corporate and Administration would handle this type of situation, it was too big for SW-I to handle. On 11/6/2024 at 3:00 PM, Surveyor shared with Director of Operations-C, Director of Nursing-B and ANHA-D the concerns R7 had an activated POA, FM-Z, that was not involved in the admission process, and when R7 revoked their POA, Social Services did not assist R7 with completing an advanced directive, such as guardianship to represent R7. No additional information was provided.

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	525565	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview, and record review the Facility did not address and resolve grievances conveyed on behalf of 4 (R2, R5, R10 and R12) of 4 residents reviewed for grievances. * R2's dialysis social worker contacted the Facility on numerous occasions with concerns that were not recorded or investigated. * R5's Power of Attorney (POA) filed a grievance related to medication administration that was not thoroughly investigated. * R10 expressed care concerns. There was not documentation they the concerns were thoroughly investigated, along with appropriate resolution. * A grievance was filed on behalf of R12 by Hospice for neglect when R12 was found in bed soiled and wet. The grievance was not thoroughly investigated. Findings include: The Facility Policy titled Grievance with no implementation or revision date documents (in part): Policy: It is the policy of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their stay. The facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed throughout the investigation and resolution process. The facility grievance process will be overseen by the Administrator, Grievance Official, who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations, maintaining the confidentiality of all information associated with grievances, communicate with residents and resident representative throughout the process to resolution and coordinate with other staff and with state or federal agencies as may be indicated by specific allegations. The facility will provide a mechanism for filing a grievance/complaint without fear of retaliation and/or barriers of service; will provide residents, resident representatives and others information about the mechanisms and procedure to file a grievance; provide a designated individual to oversee the grievance process; provide a planned, systematic mechanism for receiving and promptly acting upon issues expressed by residents and resident representatives and will provide an ongoing system for monitoring and trending grievances and complaints. OBJECTIVE OF GRIEVANCE POLICY (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The objective of the grievance policy is to ensure the facility makes prompt efforts to resolve grievances a resident may have. The intent of the grievance process is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost articles, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident and resident representative appropriately apprised of its progress toward resolution. The grievance policy will be reviewed on an annual basis or more frequently and will be integrated into the facility Quality Assurance and Performance Improvement Program (QAPI). 1.) R2 was admitted to the facility on [DATE] and has diagnoses which include, in part, type 2 diabetes with foot ulcer, end stage renal disease, dependence on renal dialysis, and dementia. R2's annual Minimum Data Set (MDS) with an assessment reference date of 5/24/2024 indicated R2 had a Brief Interview for Mental Status score of 11 (moderately impaired cognition). R2 is able to make decision for themselves. R2's MDS showed that no behaviors were noted. R2 is always continent of bladder and bowel. The MDS noted that R2 receives dialysis. On 11/5/2024, at 9:10 AM, Surveyor interviewed DON (Director of Nursing)-B and asked about the phone calls from the dialysis center regarding medications not given to R2 and DON-B stated that they did not know or remember any calls. DON-B stated DON-B would look into these calls. On 11/5/2024, at 9:35 AM, Surveyor interviewed Social Worker (SW)-E from DaVita, the dialysis center R2 visited, who informed Surveyor that they contacted the Facility on numerous occasions regarding R2's complaints of not enough staff and medications not given at all or incorrectly. Surveyor asked if R2 was a good historian and SW-E stated that R2 was alert and oriented and knew staff names and was good at remembering details. SW-E agreed to fax progress notes to Surveyor to review related to contact with Facility. Surveyor reviewed the Facility's Grievance Log but did not locate any grievances for R2. On 11/5/2024, at 10:06 AM, Surveyor received the fax from DaVita and reviewed the progress notes. On 3/27/2024, at 7:43 AM, progress note reads Patient reported today that he had no medications all day yesterday at nursing home. Pt (patient) came with elevated BP's (blood pressures), reported concerns to DON (Director of Nursing) at NH (Nursing Home) . On 5/13/2024, at 10:05 AM, progress note reads Pt (patient) reported dissatisfaction with SNF (Skilled Nursing Facility) at this time d/t (due to) lack of staff and per pt. 'I only got 2 of my 12 pills this morning and my bp was in the 200's when I came here', RN (Registered Nurse) confirmed bp was 209/73. MSW (Master of Social Work) called and spoke to ADON (Assistant Director of Nursing) and relayed concerns. ADON reported she will further look into and address accordingly . (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/2024, at 11:34 AM, progress note reads BP (blood pressure) continues to be elevated, patient stated 'All my medications were given today in powdered form which is very unusual' MD (medical doctor) advised patient to report to RN in charge if anything is looking different. IDT (interdisciplinary team) called DON at Nursing home and reported this concern. Spoke with RN . who stated 'We are not sure what he took, but night nurse was from agency'. RN advised to educate all other RN's to follow up MAR (Medication Administration Report) and give patient correct medications and on time. Verbalized understanding . On 6/10/2024, at 8:21 AM, progress note reads patient with c/o (complaint of) SNF not giving binder at mealtime or miss dose of binder. RD (registered dietician) has faxed phosphorus lab results to SNF with note of importance of giving Sevelamer with meals . On 6/25/2024, at 8:29 AM, progress note reads BP's continue to be issue d/t not given as ordered to NH. This communicated with DON at NH. Surveyor notes 5 documented times the Facility was contacted regarding concerns and that no grievances were filed to show investigation was completed. On 11/6/2024, at 8:35 AM, Assistant Nursing Home Administrator (ANHA)-D and DON-B confirmed with Surveyor that there was nothing completed for grievances after the DaVita calls. On 11/6/2024, at 2:59 PM, during the daily exit meeting with the Facility, Surveyor shared the concern that contact from DaVita regarding medications and staffing were not recorded as grievances and investigated. ANHA-D, DON-B and Director of Operations-C were present. No additional information was provided. 2.) R5 was admitted to the facility on [DATE] and has diagnoses which include, in part, encephalopathy, vascular dementia, benign neoplasm colon, muscle weakness and general anxiety disorder. R5's quarterly Minimum Data Set (MDS) with an assessment reference date of 10/30/2024 indicated R5 had a Brief Interview for Mental Status score of 99 (unable to complete interview). R5 has an activated Power of Attorney (POA). R5's MDS showed that a wheelchair is used for mobility. R5 has an indwelling catheter and is always incontinent of bowel. R5 is coded as being on hospice. On 10/20/2024, R5's POA filed a grievance with Social Worker (SW)-I. SW-I wrote that I received a text about 9 PM from Activated POA that R5's meds (medications) were not passed. The witnesses section was left blank. The investigation section reads I went into unit and spoke with R5's nurse who reassured me that meds were received. I checked on R5 who was sleeping peacefully in bed. The resolution sections reads I scheduled a care conference with R5, MD (medical doctor), Director of Nursing (DON) and SW to speak about med concerns. Some meds (medications) were changed to help R5 sleep. Surveyor notes the only investigation was to interview the nurse. No other witnesses were interviewed. The medication record was not reviewed. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/2024, at 10:44 AM, Surveyor interviewed SW-I who stated that they spoke with two nurses on the unit that night. The SW-I stated they did nothing further because R5 was not in distress. When asked if the medication administration record was reviewed SW-I stated yes, but that the actual medication cards were not reviewed. SW-I stated that the issue was the POA felt R5 was restless at night and texted because worried and could not come out that night. Since R5 was sleeping SW-I felt there was no issue. On 11/6/2024, at 2:59 PM, during the daily exit meeting with the Facility, Surveyor shared the concern that a grievance was filed but not thoroughly investigated regarding medications being given to R5. ANHA-D, DON-B and Director of Operations-C were present. No additional information was provided. 47094 3.) R12 was admitted to the facility on [DATE] with a diagnosis that includes cellulitis of right and left lower limbs, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, chronic pain, chronic peripheral venous insufficiency, dysphagia, heart failure, syncope/ collapsing, and adult failure to thrive. R12's significant change minimum data set (MDS) dated [DATE] indicated R12 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 and the facility assessed R12 needing total assist with one staff member for toileting hygiene, repositioning, lower body dressing and minimal assist with one staff member for upper body dressing and personal hygiene. R12 was incontinent of bowel and bladder and wore a protective brief. R12 required a Hoyer lift transfer with assist of two staff members for transferring. R12 was enrolled into Hospice services on 8/9/2024 for COPD. A grievance was filed with the facility on 9/6/2024 reporting that R12 was found by hospice staff on 8/28/2024 with urine and feces on R12 and that facility staff would not help hospice staff when R12 experienced a fainting episode that same day. Hospice staff stated they reported the concerns to the nurse on duty and that R12 stated R12 felt neglected to the hospice staff. On 11/5/2024, at 8:10 AM, Surveyor observed R12 lying in bed. R12 appeared to be comfortable and content. Surveyor asked R12 how R12 liked being at the facility and how staff were. R12 replied that R12 enjoyed the facility and staff were great. Surveyor asked if there was a time R12 ever felt neglected or felt like staff were not meeting R12's needs. R12 replied R12 could not remember a time R12 felt neglected and stated staff assist R12 as needed. Surveyor asked if R12 remembered a time when R12 was wet and dirty in the morning and hospice assisted R12 to be cleaned. R12 replied that R12 could not remember that ever happening. Surveyor reviewed in R12's hospice binder and noted hospice nursing and CNA notes dated 8/28/2024 that documents: Hospice Nurse: -Routine visit, vital signs stable. (R12) became unresponsive with syncope (fainting) episodes when in shower. (R12) put back to bed and back to (R12's) baseline. (R12) denied pain, wound care was provided. (Hospice nurse) told floor staff resident felt neglected. Hospice CNA: (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Transfer/ shower/ dressing/ hair care/ skin care/ oral care/ incontinence care (provided for R12), Xlg (extra-large) incontinence and medium BM (bowel movement). (R12) provided fluids and socialization period. (completed) light housekeeping, trash emptied, and linens changed. On 11/5/2024, at 1:21 PM, Surveyor interviewed Registered Nurse (RN)-P who stated RN-P recalled being approached by the hospice staff regarding R12 but could not recall specific details. Surveyor asked RN-P if RN-P recalled concerns with R12 being found wet and soiled. RN-P stated she did recall that and when she went to check on R12, R12 had already gotten a shower, dressed, and was back in bed. RN-P stated that RN-P educated with the certified nursing assistants (CNA's) on the unit to remember to check residents often. On 11/8/2024, at 8:41 AM, Surveyor interviewed Assistant Nursing Home Administrator (ANHA)-D who stated ANHA-D was not notified of the grievance until 9/6/2024. The grievance was related to R12 that was reported from Hospice via phone call from the hospice social worker. ANHA-D stated when the concern from hospice came through on 9/6/2024 ANHA-D started an investigation into the concern. Surveyor attempted to interview NHA-A regarding the above concern, however NHA-A was not feeling well during survey and was not available for interviews. Surveyor reviewed the investigation and noted that no other residents were interviewed, and staff education was not included. On 11/6/2024, at 9:00 AM, Surveyor shared with ANHA-D that the investigation did not include resident interviews or staff education. ANHA-D stated that ANHA-D recalled talking with residents and that education was provided at an all staff that same month. On 11/6/2024, at 10:33 AM, Surveyor received education from an all staff meeting that was dated 9/27/2024. ANHA-D stated that the all staff meeting including education on abuse, neglect, etc. and believed the situation with R12 was included with that. Surveyor reviewed the sign in sheet and noted that not all staff was present for the education. ANHA-D stated that the education would have been done at the all staff meeting on 9/27/2024. Surveyor shared concern with ANHA-D that education that was provided, did not include all staff after the concern of neglect was reported to the facility on [DATE] and that it should have included all staff and the specific concern with R12. On 11/6/2024, at 11:17 AM, ANHA-D shared with Surveyor that other residents were not interviewed regarding patient cares on 8/28/2024. ANHA-D stated that audits were done on residents that resided in the same hall as R12 on 9/8/2024, 9/9/2024, and 9/10/2024 and observed if the residents were clean, dry, and cared for. Surveyor asked ANHA-D why residents were not interviewed regarding if there were any concerns with care on 8/28/2024. ANHA-D stated that ANHA-D thought the audits were enough. Surveyor explained that residents should have been interviewed to determine if there were any other care concerns the same day R12 had a concern on 8/28/2024 and that the audits were a good tool to use for the any follow up to concerns and education provided to staff, but residents should have been interviewed. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/2024, at 3:00 PM, Surveyor shared concerns with ANHA-D, Director of Nursing (DON)-B, and Director of Operations-C that the concern of neglect for R12 reported to RN-P was not reported and investigated on 8/28/2024 until a grievance was filed by the hospice agency on 9/6/2024 and that the investigation was not thoroughly investigated by getting resident interviews or educate staff after the concern was reported. No additional information was provided. 21855 4.) R10 was admitted to the facility on [DATE]. R10 is their own person and obtained a left hip fracture in the community. R10's admission MDS (minimum data set) completed 5/27/24 documents that R10 has no cognitive impairments, assistance with transfers and dressing. R10 was discharged home on 6/10/24. On 5/22/24, R10 expressed a grievance to (Social Worker) SW-I. The concern occurred on 5/20/24 and 5/22/24. R10 expressed long call light response time in the morning, a (Certified Nursing Assistant) CNA would not close their blinds when asked, then reactivated their call light, and it took another 30 minutes. On 5/20/24 R10 soiled themselves due to long wait time. The Investigation states: Social Services spoke with the (Director of Nurses) about the concern. The DON plans on finding out who the CNA's were and attempting to re-educate them. The Resolution states: Followed up with nursing who identified the CNA's involved from agency and marked them unable to come back. On 11/5/24, at 8:45 AM, Surveyor interviewed SW-I. SW-I stated they review concerns with the stand-up meetings. SW-I directs the concern to the appropriate department. They shared this concern with the (Director of Nurses) at that time. That DON no longer works at the facility. SW-I stated they did not attach any interviews or call logs. They were new at the time and have gotten better. SW-I stated they just had the agency staff that worked with R10 on the do not return list. There are not staff statements documented to determine possible causes of delayed response. There are not resident interviews documented to determine others potentially affected. There is not documented resolution that identifies the cause and a plan to prevent reoccurrence. On 11/5/24, at 8:55 AM, Surveyor shared concerns with (Director of Nurses) DON-B and (Director of Operations) DOO-C. The DON-B did not recall the concern. On 11/5/24, at 3:03 PM, Surveyor shared the investigation concerns with DON-B, DOO-C and (Assistant Nursing Home Administrator) ANHA-D. No additional information provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47094 Based on interview and record review the facility did not report 4 (R12, R9, R10, and R5) allegations to the Nursing Home Administrator or the State Agency during the required time frames. * R12 had an allegation of neglect on 8/28/2024 that was not reported to the Nursing Home Administrator (NHA) until 9/6/2024 when a grievance was filed. The allegation/grievance was not reported to the State Agency. * R5's injury of unknown origin was not reported to the Nursing Home Administrator (NHA) or state agency. * R9 had an injury of unknown origin and was not reported to the state agency. * R10 expressed in a Grievance that staff did not answer the call light timely. This resulted in R10 having an incontinent episode. Findings include: The facility policy entitled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating revised September 2022 documents: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The State licensing/ certification agency responsible for surveying/ licensing the facility. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury. b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions if any are needed for the protection of residents. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) R12 was admitted to the facility on [DATE] and has diagnoses that include cellulitis of right and left lower limbs, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, chronic pain, chronic peripheral venous insufficiency, dysphagia, heart failure, syncope/ collapsing, and adult failure to thrive. R12's significant change minimum data set (MDS) dated [DATE] indicated R12 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 and the facility assessed R12 needing total assist with one staff member for toileting hygiene, repositioning, lower body dressing and minimal assist with one staff member for upper body dressing and personal hygiene. R12 was incontinent of bowel and bladder and wore a protective brief. R12 required a Hoyer lift transfer with assist of two staff members for transferring. R12 was enrolled into Hospice services on 8/9/2024. A grievance was filed with the facility on 9/6/2024 reporting that R12 was found by hospice staff on 8/28/2024 with urine and feces on R12 and that facility staff would not help hospice staff when R12 experienced a fainting episode that same day. Hospice staff stated they reported the concerns to the nurse on duty and that R12 stated R12 felt neglected to the hospice staff. On 11/5/2024, at 1:21 PM, Surveyor interviewed registered nurse (RN)-P who stated RN-P recalled being approached by the hospice staff regarding R12 but not specific details. Surveyor asked RN-P if RN-P recalled concerns with R12 being found wet and soiled. RN-P stated she did recall that and when she went to check on R12, R12 had already gotten a shower, dressed, and was back in bed. RN-P stated that RN-P educated with the certified nursing assistants (CNA's) on the unit to remember to check residents often. Surveyor asked RN-P if RN-P reported the concern from hospice to anyone. RN-P could not remember, RN-P stated that R12 also had a fainting episode, so RN-P was probably more concerned with that so probably did not mention anything. On 11/6/2024, at 9:00 AM, Surveyor interviewed assistant nursing home administrator (ANHA)-D who stated ANHA-D was not notified until the grievance on 9/6/2024 concerning R12. ANHA-D stated when the concern from hospice came through on 9/6/2024 NHA-A and ANHA-D started an investigation into the concern. Surveyor asked why the concern was not submitted to the state agency. ANHA-D stated that it never dawned on ANHA-D to submit a report, as ANHA-D just wanted to see what happened. Surveyor shared concern that the concern should have been reported on 8/28/2024 when facility staff were notified and on 9/6/2024 when ANHA-D was notified. No additional information was provided. 20025 2.) R9 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, poly neuropathy, hypertension and atrial fibrillation. The significant MDS (minimum data set) dated 8/30/24 indicate R9 is cognitively impaired. Surveyor reviewed the facility self report dated 8/17/24 which indicated on 8/17/24 R9 was observed with bruising to the left side of her face. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525565	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation indicate on 8/17/24 at 12:30 a.m. CNA (certified nursing assistant) DD observed R9 in bed with facial bruising to the left side of the head. It indicates CNA-DD notified RN (registered nurse) EE regarding the bruising and RN-EE Stated R9 had a fall on 8/13/24. The investigation indicates it wasn't until the first shift staff came on shift that R9 was assessed and was discovered to have bruising to the left side of her face. The nurses note dated 8/17/24 at 6:21 a.m. indicate at 0600 writer went into room to take resident vitals and give Synthroid. Observed patient in bed lying on her side. Patient had a hand sized bruise noted to left forehead with small 3 cm laceration noted to middle of bruise. Patient was in low bed sleeping on side. Writer (RN-EE) and CNA (CNA-DD) walked past room many times from 2330 to 06 and observe patient sleeping in bed. At 0600 patient was in bed with covers pulled up. No blood was noted to sheets. Assessment was done. AM nurse called family, notified family, notified DON, notified MD. 911 was called and patient was transported to (hospital) for treatment and evaluation. The investigation indicate when R9 returned to the facility from the hospital, at 1:20 p.m. the NHA (nursing home administrator)-A was notified of the injury of unknown origin and the significant injury. NHA-A then began the investigation and contacted the state agency and police. On 11/5/24 at 2:00 p.m. Surveyor interviewed DON-B. DON-B stated NHA-A is not feeling well and is not in the facility. Surveyor explained R9 injury of unknown source was significant, and this was not reported to NHA-A, the state agency and the police within 2 hours. DON-B stated she understood the concern and had no additional information. 21855 3.) R10 was admitted to the facility on [DATE]. R10 is their own person and obtained a left hip fracture in the community. R10's Admission (minimum data set) MDS assessment completed 5/27/24 documents no cognitive impairments, assistance with transfers and dressing. The MDS assessment also documents that R10 required assistance from staff for toileting and transfers. R10 was discharged home on 6/10/24. On 5/22/24, R10 expressed a grievance to (Social Worker) SW-I. The concern occurred on 5/20/24 and 5/22/24. R10 expressed long call light response time in the morning, a (Certified Nursing Assistant) CNA would not close their blinds when asked, then reactivated their call light, and it took another 30 minutes. On 5/20/24 R10 soiled themselves due to long wait time. The Investigation states: Social Services spoke with the (Director of Nurses) about the concern. The DON plans on finding out who the CNA's were and attempting to re-educate them. The Resolution states: Followed up with nursing who identified the CNA's involved from agency and marked them unable to come back. The Resolution does not document this was reported to the State Agency for neglect. On 11/5/24, at 8:45 AM, Surveyor interviewed SW-I. SW-I stated they review concerns with the stand-up meetings. SW-I directs the concern to the appropriate department. They shared this concern with the (Director of Nurses) at that time. That DON no longer works at the facility. SW-I stated they just had the agency staff that worked with R10 on the do not return list. SW-I was not aware of this being reported to the State Agency. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There is not a resolution that identifies the cause and a plan to prevent reoccurrence. For an allegation of neglect of care, would meet the reporting criteria, to report it to the State Agency. On 11/5/24, at 8:55 AM, Surveyor shared concerns with (Director of Nurses) DON-B and (Director of Operations) DOO-C. The DON-B did not recall the concern. On 11/5/24, at 3:03 PM, Surveyor shared the investigation concerns with DON-B, DOO-C and (Assistant Nursing Home Administrator) ANHA-D. No additional information was provided. 49011 4.) R5 was admitted to the facility on [DATE] and has diagnoses which include, in part, encephalopathy, vascular dementia, benign neoplasm colon, muscle weakness and general anxiety disorder. R5's quarterly Medicare Minimum Data Set (MDS) with an assessment reference date of 10/30/2024 indicated R5 had a Brief Interview for Mental Status score of 99 (unable to complete interview). R5 has an activated Power of Attorney (POA). R5's MDS showed that a wheelchair is used for mobility. R5 has an indwelling catheter and is always incontinent of bowel. R5 is coded as being on hospice. Surveyor was reviewing the electronic medical record of R5 and saw a progress note written on 11/3/2024, at 10:09 PM, Resident has bruise on left wrist. Previous shift was unaware and didn't get report on it. unknown cause. bruise is reddish/purple written by Licensed Practical Nurse (LPN)-K. Surveyor conducted a further review and noted that the Department of Health Services Form, F- 62617, was not submitted to the State Survey Agency. On 11/6/2024, at 10:55 AM, Surveyor interviewed Director of Nursing (DON)-B about the progress note. DON-B states that they round and review progress notes each morning, but since State Agency came to building it threw off schedule and this is new to DON-B's knowledge. On 11/6/2024, at 3:54 PM, Surveyor interviewed LPN-K who stated they overheard a certified nursing assistant telling the medication technician about a bruise on R5's wrist. LPN-K then went over and looked at wrist and wrote the progress note about the bruise. LPN-K stated did not report the bruise to anyone, thought the progress note would count as reporting to the Facility. On 11/6/2024, at 2:59 PM, during the daily exit meeting with the Facility, Surveyor shared the concern regarding lack of investigation and reporting of the bruise to R5's wrist. ANHA-D, DON-B and Director of Operations-C were present. On 11/7/2024, at 8:24 AM, DON-B and Assistant Nursing Home Administrator (ANHA)-D shared with Surveyor the investigation that had been initiated. No additional information was provided.

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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** 49011 Based on interview and record review, the Facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were thoroughly investigated for 1 (R5) of 2 allegations of abuse or neglect reviewed. * R5 had an injury of unknown origin that was not thoroughly investigated. Findings include: The Facility Policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 9/2022, documents (in part) . Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations. 2. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. 3. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. a. Any evidence that may be needed for a criminal investigation is sealed, labeled and protected from tampering or destruction. 4. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation. 5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly . d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement or the investigator may obtain a statement . 1.) R5 was admitted to the facility on [DATE] and has diagnoses which include, in part, encephalopathy, vascular dementia, benign neoplasm colon, muscle weakness and general anxiety disorder. R5's quarterly Medicare Minimum Data Set (MDS) with an assessment reference date of 10/30/2024 indicated R5 had a Brief Interview for Mental Status score of 99 (unable to complete interview). R5 has an activated Power of Attorney (POA). R5's MDS showed that a wheelchair is used for mobility. R5 has an indwelling catheter and is always incontinent of bowel. R5 is coded as being on hospice. Surveyor was reviewing the electronic medical record of R5 and saw a progress note written on 11/3/2024, at 10:09 PM, regarding a bruise to the left wrist from an unknown cause written by Licensed Practical Nurse (LPN)-K. On 11/6/2024, at 10:55 AM, Surveyor interviewed Director of Nursing (DON)-B about the progress note. DON-B stated Assistant DON and a nurse manager would be assigned to investigate the bruise and determine if it is an injury of unknown origin. On 11/6/2024, at 2:59 PM, during the daily exit meeting with the Facility, Surveyor shared the concern regarding lack of investigation of the bruise to R5's wrist. ANHA-D, DON-B and Director of Operations-C were present. On 11/7/2024, at 8:24 AM, DON-B and Assistant Nursing Home Administrator (ANHA)-D shared with Surveyor an investigation into R5's injury of unknown origin had been initiated. Surveyor noted that the facility only investigated R5's injury of unknown origin after it was brought to the facility's attention. No additional information was provided as to why the Facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were thoroughly investigated for R5.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not develop and implement a baseline care plan that includes the instructions needed to provide effective and person centered care for 2 (R16 and R7) of 2 residents reviewed. * R16 was admitted to the facility on [DATE] and did not have a baseline care plan initiated. * R7's baseline care plan did not include individualized, person-centered interventions. Findings include: The facility policy, entitled Care Plans-Baseline, revised March 2022, documents: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation: 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident . 2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person centered comprehensive care plan The baseline care plan is updated as needed to meet the residents needs until the comprehensive care plan is developed. 1.) R16 was admitted to the facility on [DATE] and has diagnoses that include metabolic encephalopathy, enterocolitis due to clostridium difficile (C-Diff), vascular dementia, memory deficit following cerebral infarction, anxiety disorder without behaviors, adult failure to thrive, severe sepsis, fibromyalgia, chronic cough, and weakness. R16's admission minimum data set (MDS) dated [DATE] documents that R16 had intact cognition with a brief interview for mental status (BIMS) score of 14 and the facility assessed R16 needing total assistance with 1 staff member for toileting hygiene and lower body dressing and required a Hoyer lift transfer with 2 staff members, and moderate assist with 1 staff member for personal hygiene and upper body dressing. R16 was incontinent of bowel and bladder and wore adult briefs and was on contact isolation for the diagnosis of C-Diff. Surveyor reviewed R16's medical record and noted a baseline care plan was not initiated upon R16's admission to the facility. R16's did not have a care plan initiated until 8/6/2024, 4 days after R16's admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/2024, at 10:13 AM, Surveyor interviewed Director of nursing (DON)-B who confirmed with the Surveyor that a care plan was not initiated for R16 until 8/6/2024. DON-B stated a baseline care plan should have been initiated when R16 was admitted to the facility on [DATE]. DON-B was not sure why a care plan was not initiated until 8/6/2024. DON-B stated at that time the facility was having a transition and there was not an admissions nurse at that time and maybe got missed by the floor nurses, DON-B stated but that should not have happened and R16 should have had a baseline care plan in place. On 11/6/2024, at 3:00 PM, Surveyor shared concerns that R16 did not have a baseline care plan once admitted to the facility on [DATE] until 8/6/2024. DON-B and assistant nursing home administrator (ANHA)-D understood the concern. No additional information was provided. 38253 2.) R7 was admitted to the facility on [DATE] with diagnoses of wedge compression fracture of T11-T12 vertebra, cancer of the lung, malnutrition, Parkinsonism, congestive heart failure, atrial fibrillation, emphysema, and peripheral vascular disease. R7's Baseline Care Plan was initiated on 6/15/2024 targeting problems based on the admission assessment. All the interventions documented for each problem area of the Care Plan did not have individualized approaches for the care of R7. A generic baseline care plan was documented without selecting the pertinent interventions for R7. The Activities of Daily Living (ADL) Care Plan within the Baseline Care Plan documents the following interventions: I am (independent) of all activities of daily living. (OR) Overall I require (supervision, limited, extensive, dependent) assistance with oral care; (supervision, limited, extensive, dependent) with bathing; (supervision, limited, extensive, dependent) with grooming; (supervision, limited, extensive, dependent) with eating; (supervision, limited, extensive, dependent) with toileting; (supervision, limited, extensive, dependent) with dressing; (supervision, limited, extensive, dependent) with mobility. I will need (support, assistance) to have my personal care needs met while supporting my strengths and personal goals. All subsequent care plan problems within the Baseline Care Plan have the same documentation of supplying all possible needs without selecting the appropriate care based on R7's needs and assessment. On 6/17/2024, three days after admission, R7's care plan was revised to incorporate individualized approaches for care. In an interview on 11/6/2024 at 12:50 PM, Surveyor asked Assistant Nursing Home Administrator (ANHA)-D if ANHA-D had reviewed R7's Baseline Care Plan when it had been provided to Surveyor. ANHA-D stated ANHA-D had printed the document but had not looked closely at the care plan. Surveyor showed ANHA-D R7's Baseline Care Plan to ANHA-D for ANHA-D to review. Surveyor shared with ANHA-D the concern R7's Baseline Care Plan had no personalization of interventions on how to care for R7 until the care plan was revised on 6/17/2024. ANHA-D agreed the care plan looked like the nurse had initiated the care plan in the computer charting system but did not address any of the problem topics by selecting what care level R7 needed. ANHA-D stated it appeared to ANHA-D that on 6/17/2024, the care plan was reviewed and revised with the information that individualized the interventions. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why the facility did not develop and implement a baseline care plan that includes the instructions needed to provide effective and person centered care.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not ensure a discharge plan was in place to effectively transition the resident to post-discharge care for 1 (R7) of 2 residents reviewed for discharge. R7 was discharged to home while incapacitated with no appointed decision maker. R7 did not receive home health services upon discharge due to no appointed Power of Attorney (POA) to sign contracts for services and no medications were available for R7 upon return to home. Findings include: The facility Policy and Procedure titled Discharge Summary and Plan revised 10/2022 documents: 3. Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. 4. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes: a. where the individual plans to reside; b. arrangements that have been made for follow-up care and services; c. a description of the resident's stated discharge goals; d. the degree of caregiver/support person availability, capacity and capability to perform required care; e. how the IDT will support the resident or representative in the transition to post-discharge care; f. what factors may make the resident vulnerable to preventable readmission; and g. how those factors will be addressed. 5. The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge. 6. The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan. 7. Residents are asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences. 8. If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the determination. 9. Residents transferring to another skilled nursing facility or who are discharged to a home health agency, long-term care hospital or inpatient rehabilitation facility are assisted in selecting a post-acute care provider that is relevant and applicable to the resident's goals of care and treatment preferences. 10. The resident or representative (sponsor) is asked to provide the facility with a minimum of seventy-two (72) hour notice of a discharge to assure that an adequate discharge evaluation and post-discharge plan can be developed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. A member of the IDT reviews the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. 1.) R7 was admitted to the facility on [DATE] with diagnoses of wedge compression fracture of T11-T12 vertebra, cancer of the lung, malnutrition, Parkinsonism, congestive heart failure, atrial fibrillation, emphysema, and peripheral vascular disease. R7's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R7 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and had a fall prior to admission. The Cognitive Care Area Assessment documented R7 had a current BIMS of 15, an activated Power of Attorney (POA) in place, and had some forgetfulness noted. R7 had completed a POA for Healthcare document on 3/27/2018 designating Family Member (FM)-Z as the primary POA and FM-AA as secondary POA if R7 should become incapacitated. The document was signed by R7, two witnesses, FM-Z as the healthcare agent, and FM-AA as the alternate healthcare agent. R7 was hospitalized from 6/9/2024 to 6/14/2024 with a T12 compression fracture and on 6/11/2024 was found to be incapacitated by a physician and a psychologist therefore activating the POA, FM-Z. The hospital Social Worker documented on 6/12/2024 in a progress note that the activated POA was contacted to discuss discharge arrangements from the hospital. FM-Z returned the call on 6/13/2024 and the Social Worker documented FM-Z was given a list of subacute rehab referrals; FM-Z approved of referrals to the facilities provided. The hospital Discharge Summary dated 6/14/2024 documents the physician had an in-depth conversation with FM-Z regarding R7's medications, a final plan about the several medical issues, and the Do Not Resuscitate wishes R7 had expressed with the admitting physician. The Hospital Face Sheet documented FM-Z was the active substitute decision maker. The hospital documentation was provided to the facility prior to and upon R7's discharge from the hospital. R7's Admission Sheet completed by the facility prior to R7 being admitted documented R7 would be admitted on [DATE] and had an activated POA for healthcare. No documentation was found indicating that FM-Z was contacted or provided admission paperwork. FM-Z's signature was not found on any documentation in R7's medical record. On 6/17/2024, a Discharge Care Plan was initiated to discharge from the facility. The following interventions were implemented at that time: -Arrange for discharge planning conference with interdisciplinary team (IDT) for discharge planning within 48-72 hours. -Arrange for necessary home modifications per therapy recommendations. -Assist R7 and/or support person in locating and coordinating post discharge services. -Consider R7's and family preference for care. -Define roles and expectations with R7 and support person. -Ensure access to services. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Obtain needed equipment and supplies per therapy and nursing recommendations. -Plan for specific needs/continuing care needs after discharge: e.g., personal care, sterile dressings, physical therapy, etc. -Provide education for medications, treatment, therapy, safety, equipment, etc. prior to discharge. -Provide opportunity for R7/support person to return demonstrate treatment regime/skills prior to discharge. -Provide written instructions for care and resources to use in case of emergency. -Refer to home health services. On 6/18/2024 at 10:00 AM, in R7's progress notes, Social Worker (SW)-I documented a Care Conference was held with the IDT, R7, and FM-Z. At 11:38 AM in the progress notes, SW-I documented FM-Z sent an email about concern for R7 wanting to go home and FM-Z wanted to meet with SW-I to discuss Assisted Living Facilities (ALFs). SW-I documented R7 was very against going to an ALF and wanted to return home. SW-I documented SW-I informed FM-Z that SW-I was more than happy to speak with FM-Z about this but also informed FM-Z that regardless of if the POA was active or not, they cannot force R7 to go to an ALF. FM-Z was provided with Ombudsman-T's number in case FM-Z had concerns regarding the rights as Active POA. On 6/18/2024 at 2:04 PM in the progress notes, Director of Rehab (DoR)-U documented a care plan meeting was held that day with the IDT, R7 and FM-Z on the phone. Therapy goals were discussed, and discharge planning was completed with R7 reporting that R7's goal was to return home. Home physical therapy (PT), occupational therapy (OT), and Home Health Aide (HHA) was recommended upon discharge. On 6/22/2024 at 2:07 PM in the progress notes, nursing documented FM-BB arrived to take R7 home and was informed R7 was not able to go home because the physician and insurance had not released R7. FM-BB stated FM-BB was going to take R7 home and they could not keep R7 at the facility like a prisoner. Nursing staff explained to FM-BB that FM-Z did not want R7 to leave the facility. FM-Z was contacted via the phone and FM-Z talked to R7 to explain the situation to R7. FM-BB had removed some of R7's belongings and put them in the car. The police were notified and spoke to FM-BB who then brought back R7's belongings. On 6/24/2024 at 2:57 PM in the progress notes, SW-I documented SW-I had a long conversation with R7 about R7's wants. R7 did not want to go to an ALF while FM-Z was insisting R7 had to. R7 stated R7 barely had any contact with FM-Z and FM-AA until R7's POA was activated. R7 stated FM-Z wants R7 to go into an ALF so FM-Z can live in R7's house rent free. R7 could not recall when FM-Z was picked to be R7's POA and does not want FM-Z to be the POA. SW-I documented SW-I had spoken to Ombudsman-T about this and Ombudsman-T told SW-I that R7 had the right to revoke the POA whether R7 was activated or not. R7 felt FM-Z was abusing their POA power and would like FM-BB to be the POA since FM-BB might start living with R7 as R7's caretaker. On 6/24/2024, R7 signed a Revocation of Power of Attorney for Health Care form removing both FM-Z as the primary POA and FM-AA as alternate POA. R7 no longer had a designated decision maker. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/2024 at 3:58 PM in the progress notes, Business Office Manager (BOM)-V documented BOM-V met with R7 to discuss the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN). BOM-V documented BOM-V explained R7 was covered through 6/27/2024 and would discharge on 6/28/2024. R7 said FM-BB would be taking R7 home around 11:00 AM on Friday (6/28/2024). BOM-V documented a voicemail was left for FM-AA as well to inform FM-AA of the insurance update. The NOMNC and SNFABN paperwork was signed by R7 on 6/25/2024. No other family members witnessed or were a part of the conversation regarding the end of coverage or if any conversation was had about applying for Medicaid assistance. On 6/26/2024 at 11:47 AM in the progress notes, SW-Y documented SW-Y spoke with R7's POA, FM-AA. Surveyor noted R7 did not have a designated POA at this time due to the revocation and FM-AA was revoked as the alternate POA. SW-Y explained to FM-AA that FM-Z was revoked from being the POA which bumped FM-AA up to R7's primary POA. SW-Y documented R7 was to be discharged on Friday. FM-AA stated that FM-AA was not okay with that and R7 needed to be in an ALF or nursing home. SW-Y informed FM-AA that the facility had suggested an ALF several times to R7 and R7 refused. FM-AA then questioned what the point of being a POA was if FM-AA had no say in what goes on with R7's care. SW-Y informed FM-AA that per Ombudsman-T, the state agency for resident rights, R7 gets to make the call of what R7 wants to do and that we cannot deny R7 that right, with or without a POA. SW-Y told FM-AA that R7 would be discharged with home health to make the transition back home a little easier. FM-AA stated FM-AA understood and requested that SW-Y call FM-Z to explain to FM-Z what is going on. SW-Y told FM-AA SW-Y could not do that as FM-Z was no longer R7's POA. FM-AA did not agree with R7's decision to go back home but stated if FM-AA has no say, then it is what it is and that FM-AA would be there on Friday. On 6/26/2024 at 12:53 PM in the progress notes, SW-I documented a signed referral for home health services was sent. The Home Health referral paperwork documented R7 was seen by PCP-X on 6/26/2024 and R7 was to receive Physical Therapy (PT) and Occupational Therapy (OT). On 6/26/2024 at 1:00 PM in the progress notes, SW-Z documented FM-BB called and explained that R7 was calling FM-BB saying that R7 can go home on Friday. Since FM-BB was not the POA, FM-BB stated FM-BB would prefer FM-AA, the Active POA, to pick up R7. Surveyor noted R7 did not have a designated POA at this time due to the status of incapacitation. FM-BB stated that FM-BB does not want to be in the middle of R7 and FM-AA. FM-BB stated once R7 returns home, FM-BB would be there to assist R7, such as going to the store, the doctors, etc., however FM-BB does not want to stay there since FM-BB is not the active POA and does not want to get caught up in the mess. FM-BB stated FM-BB felt FM-AA and FM-Z were stealing money from R7 along with belongings from R7's home. SW-Y informed FM-BB that R7 was being taken care of and that R7 would receive the support R7 needs along with receiving home health upon discharge. On 6/26/2024 at 1:20 PM in the progress notes, SW-I documented Meals on Wheels was contacted and the service would be starting for R7 on 7/1/2024. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2024 at 5:22 PM in the progress notes, SW-I documented APS SW-S visited with R7 and then came to speak with SW-I. R7 had revoked both FM-Z and FM-AA as POAs but from the hospital was still deemed incapacitated and does not currently have a decision maker. APS SW-S felt that since both sides of the family were fighting over R7 and R7's house that the best option at that point would be to file for guardianship so the courts could handle the family dynamic and it can be decided/finalized. APS SW-S said SW-I would need a letter from PCP-X stating incapacity. SW-I spoke with PCP-X's nurse who said that PCP-X would like to look over the documents again before writing the letter but will get it to SW-I by Friday. SW-I went to speak with R7 to update R7 and R7 was upset but also said R7 understood what had to happen now. On 6/27/2024 on the OT Discharge Summary, the OT therapist documented R7's discharge recommendations: R7 was staying at the long term care facility with 24/7 care at standby assist 4-wheeled walker level; R7 will have assist for AM and PM activities of daily living and putting on and taking off the back brace. On 6/27/2024 on the PT Discharge Summary, the PT therapist documented R7's discharge recommendations: R7 required standby assist for safety of transfers with vocal cues for safety of locking and unlocking the walker and hand placement; R7 needed minimal assist for putting on back brace; R7 was to have assist with bathing and dressing; R7 was to stay with long term care since it was not safe for R7 to discharge home. On 6/28/2024, PCP-X faxed a letter to the facility documenting R7 had undergone a psychological evaluation with a Neuropsychologist where R7 was found to have a neurocognitive disorder. PCP-X agreed that R7 was unable to make rational decisions with regard to R7's healthcare or fully understand R7's medical condition and need for care. PCP-X was the third medical professional to deem R7 incapacitated. On 6/28/2024 at 3:06 PM in the progress notes, SW-I documented spoke to FM-AA and FM-BB and both were aware they needed to pick up R7. At 3:19 PM in the progress notes, SW-I documented a discharge folder was placed in the nurses station and home health had been updated. A medication list had been faxed to the pharmacy. No documentation was found indicating the circumstances of why R7 was not discharged on [DATE]. On 7/8/2024 at 10:00 AM in the progress notes, SW-I documented Assistant Nursing Home Administrator (ANHA)-D and SW-I spoke with Ombudsman-T and Ombudsman-T told the facility that R7 had the right to go home regardless of whether R7 was activated or not for POA. On 7/8/202 at 11:27 AM in the progress notes, SW-I documented Ombudsman-T was contacted and Ombudsman-T said R7 had the right to go home, no one could stop R7 from going home. Ombudsman-T said R7 should be able to sign a new POA as long as the primary doctor PCP-X would write a statement R7 could. PCP-X's office was called who agreed FM-BB should be the POA but would call back after lunch. No further documentation was found regarding PCP-X calling the facility back. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/2024 at 12:28 PM in the progress notes, SW-I documented SW-I spoke with FM-BB about R7's discharge plan. FM-BB stated FM-BB was there to support R7 and so are other family members that live close to R7. FM-BB stated FM-BB would be going grocery shopping for R7 and calling Meals on Wheels to get restarted. SW-I documented per Ombudsman-T, the facility cannot hold R7 there against R7's will and R7 had the right to go home regardless of if R7 was activated or not. R7 currently had a safe discharge plan to go home with family support. At 1:24 PM in the progress notes, SW-I documented SW-I spoke with FM-BB and would fax medications to the pharmacy. On 7/10/2024 at 12:48 PM in the progress notes, SW-I documented home health confirmed that everything was set up for R7 to receive home health. On 7/10/2024 at 5:21 PM in the progress notes, nursing documented R7 was discharged to home at 5:00 PM with family and the discharge folder was sent with R7. The Transition of Care/Discharge Summary for R7 dated 7/10/2024 documented R7 was not resident responsible. No special instructions were documented. No discharge medications were documented. No signatures were found indicating who received the discharge instructions and information. In an interview on 11/5/2024 at 10:10 AM, Surveyor asked SW-I if SW-I knew the circumstances around FM-BB coming to pick up R7 on 6/22/2024. SW-I stated that was on the weekend and R7 was not set to discharge at that time. SW-I stated SW-I was not informed of the situation until a couple hours after it happened. SW-I stated nursing did not know what to do so they called the police; there were no other instances of FM-BB coming to get R7. SW-I stated APS SW-S talked to R7 and in that conversation, R7 told APS SW-S R7 was fine with going to an ALF, but when R7 talked to SW-I, R7 did not want to go to an ALF. SW-I stated SW-I called Ombudsman-T to get clarification of what R7 could and could not do as R7 had an activated POA. SW-I stated Ombudsman-T informed SW-I that R7 could not be kept at the facility against R7's will and R7, even though was deemed incapacitated, still had the right to be discharged . SW-I stated SW-I had multiple conversations with R7 and Ombudsman-T. SW-I stated R7 was against what FM-Z wanted and SW-I explained to R7 what it meant to revoke the POA. SW-I stated R7 felt R7's rights were being taken away. Surveyor asked SW-I what was done for R7 once R7 revoked the POA and had no one as the decision maker. SW-I stated they were going to start getting corporate guardianship, but R7 became very pushy about going home and Ombudsman-T told them R7 had the right to discharge. SW-I stated R7 had safe discharge arrangements. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/5/2024 at 10:48 AM, Surveyor asked Ombudsman-T if Ombudsman-T could recall R7 and the conversations with the facility regarding R7's POA being revoked and R7's discharge from the facility. Ombudsman-T stated Ombudsman-T never knew the resident's name. Ombudsman-T stated the facility called Ombudsman-T with questions about discharge. Ombudsman-T stated Ombudsman-T told the facility that the resident had the right to go home, and they need a discharge meeting. Ombudsman-T stated the resident was not under protective placement so they could not keep the resident against their will. Ombudsman-T stated the resident did not want the POA listed anymore so Ombudsman-T told the facility that if the resident revokes the POA, they have to reach out to their legal team for guardianship or a new POA. Ombudsman-T stated APS got involved. Ombudsman-T stated APS called Ombudsman-T and Ombudsman-T reiterated to APS what Ombudsman-T told the facility. Ombudsman-T stated Ombudsman-T would never tell inaccurate information to the facility and it has to be a safe discharge. Ombudsman-T stated what the facility did was the facility choice, not what Ombudsman-T told them to do. Ombudsman-T stated Ombudsman-T could tell the facility the regulations but cannot tell the facility what to do. Ombudsman-T stated they needed to go through their legal team before the resident was discharged . Ombudsman-T stated Ombudsman-T talked to SW-I and ANHA-D many times about this situation. In an interview on 11/5/2024 at 1:55 PM, Surveyor asked DoR-U how the facility or therapy determines a resident is safe to discharge home. DoR-U stated DoR-U attends the initial care plan meeting to discuss discharge goals, what level the resident should be at in order to go home, and the home environment, such as stairs and home layout. Surveyor asked DoR-U if PT or OT assessed R7 prior to discharge from the facility. DoR-U stated R7 discharged from therapy services on 6/27/2024 and therapy was told R7 was going to stay at the facility long term so R7 was never evaluated after that date. DoR-U stated R7 did not have any Med B visits with therapy after 6/27/2024 and was not aware of R7 discharging from the facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/6/2024 at 8:09 AM, APS SW-S stated R7 was admitted to the facility with an activated POA and R7 wanted to discharge home. APS SW-S stated the activated POA, FM-Z, did not feel it was safe for R7 to go home. APS SW-S stated FM-Z had a lot of concerns such as R7 had no food or medications at home. APS SW-S stated FM-Z wanted R7 to enroll in Medicaid and R7 was told R7 would lose the house so if there was no POA, R7 could keep the house. APS SW-S stated R7 thought if R7 revoked the healthcare POA, both primary and secondary, R7 would be able to go home. APS SW-S stated with R7 revoking the POA, maybe the facility thought that would be an easy discharge. APS SW-S stated PCP-X determined R7 was still incapacitated so APS SW-S recommended the facility seek guardianship for R7. APS SW-S stated APS SW-S and the APS supervisor talked to their legal counsel about the process needed to have a decision maker for R7 since R7 revoked the POA and APS SW-S told the facility to consult with their attorneys to have the courts involved. APS SW-S stated Ombudsman-T said the facility cannot hold R7 against their will, but APS SW-S did not think Ombudsman-T knew the whole picture, that R7 lacked capacity and did not have a decision-maker. APS SW-S stated FM-BB told APS SW-S that the facility called FM-BB to come and pick up R7 and when R7 got home, R7 could not be admitted to home health services because there was no one to sign the admission contract. APS SW-S stated the facility documented in R7's chart that the family could create a new POA per PCP-X which was not true. APS SW-S stated PCP-X was confused about revoking R7's POA when R7 was incapacitated. APS SW-S stated R7 did not have a decision maker on discharge and R7 did not have any medications when discharged home; R7 needed refills, and no one picked them up from the pharmacy. APS SW-S stated R7's discharge folder barely had any paperwork in it. APS SW-S stated FM-BB did not stay with R7 longer than two days after discharge. APS SW-S stated FM-Z got temporary guardianship with the assistance of APS after R7 was home. APS SW-S stated APS SW-S talked to Administrator of Home Health (AHH)-W to find out about R7 getting home health services. APS SW-S stated AHH-W said the facility paperwork listed FM-BB as R7's POA with no documentation to support that; there was no evidence of POA paperwork. AHH-W told APS SW-S that R7 could not be admitted for services because there was no responsible party to sign the paperwork. APS SW-S stated FM-BB was not reliable, and FM-BB yelled at R7 on the phone not to call FM-BB. APS SW-S stated the facility never notified APS that R7 was discharged . In an interview on 11/6/2024 at 9:31 AM, ANHA-D stated SW-I informed ANHA-D and Nursing Home Administrator (NHA)-A that R7 did not want FM-Z or FM-AA as R7's POA anymore because FM-Z and FM-AA were going to sell R7's house and take the money. ANHA-D stated R7 was angry at FM-Z and FM-AA. ANHA-D stated SW-I contacted Ombudsman-T and was told R7 could revoke the POA. ANHA-D stated SW-I ran with that and had R7 revoke the POA. Surveyor shared with ANHA-D that no one signed R7's discharge paperwork. ANHA-D stated ANHA-D saw that when ANHA-D was printing the discharge paperwork. Surveyor asked ANHA-D how it was determined R7 had a safe discharge. ANHA-D stated SW-I had services set up. Surveyor shared the concern the services had been set up for discharge on 6/28/2024 and R7 did not discharge until 7/10/2024 with no input from therapy or family. Surveyor shared with ANHA-D R7 did not have home health services once R7 arrived home because there was no decision maker to sign the admission paperwork for home health services and FM-BB did not pick up any of R7's medications from the pharmacy. ANHA-D was not aware of that. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/6/2024 at 9:49 AM, AHH-W stated R7 was rejected for services by the home health company. AHH-W stated R7's POA was revoked while at the facility and was still deemed incapacitated with no legal guardian in place to sign admission paperwork and contract. AHH-W stated AHH-W contacted APS and alerted APS SW-S of the situation. Surveyor asked AHH-W if AHH-W was aware of R7 not having a POA in place at the time of R7's discharge or was it discovered after R7 was home. AHH-W stated the referral from the facility was accepted and the referral showed the POA was activated with FM-BB as the POA. AHH-W stated FM-BB was contacted and FM-BB wanted to wait one week for services to start. AHH-W stated they scheduled the first visit for 7/15/2024 and left a voicemail with FM-BB to have FM-BB send POA paperwork to them. AHH-W stated that was when APS got involved and APS got FM-Z to have temporary guardianship. AHH-W stated multiple messages were left for FM-Z with no return call, so the referral was rejected; R7 did not receive any home health services. In an interview on 11/6/2024 at 10:22 AM, Surveyor asked SW-I how FM-BB was aware that R7 was discharging on 7/10/2024. SW-I stated SW-I called FM-BB to come and get R7. SW-I stated home health was set up and medications had been called to the pharmacy from the physician. SW-I stated FM-BB was going to restart Meals on Wheels. SW-I stated SW-I sends an order sheet signed by the physician and a signed medication sheet to the home health service through email. SW-I provided a copy of the email. The information sent had been signed by PCP-X on 6/24/2024 and 6/26/2024. SW-I stated AHH-W comes in weekly to talk over any questions with upcoming discharges. SW-I stated R7 wanted FM-BB to be the point of contact and PCP-X thought FM-BB was the POA, too. Surveyor asked SW-I if APS was notified at the time of R7's discharge. SW-I thought APS was notified by leaving a message for APS SW-S and PCP-X was called as well when R7 discharged . On 11/6/2024 at 3:00 PM, Surveyor shared with Director of Operations-C, Director of Nursing-B and ANHA-D the concern R7 did not have a safe discharge and no discharge meetings were held with R7's family members prior to discharge. Surveyor shared with ANHA-D R7 did not receive any home health services upon discharge due to no designated decision maker to sign admission contracts and no medications were obtained for R7 after discharge. No additional information was provided.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 21855 Based on record review and interviews, the facility did not ensure resident's experiencing a medical change in condition, received appropriate treatment and care, per standards of practice consistent with N6 Wisconsin Nurse Practice Act. This was discovered with 2 (R13 and R6) of 5 residents reviewed with a medical change in condition. * On [DATE], at 3:15 PM, R13 developed a high fever that was not resolved with medication. R13's blood sugar was to high to register on a testing meter. Their pulse and oxygen saturations were erratic. They had rapid gargled breathing. There is no evidence their symptoms were communicated to a medical provider for consultation and treatment. They experienced a cardiac arrest and passed away in the facility on [DATE], at 7:35 PM. The facility's failure to provide medical intervention with a high temperature not resolving, gargled breathing, high blood sugar, erratic pulses and oxygen saturations, created a finding of immediate jeopardy that began on [DATE]. Surveyor notified the Director of Operations (DOO)-C and Assistant Nursing Home Administrator (ANHA)-D of the immediate jeopardy on [DATE], at 10:26 AM. The immediate jeopardy was removed on [DATE], however the deficient practice continues at a scope/severity of D (no harm/isolated). * R6 on [DATE] experience blood in their urine after completing an antibotic for a UTI on [DATE]. There is no assessment completed of R6 on [DATE], or notification to a medical provider about R6's change in condition, until [DATE]. R6 was taken to the hospital by their family on [DATE] and was diagnosed with a UTI and sepsis. Findings include: The facility policy and procedure Change in a Resident's Condition or Status dated ,d+[DATE]. The policy states: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental conditions and/or status. Under 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. According to the State of Wisconsin Nurse Practice Act: N 6.03 - Standards of practice for registered nurses. (1) General nursing procedures. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.'s or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. The American Medical Directors Association (AMDA) for clinical practice guidelines for long-term care facilities has guidelines for acute changes in condition that should be reported to a practitioner immediately. This includes a oral temperature over 101 degree Fahrenheit; blood sugar over 430 (or machine registers high) in diabetic patient using sliding scale insulin. 1.) R13 was reviewed as a closed record review. R13 passed away in the facility on [DATE] and had resided in the facility since [DATE]. R13 had diagnoses of aphasia, hemiplegia, gastrostomy, diabetes and severe sepsis with septic shock. R13 is a full code status with a Legal Guardian appointed for decision making. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note written by (Licensed Practical Nurse) LPN-L documents: On [DATE], at 9:33 PM, after receiving report from 1st shift nurse, CNA (Certified Nursing Assistant) informed writer that patient feels like he has a fever. Writer assessed patient. Patient was very warm to the touch, diaphoretic with rapid gargle breathing. Temp was taken @1515 (3:15 PM) 101.7. Acetaminophen 650 mg (milligrams) was administered @1530 (3:30 PM). Temp was taken again @1630 (4:30 PM) 103.8. Temp and vitals were taken again @1730 (5:30 PM) Temp was 103.4. B/P (blood pressure) ,d+[DATE], Pulse jumping from 48 to 114 to 128 and back to the 40's. Respirations were 24. Spo2 (oxygen saturation) jumped from 68 to 75 to 85. Multiple attempts were made to obtain a blood glucose reading, the writer could not get a reading except for HIGH. The writer called the on call NP (Nurse Practitioner) at [name of medical group] @1831 (6:31 PM) and was on hold for 27 minutes and 32 seconds. Temp (temperature) was taken again @1841 (6:41 PM) 103.1. Writer and CNAs were in the room with the patient when he expired. 911 was called and CPR (cardiopulmonary resuscitation) was started by writer. EMS (emergency medical staff) arrived and took over doing compressions, AED (automated external defibrillator) was initiated. The patient was pronounced dead @1935 (7:35 PM). The family arrived at 2200 (10:00 PM) to see the patient. The family asked the writer for a covid test to be done on the patient. Writer called DON (Director of Nurses) to see if this is ok to do, DON stated no and that the funeral can give a covid test if they would like to. Charge nurse updated sister/guardian throughout the entire process once CPR had begun. Currently awaiting funeral home arrangement information as of 22:20 (10:22 PM). Surveyor reviewed the blood sugar testing machine instructions. Surveyor noted there is is a bolded important statement documented which reads, if you see Hi displayed, the patient's blood glucose level may be above 600 mg/dl (milligrams/deciliter). Repeat the blood glucose test. If you receive the same result contact the patient's physician or healthcare provider. Surveyor notes R13's medical record does not contain documentation of communication with a medical provider to consult on R13's temperature being over 100 degrees Fahrenheit at 4 different opportunities; with a high blood sugar readings with multiple attempts; low pulse and low oxygen saturations. Surveyor notes there is no comprehensive assessment documented as to R13's change of condition. On [DATE], at 9:26 AM, Surveyor interviewed LPN-L. LPN-L stated they could not recall much from [DATE]. When Surveyor queried about opportunities LPN-L had to communicate with a RN, and/or a medical provider, LPN-L indicated there is never a (Registered Nurse) RN supervisor around on 3rd shift and they were on hold for a NP for a long time. They did (cardiopulmonary resuscitation) CPR and had a staff member call 911. LPN-L stated they did not have any further information about the opportunities for medical provider consultation or interventions. On [DATE], at 9:43 AM, Surveyor interviewed Registered Nurse (RN)-P who was the DON (Director of Nurses) at the time of R13's change of condition. RN-P stated they could not recall much. They remember getting a call about R13 having a high temp and they couldn't get a hold of the (Nurse Practitioner). They directed LPN-L to call 911. There was another RN in the building that they thought looked at R13. Surveyor notes there is no documentation of an assessment or communication with RN-P related to the changes in condition with R13. RN-P stated the RN on that shift quit shortly after this event. RN-P recalls discussing this event with the Nursing Home Administrator (NHA) at the time. RN-P does not recall any details, nor could they provide any documentation of this event. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 3:03 PM, Surveyor spoke with DON-B, Director of Operations (DOO)-C, and Assistant Nursing Home Administrator (ANHA)-D. Surveyor shared the concerns related to R13's change of condition, lack of a thorough assessment, lack of collaboration with a physician and lack of an emergency transfer of R13 to a higher level of care for evaluation and treatment. On [DATE], at 8:29 AM, DON-B and ANHA-D, spoke with Surveyor regarding R13's change of condition. Surveyor was informed there was no documentation in the HUCU (Secured electronic communication system used with providers versus calling the provider directly) communication system with a medical provider related to R13's change in condition. DON-B and ANHA-D did inform Surveyor there were licensed nurses in the facility during this event and there is always a manager on call, which was RN-P (the former DON). On [DATE], at 1:00 PM, Surveyor called the NP's medical group phone number. The message states If this is a medial emergency. Hang up and call 911. Otherwise, you can leave a message and someone will call you back. Surveyor notes the facility uses the HUCU electronic communication system when communicating with providers. On [DATE], at 2:46 PM, Surveyor interviewed CNA-O who worked with R13 during this event. CNA-O stated, I don't recall anything. On [DATE] Surveyor reviewed the EMS report for event that occurred on [DATE] with R13. The EMS report documents on [DATE], at 7:03 PM the facility contacted 911. The report documents EMS found R13 unresponsive and pulseless. R13 was in cardiac arrest. Surveyor notes the facility contacted 911 only after R13 was found unresponsive and pulseless and not with the prior noted change of condition. On [DATE], at 8:58 AM, Surveyor shared concerns related to R13's change in condition, lack of a thorough assessment, lack of consultation with a medical provider, or implementation of other interventions, with DON-B and ANHA-D. No further information was provided. The immediate jeopardy was removed on [DATE] when the facility completed the following: -All nurses were provided education related to recognition of physiological changed of condition as well as reporting of such changes of condition. -Education provided includes interventions, notifications and documentation. The education includes review of facility policy and procedure as it relates to condition changes, response to those changes and appropriate notifications to provider. -Establish a standard for vital signs parameters so that nursing staff call 911 if they are unable to reach a medical provider. -The Stop and Watch Early Warning Tool Interact tool has been implemented. The tool is available electronically within the EHR (Electronic Health Record) and copies have been made and placed in all nursing assistant and ancillary staff work stations. -All direct care staff will be educated on the Stop and Watch Early Warning tool as well as reporting any resident change of condition to a nurse. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Mandatory education is to include agency staff. -Post tests given following education to ensure competency in both notification and treatment responses as well as when to use the Stop and Watch tool. -The Change of Condition policy has been reviewed by the DON and with the Medical Director. Modifications include the addition of: *Examples of change of condition *Use of Interact tools-Stop and Watch *VS (Vital Signs) will be taken immediately or as soon as possible with a change of condition. *Once VS and immediate assessment is completed, MD (Medical Doctor) will be notified. VS will be taken a minimum of every 4 hours and more frequently as indicated by the change in condition or MD order. -All changes of condition will be listed on the 24-hour report board. -The DON and ADON will review progress notes and 24-hour report board daily for any changes of condition to ensure all resident condition changes have been identified and action taken in response to resident condition changes. -Audits will continue and results will be brought to the quality improvement committee for review. 2.) R6 had a readmission to the facility on [DATE] and was discharged to the hospital on [DATE]. R6 was reviewed as a closed record review. R6 has diagnoses of vascular dementia and urinary tract infection. R6 was on a antibiotic for a urinary tract infection from [DATE] - [DATE]. R6's progress notes on [DATE], at 4:17 AM, documented by (Licensed Practical Nurse) LPN-Q documents they were informed by an Aide there was blood in their (R6's) urine. R6 would not let LPN-Q assess them. Surveyor notes there is no documentation of a comprehensive assessment by a RN (Registered Nurse) or communication with a medical provider. There is no further documentation until [DATE], at 2:32 PM, by RN-N. RN-N documents R6 had blood in their urine. Completed a full set of vitals and notified the medical provider. The medical provider was in communication with RN-N through the HUCU text application system starting on [DATE]. Surveyor notes there is no HUCU communication from the facility to the medical provider from [DATE] or [DATE] related to R6's change of condition. Surveyor notes there is no documentation of a comprehensive assessment, or consultation with a with medical provider with R6's onset of blood in the urine on [DATE] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the facility, using the HUCU text application, communicates with the physician that R6 is having hemauria ,d+[DATE] (Blood Pressure), 97.7 (temperature), 94% (oxygen saturation). No complaints or urinary symptoms and that she is on Eliquis (blood thinner). The physician ordered stat (immediate) labs to be drawn and to hold the Eliquis the next morning. The facility later sends a message to the physician that they are unable to obtain a blood sample for the stat labs. The physician approved trying again on [DATE] and to push fluids. On [DATE], at 4:37 AM, R6's progress notes document R6 has hematuria of the urine observed during day shift. No hematuria observed or reported on NOC (night) shift. Resident was hallucinating and calling out peoples names at the beginning of NOC shift. Resident also had complaints of pain and could not tell nurse where but was holding upper right chest and shoulder. Vital signs: 97.6, ,d+[DATE], 96% on room air. CBC to be drawn this morning for follow up on hematuria. On [DATE], at 5:48 PM, R6's progress notes document . Family saved urine in toilet for writer to look at and it is cloudy and blood tinged. On [DATE], the facility, using the HUCU text application communicates with the physician indicating the got a blood draw, but there was not enough blood to complete the tests. The facility also communicated the family wanted R6 placed on a antibiotic right away and did not want to wait for tests. The physician declined to start an antibiotic without evidence of an infection. The facility staff did inform the physician R6 was hallucinating and calling out peoplea names at the beginning of noc shift, but this shift had no other symptoms. On [DATE], using the HUCU text application, the facility communicated that R6;s white blood count was within normal limits, and that daughter believes R6 has a UTI and is requesting a u/a Facility staff: CBC results in WBC 10.8 (normal range 4.5 to 11.0) . daughter believes she has UTI, still trying to get u/a. On [DATE], at 5:31 PM, R6's progress notes document UA obtained and sent to lab, results pending. On [DATE], at 2:29 PM, R6's progress notes document at 1:00 PM Pt had 200 cc (cubic centimeters) of dark red urine, daughter at bed side, stated she will not wait for culture to be back and she is taking her straight to the hospital. DON (Director of Nursing) notified, proivder notified. Surveyor notes R6 had a urine analysis, and a CBC (complete blood count) lab, completed on [DATE]. The CBC from [DATE] did not show any infection. The urine culture and sensitivity results were obtained after R6 was in the hospital. R6's family member did not want to wait for the urine culture results and took R6 themselves to the hospital. R6 was diagnosed in the hospital as having a urinary tract infection with acute kidney injury and sepsis. R6 was treated in the hospital however, did not return to the facility. On [DATE], at 10:35 AM, Surveyor interviewed RN-N. RN-N stated R6 did not have any other symptoms. The medical provider ordered labs and R6 has difficult veins. R6's family wanted them to be on antibiotics. R6 did not meet the criteria for infection. R6's family did take R6 to the hospital themselves on [DATE]. R6 did not have any additional symptoms besides blood in the urine. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 12:46 PM, Surveyor interviewed LPN-Q. LPN-Q stated they don't recall anything related to R6 having blood in their urine. On [DATE], at 3:03 PM, Surveyor shared the concerns with R6's change of condition, delay in consultation with a medical provider and obtaining STAT ordered lab work with Director of Nurses (DON)-B, Director of Operations (DOO)-C and Assistant Nursing Home Administrator (ANHA)-D. There was no additional information provided.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not ensure medically related social services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 (R7) of 2 residents reviewed for discharge. R7 had an activated Power of Attorney (POA) on admission that was not included in the admission process, social services did not assist R7 in obtaining a decision-maker or guardian prior to R7 revoking the POA, R7 was not assisted in applying for Medicaid after changing payor sources from Medicare, and social services did not ensure R7 had a safe discharge. Findings include: The facility policy and procedure titled Social Services from the publication Med-Pass (C)2001 revised , d+[DATE] documents: Policy Interpretation and Implementation: . 3. The facility staff is able to identify and address factors that have a potentially negative effect on psychosocial functioning of a resident, for example: a. situations that impede the resident's dignity and sense of control; b. lack of family/community support; c. distress resulting from depression, chronic diseases, difficulty with personal interactions or social skills, and/or resident to resident altercations; d. abuse of any kind; e. difficulty coping with change or loss; f. financial needs or problems; g. behaviors problems (i.e., confusion, anxiety, loneliness, depressed mood, anger, fear, wandering, psychotic episodes); h. substance abuse; and i. bereavement or unresolved grief. 4. The social worker/social services staff are responsible for: a. being knowledgeable about the rights of residents in accordance with federal requirements, including . Resident Rights .Freedom from Abuse, Neglect and Exploitation .Transitions of Care . b. advocating for and assisting residents with asserting their rights in the facility; c. assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights and accommodation of needs; . f. assisting with informing and educating residents, families and representatives about health care options and ramifications; g. making referrals and obtaining needed services from outside entities; h. assisting residents with financial and legal matters; i. helping residents with transitions of care services (for example, community placement options, home care services, transfer arrangements, etc.); . m. assisting residents with advance care planning, including but not limited to completion of advance directives (F578, Advance Directives); . o. meeting the needs of residents who are grieving from losses and coping with stressful events. 1.) R7 was admitted to the facility on [DATE] with diagnoses of wedge compression fracture of T11-T12 vertebra, cancer of the lung, malnutrition, Parkinsonism, congestive heart failure, atrial fibrillation, emphysema, and peripheral vascular disease. R7's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R7 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and had a fall prior to admission. The Cognitive Care Area Assessment documented R7 had a current BIMS of 15, an activated Power of Attorney (POA) in place, and had some forgetfulness noted. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7 had completed a POA for Healthcare document on [DATE] designating Family Member (FM)-Z as the primary POA and FM-AA as secondary POA if R7 should become incapacitated. The document was signed by R7, two witnesses, FM-Z as the healthcare agent, and FM-AA as the alternate healthcare agent. R7 was hospitalized from [DATE] to [DATE] with a T12 compression fracture and on [DATE] was found to be incapacitated by a physician and a psychologist therefore activating the POA, FM-Z. The hospital Social Worker documented on [DATE] in a progress note that the activated POA was contacted to discuss discharge arrangements from the hospital. FM-Z returned the call on [DATE] and the Social Worker documented FM-Z was given a list of subacute rehab referrals; FM-Z approved of referrals to the facilities provided. The hospital Discharge Summary dated [DATE] documents the physician had an in-depth conversation with FM-Z regarding R7's medications, a final plan about the several medical issues, and the Do Not Resuscitate wishes R7 had expressed with the admitting physician. The Hospital Face Sheet documented FM-Z was the active substitute decision maker. The hospital documentation was provided to the facility prior to and upon R7's discharge from the hospital. R7's Admission Sheet completed by the facility prior to R7 being admitted documented R7 would be admitted on [DATE] and had an activated POA for healthcare. On [DATE] at 12:25 PM in the progress notes, Admissions-R documented R7's POA was activated at the hospital and documented R7's POA as FM-Z. At 8:02 PM in the progress notes, Admissions-R documented Admissions-R sat with R7 and went over the admission packet and paperwork. Admissions-R documented R7 signed: payor source verification, informed consent for telemedicine, Medicare coverage, consent to treat, transportation policy, authorization for disclosure of contact information, influenza vaccine, pneumonia vaccine, TB risk assessment, and Advanced Directives; discharge planning was started. The following forms were signed on [DATE] by R7 and scanned into R7's medical record: -Skilled Nursing Facility Services Agreement -Advanced Directives (for code status) -Resident Social History -Responsible Person Agreement -Resident Rights -Resident Responsibilities -Resident Grievance/Concern Procedures -HIPAA Notice of Privacy Practices -Privacy Act Statement - Health Care Records -TB Skin Test -Consent to Administer Influenza Vaccine (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pneumococcal and Prevnar Vaccine Administration Assessment and Consent Form -Authorization for Disclosure of Contact Information -Consent to Treat -Informed Consent for Your Telemedicine Visit -Wisconsin Tuberculosis (TB) Risk Assessment and Symptom Evaluation -Medicare Coverage -Transportation Policy No documentation was found indicating that FM-Z was contacted or provided admission paperwork. FM-Z's signature was not found on any documentation in R7's medical record. On [DATE], a Discharge Care Plan was initiated to discharge from the facility. The following interventions were implemented at that time: -Arrange for discharge planning conference with interdisciplinary team (IDT) for discharge planning within , d+[DATE] hours. -Arrange for necessary home modifications per therapy recommendations. -Assist R7 and/or support person in locating and coordinating post discharge services. -Consider R7's and family preference for care. -Define roles and expectations with R7 and support person. -Ensure access to services. -Obtain needed equipment and supplies per therapy and nursing recommendations. -Plan for specific needs/continuing care needs after discharge: e.g., personal care, sterile dressings, physical therapy, etc. -Provide education for medications, treatment, therapy, safety, equipment, etc. prior to discharge. -Provide opportunity for R7/support person to return demonstrate treatment regime/skills prior to discharge. -Provide written instructions for care and resources to use in case of emergency. -Refer to home health services. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:27 PM in the progress notes, SW-I documented R7 stated FM-CC would like to talk with SW-I. FM-CC told SW-I that what the facility did was illegal, and no one explained to R7 that now the state was in charge of R7. FM-CC stated FM-CC was contacting an attorney and would becoming after SW-I and the facility. SW-I documented SW-I would file an Adult Protective Services (APS) report. At 3:32 PM in the progress notes, SW-I documented APS was called and a voice mail was left. On [DATE] at 10:09 AM in the progress notes, SW-I documented SW-I spoke with an APS SW about R7. The APS SW during the conversation said that R7 had been an open case in the past but was not at that time. Per the APS SW, APS had been working with FM-Z for years to have R7's Primary Care Physician (PCP)-X sign to make R7 incapacitated but PCP-X would not sign it and now R7's POA had been activated in the hospital. SW-I documented the APS SW seemed very biased towards FM-Z and made it known that SW-I should have been in full contact with FM-Z regardless of what R7 wanted. R7 wanted to go home and made allegations that FM-Z was wanting to live in R7's house rent free and had been stealing money out of R7's account. The APS SW stated the APS SW would make an APS report about this. SW-I documented the APS SW said that SW-I revoked the POA and R7 is activated so R7 cannot sign a different POA document, and the facility must file for guardianship. SW-I documented SW-I needed clarification on this as Ombudsman-T made it sound like R7 could still sign a new POA document if two witnesses were present. SW-I documented R7 was very distraught by this whole process and said R7 needed someone to advocate for R7 and be on R7's side as R7's family was always making decisions about R7 that R7 does not want. SW-I documented the APS SW claimed that the house was in R7's name and that FM-BB stands to gain it after R7 passes. R7 does not want to sell the house and per the APS SW, FM-Z and FM-AA are trying to sell it so R7 can go to an ALF. R7 was very against an ALF and wants to go home where R7 is comfortable. The APS SW said that FM-BB was not living with R7 but R7 and FM-BB said that FM-BB was. On [DATE] at 1:59 PM in the progress notes, SW-I documented PCP-X was going to assess R7 the next day. On [DATE] at 3:58 PM in the progress notes, Business Office Manager (BOM)-V documented BOM-V met with R7 to discuss the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN). BOM-V documented BOM-V explained R7 was covered through [DATE] and would discharge on [DATE]. R7 said FM-BB would be taking R7 home around 11:00 AM on Friday ([DATE]). BOM-V documented a voicemail was left for FM-AA as well to inform FM-AA of the insurance update. The NOMNC and SNFABN paperwork was signed by R7 on [DATE]. No other family members witnessed or were a part of the conversation regarding the end of coverage or if any conversation was had about applying for Medicaid assistance. (continued on next page)

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	525565	A. Building B. Wing	11/12/2024

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:47 AM in the progress notes, SW-Y documented SW-Y spoke with R7's POA, FM-AA. Surveyor noted R7 did not have a designated POA at this time due to the revocation and FM-AA was revoked as the alternate POA. SW-Y explained to FM-AA that FM-Z was revoked from being the POA which bumped FM-AA up to R7's primary POA. SW-Y documented R7 was to be discharged on Friday. FM-AA stated that FM-AA was not okay with that and R7 needed to be in an ALF or nursing home. SW-Y informed FM-AA that the facility had suggested an ALF several times to R7 and R7 refused. FM-AA then questioned what the point of being a POA was if FM-AA had no say in what goes on with R7's care. SW-Y informed FM-AA that per Ombudsman-T, the state agency for resident rights, R7 gets to make the call of what R7 wants to do and that we cannot deny R7 that right, with or without a POA. SW-Y told FM-AA that R7 would be discharged with home health to make the transition back home a little easier. FM-AA stated FM-AA understood and requested that SW-Y call FM-Z to explain to FM-Z what is going on. SW-Y told FM-AA SW-Y could not do that as FM-Z was no longer R7's POA. FM-AA did not agree with R7's decision to go back home but stated if FM-AA has no say, then it is what it is and that FM-AA would be there on Friday. On [DATE] at 12:53 PM in the progress notes, SW-I documented a signed referral for home health services was sent. The Home Health referral paperwork documented R7 was seen by PCP-X on [DATE] and R7 was to receive Physical Therapy (PT) and Occupational Therapy (OT). On [DATE] at 1:00 PM in the progress notes, SW-Z documented FM-BB called and explained that R7 was calling FM-BB saying that R7 can go home on Friday. Since FM-BB was not the POA, FM-BB stated FM-BB would prefer FM-AA, the Active POA, to pick up R7. Surveyor noted R7 did not have a designated POA at this time due to the status of incapacitation. FM-BB stated that FM-BB does not want to be in the middle of R7 and FM-AA. FM-BB stated once R7 returns home, FM-BB would be there to assist R7, such as going to the store, the doctors, etc., however FM-BB does not want to stay there since FM-BB is not the active POA and does not want to get caught up in the mess. FM-BB stated FM-BB felt FM-AA and FM-Z were stealing money from R7 along with belongings from R7's home. SW-Y informed FM-BB that R7 was being taken care of and that R7 would receive the support R7 needs along with receiving home health upon discharge. On [DATE] at 1:20 PM in the progress notes, SW-I documented Meals on Wheels was contacted and the service would be starting for R7 on [DATE]. On [DATE] at 5:22 PM in the progress notes, SW-I documented APS SW-S visited with R7 and then came to speak with SW-I. R7 had revoked both FM-Z and FM-AA as POAs but from the hospital was still deemed incapacitated and does not currently have a decision maker. APS SW-S felt that since both sides of the family were fighting over R7 and R7's house that the best option at that point would be to file for guardianship so the courts could handle the family dynamic and it can be decided/finalized. APS SW-S said SW-I would need a letter from PCP-X stating incapacity. SW-I spoke with PCP-X's nurse who said that PCP-X would like to look over the documents again before writing the letter but will get it to SW-I by Friday. PCP-X's office also noted how R7's family has been fighting over R7 for a while and the family will call PCP-X's office over it. PCP-X's office felt something more was going on. SW-I went to speak with R7 to update R7 and R7 was upset but also said R7 understood what had to happen now. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 5:37 PM in the progress notes, SW-I documented SW-I spoke to FM-AA and FM-BB as per APS SW-S suggested as they would be the candidates for guardianship. SW-I did not document what the conversation entailed. On [DATE] on the OT Discharge Summary, the OT therapist documented R7's discharge recommendations: R7 was staying at the long term care facility with ,d+[DATE] care at standby assist 4-wheeled walker level; R7 will have assist for AM and PM activities of daily living and putting on and taking off the back brace. On [DATE] on the PT Discharge Summary, the PT therapist documented R7's discharge recommendations: R7 required standby assist for safety of transfers with vocal cues for safety of locking and unlocking the walker and hand placement; R7 needed minimal assist for putting on back brace; R7 was to have assist with bathing and dressing; R7 was to stay with long term care since it was not safe for R7 to discharge home. On [DATE], PCP-X faxed a letter to the facility documenting R7 had undergone a psychological evaluation with a Neuropsychologist where R7 was found to have a neurocognitive disorder. PCP-X agreed that R7 was unable to make rational decisions with regard to R7's healthcare or fully understand R7's medical condition and need for care. PCP-X was the third medical professional to deem R7 incapacitated. On [DATE] at 2:26 PM in the progress notes, SW-I documented SW-I spoke to R7 who said R7 had changed their mind and did not want to revoke FM-Z or FM-AA as POAs anymore. R7 said R7 did not have a problem with FM-Z or FM-AA. R7 said R7 was upset with them before but not anymore. Surveyor noted a revoked POA could not be reversed until authorized individuals deemed R7 to have the capacity to make that decision. On [DATE] at 3:06 PM in the progress notes, SW-I documented spoke to FM-AA and FM-BB and both were aware they needed to pick up R7. At 3:19 PM in the progress notes, SW-I documented a discharge folder was placed in the nurses station and home health had been updated. A medication list had been faxed to the pharmacy. No documentation was found indicating the circumstances of why R7 was not discharged on [DATE]. On [DATE] at 12:33 PM in the progress notes, SW-I documented SW-I went to check on R7 who was upset. R7 was crying about the whole situation. R7 said R7's family was calling R7 and were upset about what R7 did. R7 said R7 should have stayed quiet. R7 stated that for years the family members have fought over R7 and more specifically over R7's house. R7 was beyond frustrated and upset and felt like R7 could not trust anyone. R7 said R7 just wants control of their life again. SW-I explained to R7 the possible next steps. R7 understood R7 would probably have to go on Medicaid and sell the house. SW-I talked with R7 about guardianship and R7 said R7 did not even know who R7 could trust in the family and does not trust anyone to respect R7's rights. SW-I was able to calm R7 down. On [DATE] at 10:00 AM in the progress notes, SW-I documented Assistant Nursing Home Administrator (ANHA)-D and SW-I spoke with Ombudsman-T and Ombudsman-T told the facility that R7 had the right to go home regardless of whether R7 was activated or not for POA. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:27 AM in the progress notes, SW-I documented Ombudsman-T was contacted and Ombudsman-T said R7 had the right to go home, no one could stop R7 from going home. Ombudsman-T said R7 should be able to sign a new POA as long as the primary doctor PCP-X would write a statement R7 could. PCP-X's office was called who agreed FM-BB should be the POA but would call back after lunch. No further documentation was found regarding PCP-X calling the facility back. On [DATE] at 12:28 PM in the progress notes, SW-I documented SW-I spoke with FM-BB about R7's discharge plan. FM-BB stated FM-BB was there to support R7 and so are other family members that live close to R7. FM-BB stated FM-BB would be going grocery shopping for R7 and calling Meals on Wheels to get restarted. SW-I documented per Ombudsman-T, the facility cannot hold R7 there against R7's will and R7 had the right to go home regardless of if R7 was activated or not. R7 currently had a safe discharge plan to go home with family support. At 1:24 PM in the progress notes, SW-I documented SW-I spoke with FM-BB and would fax medications to the pharmacy. On [DATE] at 12:48 PM in the progress notes, SW-I documented home health confirmed that everything was set up for R7 to receive home health. On [DATE] at 5:21 PM in the progress notes, nursing documented R7 was discharged to home at 5:00 PM with family and the discharge folder was sent with R7. The Transition of Care/Discharge Summary for R7 dated [DATE] documented R7 was not resident responsible. No special instructions were documented. No discharge medications were documented. No signatures were found indicating who received the discharge instructions and information. In an interview on [DATE] at 9:57 AM, Surveyor asked Admissions-P what the process was for a newly admitted resident. Admissions-P stated a referral will come from the hospital via fax prior to a resident being admitted and then if they are accepted by the facility, the hospital will fax a discharge summary before the resident arrives. Admissions-P stated the After Visit Summary is brought to the facility by the resident. Admissions-P stated the referral and discharge summary are printed off and put at the nurses' station so the nurses have the information, and an email is sent out to all the departments and the physician to let everyone know of the new admission. Surveyor asked Admissions-P what admission paperwork is presented to the resident and who reviews that paperwork with the resident or resident representative. Admissions-P stated Admissions-P will sit with the resident or POA if the resident is activated or will call the POA if the POA is not present at the time of admission. Admissions-P stated if the POA is not present at the time of admission, Admissions-P will set up a phone call to review the paperwork with the POA and then either email the paperwork to the POA or have them come to the facility to sign the paperwork. Surveyor asked Admissions-P what happens if the POA does not respond. Admissions-P stated that had never happened to Admissions-P so was not sure. Surveyor asked if Admissions-R, who had completed R7's admission, was available. Admissions-P stated Admissions-R no longer worked at the facility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 10:10 AM, Surveyor asked SW-I if FM-Z was involved in R7's admission process. Surveyor shared with SW-I the concern the admission paperwork was signed by R7, and no signatures were found by FM-Z. SW-I stated the admission paperwork is done by the Admissions nurse and social services has nothing to do with that. SW-I stated Admissions-R no longer works at the facility. SW-I stated an activated POA would be expected to be involved with the admission process. Surveyor asked SW-I when was the first time SW-I had contact with FM-Z. SW-I stated SW-I called FM-Z on [DATE] to arrange R7's care conference for the next day. SW-I stated FM-Z was involved in the care conference that was held on [DATE] by phone. Surveyor asked SW-I if SW-I knew the circumstances around FM-BB coming to pick up R7 on [DATE]. SW-I stated that was on the weekend and R7 was not set to discharge at that time. SW-I stated SW-I was not informed of the situation until a couple hours after it happened. SW-I stated nursing did not know what to do so they called the police; there were no other instances of FM-BB coming to get R7. Surveyor asked SW-I if SW-I could recall the situation with R7 wanting to revoke the activated POA. SW-I stated therapy informed SW-I that R7 did not like FM-Z and when SW-I talked with R7, R7 claimed FM-Z was stealing money from R7. SW-I stated SW-I contacted APS to investigate that claim. SW-I stated R7 told SW-I that R7 had not seen FM-Z for five years. SW-I stated APS SW-S talked to R7 and in that conversation, R7 told APS SW-S R7 was fine with going to an ALF, but when R7 talked to SW-I, R7 did not want to go to an ALF. SW-I stated SW-I called Ombudsman-T to get clarification of what R7 could and could not do as R7 had an activated POA. SW-I stated Ombudsman-T informed SW-I that R7 could not be kept at the facility against R7's will and R7, even though was deemed incapacitated, still had the right to be discharged . SW-I stated SW-I had multiple conversations with R7 and Ombudsman-T. SW-I stated R7 was against what FM-Z wanted and SW-I explained to R7 what it meant to revoke the POA. SW-I stated R7 felt R7's rights were being taken away. Surveyor asked SW-I what was done for R7 once R7 revoked the POA and had no one as the decision maker. SW-I stated they were going to start getting corporate guardianship, but R7 became very pushy about going home and Ombudsman-T told them R7 had the right to discharge. Surveyor asked SW-I who was involved in obtaining guardianship. SW-I stated Administration and the legal department took over that part of it; SW-I did not know what happened from there with guardianship. SW-I stated R7 had safe discharge arrangements. In an interview on [DATE] at 10:48 AM, Surveyor asked Ombudsman-T if Ombudsman-T could recall R7 and the conversations with the facility regarding R7's POA being revoked and R7's discharge from the facility. Ombudsman-T stated Ombudsman-T never knew the resident's name. Ombudsman-T stated the facility called Ombudsman-T with questions about discharge. Ombudsman-T stated Ombudsman-T told the facility that the resident had the right to go home, and they need a discharge meeting. Ombudsman-T stated the resident was not under protective placement so they could not keep the resident against their will. Ombudsman-T stated the resident did not want the POA listed anymore so Ombudsman-T told the facility that if the resident revokes the POA, they have to reach out to their legal team for guardianship or a new POA. Ombudsman-T stated APS got involved. Ombudsman-T stated APS called Ombudsman-T and Ombudsman-T reiterated to APS what Ombudsman-T told the facility. Ombudsman-T stated Ombudsman-T would never tell inaccurate information to the facility and it has to be a safe discharge. Ombudsman-T stated what the facility did was the facility choice, not what Ombudsman-T told them to do. Ombudsman-T stated Ombudsman-T could tell the facility the regulations but cannot tell the facility what to do. Ombudsman-T stated they needed to go through their legal team before the resident was discharged . Ombudsman-T stated Ombudsman-T talked to SW-I and ANHA-D many times about this situation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:55 PM, Surveyor asked DoR-U how the facility or therapy determines a resident is safe to discharge home. DoR-U stated DoR-U attends the initial care plan meeting to discuss discharge goals, what level the resident should be at in order to go home, and the home environment, such as stairs and home layout. Surveyor asked DoR-U if PT or OT assessed R7 prior to discharge from the facility. DoR-U stated R7 discharged from therapy services on [DATE] and therapy was told R7 was going to stay at the facility long term so R7 was never evaluated after that date. DoR-U stated R7 did not have any Med B visits with therapy after [DATE] and was not aware of R7 discharging from the facility. In an interview on [DATE] at 2:01 PM, Surveyor asked BOM-V if BOM-V has conversations with residents and resident representatives about Medicaid such as what qualifies them and how they apply. BOM-V stated on admission, if they have the potential of staying long-term, BOM-V will talk about going from Medicare to Medicaid. BOM-V stated if the resident has a POA, then the POA is involved in the conversation as well. BOM-V stated even if the resident is resident responsible, BOM-V likes to have another family member in on the conversation because there is a lot of information to go over. BOM-V stated another conversation is had about Medicaid when the resident is given the NOMNC paperwork. Surveyor asked BOM-V if BOM-V ever had a conversation with R7 or R7's POA about Medicaid. Surveyor shared with BOM-V R7 changed from Medicare to private pay on [DATE] and did not leave the facility until [DATE]. BOM-V stated BOM-V thought R7 was going to discharge home on [DATE] so BOM-V did not pursue Medicaid. BOM-V stated BOM-V was not aware R7 did not leave on [DATE], so BOM-V never had another conversation with R7 after BOM-V provided R7 with the NOMNC and SNFABN paperwork on [DATE]. BOM-V stated BOM-V saw R7 had revoked the POA, so BOM-V had R7 sign the NOMNC and SNFABN and then notified FM-AA and FM-BB of the NOMNC and SNFABN because BOM-V did not know what to do with no resident representative or POA in place. BOM-V stated BOM-V wanted to cover all the bases and notify anyone that would need to know. Surveyor asked BOM-V if the facility had been paid for the dates R7 was paying privately. BOM-V stated no, they had not been paid. In an interview on [DATE] at 8:09 AM, APS SW-S stated R7 was admitted to the facility with an activated POA and R7 wanted to discharge home. APS SW-S stated the activated POA, FM-Z, did not feel it was safe for R7 to go home. APS SW-S stated FM-Z had a lot of concerns such as R7 had no food or medications at home. APS SW-S stated FM-Z wanted R7 to enroll in Medicaid and R7 was told R7 would lose the house so if there was no POA, R7 could keep the house. APS SW-S stated R7 thought if R7 revoked the healthcare POA, both primary and secondary, R7 would be able to go home. APS SW-S stated with R7 revoking the POA, maybe the facility thought that would be an easy discharge. APS SW-S stated PCP-X determined R7 was still incapacitated so APS SW-S recommended the facility seek guardianship for R7. APS SW-S stated APS SW-S and the APS supervisor talked to their legal counsel about the process needed to have a decision maker for R7 since R7 revoked the POA and APS SW-S told the facility to consult with their attorneys to have the courts involved. APS SW-S stated Ombudsman-T s [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not ensure a medication administration errors were thoroughly investigated to prevent reoccurrence. This was observed with 2 (R6 and R2) of 4 residents reviewed with medication administration errors. * R6 received potassium 40 (milliequivalents) meq that was not prescribed for R6. There is not documentation to how this occurred and preventative action. * R2 did not have a reported medication error investigated by the Facility. Findings include: The facility's policy and procedure Administering Medications, dated April 2019. The policy under 6. Medication errors are documented, reported, and reviewed by the (Quality Assurance and Performance Improvement) QAPI committee to inform process changes and or the need for additional staff training. 1.) R6 was readmitted to the facility on [DATE] and was discharged to the hospital on 5/29/24. R6's progress note on 5/15/24 at 2:46 PM documents: Patient administered 40 meq of potassium this morning by medication error. Order was put in R6 (electronic medication administration record) E-Mar by mistake for another resident. Surveyor noted that there was the appropriate notifications and monitoring documented after R6 was provided with the wrong medication. Surveyor reviewed R6 Medication Error report. The report only identifies the medication and notifications. There is not documentation of the possible cause of the medication error and interventions to prevent reoccurrence. On 11/5/24, at 11:03 AM, Surveyor interviewed the (Director of Nurses) DON-B. The DON-B did not have any involvement with the medication error. On 11/5/24, at 3:03 PM, Surveyor shared the concerns with R6's medication error with DON-B, (Assistant Nursing Home Administrator) ANHA-D and (Director of Operations) DOO-C. There was no additional information provided. 49011 2.) R2 was admitted to the facility on [DATE] and has diagnoses which include type 2 diabetes with foot ulcer, end stage renal disease, dependence on renal dialysis, and dementia. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's annual Medicare Minimum Data Set (MDS) with an assessment reference date of 5/24/2024 indicated R2 had a Brief Interview for Mental Status score of 11 (moderately impaired cognition). R2 is able to make decision for themselves. R2's MDS showed that no behaviors were noted. R2 is always continent of bladder and bowel. The MDS noted that R2 receives dialysis. Surveyor was at the facility investigating a complaint about R2 receiving medications crushed before dialysis. Surveyor reviewed the electronic medical record in which there was a progress note dated 05/22/2024, at 11:13 AM, which reads spoke to RN from dialysis . she reported pt (patient) received his medication crushed and that's the reason his BP (blood pressure) is high, requested he received it whole for best medication result. writer placed a nursing order for pt to receive medications whole. Surveyor reviewed medication orders and found Ensure patient takes medications whole for best medication effective result. Every Shift. Take medication whole. Effective 05/22/2024 - 06/28/2024. On 11/5/2024, at 9:10 AM, Surveyor interviewed Director of Nursing (DON)-B regarding the medications being crushed on 5/22/2024. DON-B was unaware and stated that DON-B knows the computer says to give the medications whole. On 11/5/2024, at 9:35 AM, Surveyor interviewed Social Worker (SW)-E from DaVita, the dialysis center R2 visited, who informed Surveyor that they contacted the Facility on numerous occasions regarding R2's complaints of not enough staff and medications not given at all or incorrectly. Surveyor asked if R2 was a good historian and SW-E stated that R2 was alert and oriented and knew staff names and good at remembering details. SW-E agreed to fax progress notes to Surveyor to review related to contact with Facility. On 11/5/2024, at 10:06 AM, Surveyor received the fax from DaVita and reviewed the progress notes. On 5/22/2024, at 11:34 AM, a progress note reads BP continues to be elevated, patient stated 'All my medications were given today in powdered form which is very unusual' MD (medical doctor) advised patient to report to RN (registered nurse) in charge if anything is looking different. IDT (interdisciplinary team) called DON (Director of Nursing) at Nursing home and reported this concern. Spoke with RN . who stated 'We are not sure what he took, but night nurse was from agency'. RN advised to educate all other RN's to follow up MAR (Medication Administration Report) and give patient correct medications and on time. Verbalized understanding . On 11/6/2024, at 1:58 PM, Surveyor followed up with DON-B and asked if it is a medication error to give a resident that gets medications whole, crushed medication. DON-B responded that yes it would be an error. Surveyor asked for the investigation into this occurrence. On 11/6/2024, at 2:59 PM, during the daily exit meeting with the Facility, Surveyor shared the concern that a medication error was not investigated regarding crushed medications being given to R2. Assistant Nursing Home Administrator (ANHA)-D, DON-B and Director of Operations-C were present. On 11/7/2024, at 8:35 AM, ANHA-D and DON-B let Surveyor know there was no medication error investigation completed after the 5/22/2024 crushed medication issue. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525565	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not ensure 1 (R17) of 1 resident were free of significant medication errors. R17 did not receive various medications from September 2024 through November 2024 because the medication was not available. The medications that were not administered were Trulicity (diabetic medication), losartan hydroclorothiazide 100/25 mg (milligrams) (blood pressure medication), allopurinol 300 mg (medication to treat gout), latanoprost (eye drops for glaucoma), sertraline 50 mg (depression), toprol xl 100 mg (blood pressure medications), pantoprazole EC 40mg (for GERD-gastro-esophageal reflux disease), and fluticasone (treat asthma). Findings include: R17 was admitted to the facility on [DATE] with diagnoses of cellulitis of abdomen wall, morbid obesity, type 2 diabetes and COPD (Chronic obstructive pulmonary disease). The admission MDS (minimum data set) dated 9/3/24 indicate R17 is cognitively intact and independent with eating, bed mobility and transfers with a walker. On 11/5/24 at 9:30 a.m. Surveyor interviewed R17. R17 stated she frequently doesn't get all her medications. R17 asks the staff why she doesn't have all her meds and they say they don't have it. Surveyor reviewed R17's MAR (medication administration record) from 8/28/24 through 11/4/24. The following medications were not administered due to the medication not being available. August 2024 MAR 8/29/24 Allopurinol 300 mg daily 8/31/24 AM dose Fluticasone propion-salmeterol 250/50 mcg/dose 1 puff inhalation twice a day 8/31/24 latanoprost drops 0.005% 1 drop both eyes at bedtime September 2024 MAR 9/28/24 and 9/29/24 Allopurinol 300mg daily 9/30/24 latanoprost drops 0.005% 1 drop both eyes at bedtime 9/28/24 and 9/29/24 Losartan-hydrochlorothiazide 100-25 mg daily 9/2/24, 9/4/24 and 9/5/24 Pantoprazole EC 40 mg daily (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525565	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geneva Lake Manor	211 S Curtis St Lake Geneva, WI 53147

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/28/24 sertraline 50mg daily 9/14/24, 9/18/24 and 9/22/24 Toprol XL 100 mg October 2024 MAR 10/2/24, 10/7/24, 10/27/28 and 10/28/24 Allopurinol 300 daily 10/2/24, 10/4/24 and 10/7/24 Losartan-hydrochlorothiazide 100-25 mg daily 10/7/24 omeprazole EC 20 mg daily 10/20/24 Trulicity pen injector once weekly November 2024 MAR 11/1/14, 11/4/24 Allopurinol 300mg daily Surveyor reviewed R17 blood glucose levels and blood pressure levels and found there were no unusual drops or elevation in those levels due to not receiving the medications as ordered. On 11/5/24 at 2:01 p.m. Surveyor interviewed DON (director of nursing)-B. Surveyor explained to DON-B the many medications that were not administered to R17. Surveyor explained to DON-B, R17 confirmed she has not been getting all her medications on a consistent basis. DON-B stated the facility changed how they refill medications, and the nursing staff were educated on the new way of refilling medications. DON-B stated this is education is on going because of the agency staff they utilize. DON-B stated she understood the concern but had no additonal information. No additional information was provided as to why the facility did not ensure that R17 was free of significant medication errors.