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	03/17/2025

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview and record review, the Facility did not provide written notice including the reason for the room change to a resident and offer a choice in a change of room for 1 (R13) of 1 residents reviewed for room change. R13 returned from the hospital on 2/24/2025 and was placed into a different room, the Facility did not take resident preference into account or offer to show possible rooms to the resident/resident representative prior to the change. There is no documentation R13 received prior written notice for the reason for the transfer. Findings include: The Facility's Policy and Procedure titled, Transfer, Room to Room, last revised December 2016 documents, in part: .Preparation 1. Orient the resident to the transfer in a form and manner that the resident can understand. Provide the resident with information about: a. Where the room is located. b. Who the resident's new roommate, if any, will be. c. Who will be providing the resident's care. d. That his or her family and visitors will be informed of the room change. e. Why the transfer is taking place. 2. Reassure the resident that all his or her personal effects will be brought to his or her new room . 5. If possible, take the resident to see his or her new room before the actual move is made . (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15. Store the resident's personal effects. Ask the resident how he or she would like them arranged . Documentation The following information should be recorded in the resident's medical record: 1. The date and time the room transfer was made. 2. The name and title of the individual(s) who assisted in the move. 3. All assessment data obtained during the move. 4. How the resident tolerated the move. 5. If the resident refused the move, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data . R13 was originally admitted to the facility on [DATE] and most recently readmitted [DATE] after a hospital stay. R13's pertinent diagnoses include methicillin resistant staphylococcus aureus (MRSA), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Parkinsonism, type 2 diabetes mellitus with diabetic nephropathy, and neuromuscular dysfunction of bladder. R13's 5 day Minimum Data Set (MDS), completed 2/27/25, documents R13's Brief Interview for Mental Status (BIMS) score to be 15, indicating R13 is cognitively intact for decision making. R13's MDS also documents Patient Health Questionnaire (PHQ-9) score to be 00, indicating no depression. No behavior concerns are documented. R13 is coded as making self understood and understands others. Per MDS R13 has a catheter and an ostomy for bladder and bowel function. On 02/24/2025, at 10:54 AM, a progress note was written that reads Resident returning to facility today from AMCB (name of Medical Center [NAME]). He finished his IV (intravenous) antibiotics, and per discharge summary has no new medications. He is moving rooms to (room number) due to MRSA + UTI (urinary tract infection). On 02/26/25, at 11:45 AM, Surveyor interviewed R13 who stated today was hectic. They switched his room and today they moved his belongings to the new room. R13 stated that limited notice had been given. R13 was concerned because R13 had decorated old room with pictures that were not back up in new room. On 03/03/25, at 01:06 PM, Surveyor followed up with R13 who stated that when R13 was brought back from hospital R13 was taken to a new room. It took a day or 2 for staff to bring possessions from old to new room. R13 stated that no notice was given. After R13 asked questions was told the move was because of MRSA, R13 could not share a room so was moved to a private room. R13 asked if could make new room their own and was told would be moved again, however no timeframe was given. R13 was told can't be in a room with someone else. Doesn't understand because can be out of room socializing, this confuses R13. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/25, at 01:50 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-F regarding R13 and was told Facility will continuously look into this because of MRSA, right now R13 needs to be in a private room. Surveyor asked about setting room up to R13's wishes and was told this needs to be a discussion. ADON-F is trying to find right guidelines and then will discuss options. On 03/04/25, at 09:48 AM, Surveyor interviewed Admissions-U about when the room change was communicated to R13. Admissions-U stated that when R13 came back, R13 was placed in the bed in the new room, then Admissions-U went to room to discuss with R13 the MRSA diagnosis and that R13 can't share a room. Admissions-U was not sure the length of time it will be for. Admissions-U stated that the decision was made that day by management to move R13. Admissions-U was unsure about what the plan was to organize the room to R13's liking at this time. On 03/04/25, at 09:53 AM, Surveyor observed R13's new room and there was only a clock on the walls, no pictures. There was a bookshelf with books on it. R13's clothes were laying across a chair in the room. On 03/04/25, at 10:08 AM, Surveyor interviewed Director of Nursing (DON)-B and asked about communicating to R13 about the room change. DON-B stated that to my understanding social services and admissions were to communicate with each other and they should have alerted him. Surveyor asked about the length of time the room change will be for and was told the Facility will repeat labs continuously to determine if can move back. Surveyor asked about the set up of the room and was told we can set it up. To DON-B's knowledge R13 asked someone about it, R13 can set it up per wishes. Surveyor notes no documentation was found indicating R13 had been aware of the room change, given a preference as to which room R13 would like, and there was no documented follow-up on how R13 was adjusting to the new room. On 03/04/25, at 10:12 AM, Surveyor let DON-B know this is a concern, R13 was transferred to another room and there is no documentation R13 received prior written notice of the reason for the transfer or documentation on how R13 was adjusting to new room.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview and record review, the Facility did not promote or facilitate the resident's choice for a sleep schedule. This was observed with 1 (R13) of 14 residents reviewed. * R13's morning preference of time to get up was not followed by staff. Findings include: R13 was originally admitted to the facility on [DATE] and most recently readmitted [DATE] after a hospital stay. R13's pertinent diagnoses include methicillin resistant staphylococcus aureus (MRSA), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Parkinsonism, type 2 diabetes mellitus with diabetic nephropathy, and neuromuscular dysfunction of bladder. R13's 5 day Minimum Data Set (MDS), completed 2/27/25, documents R13's Brief Interview for Mental Status (BIMS) score to be 15, indicating R13 is cognitively intact for decision making. R13's MDS also documents Patient Health Questionnaire (PHQ-9) score to be 00, indicating no depression. No behavior concerns are documented. R13 is coded as making self understood and understands others. Per MDS R13 has a catheter and an ostomy for bladder and bowel function. R13's care plan reads resident requests to be woke up at 0630 hrs (hours) every day of the week. Please document refusal for following request of resident with wake time and medications. Reassess resident requests PRN (as needed), start date 2/7/25, edited 3/4/25. The Approach and Long Term Goal Target . is resident will be woken up every day at 0630 hours per resident request. Signs will be hung in LTC (long term care) nurses' station and resident's room and closet as reminders for staff. Created: 02/07/2025. R13's care plan reads R13 has history of insomnia. The approach is encourage R13 to go to bed at the same time every day and wake up at the same time every day. Created: 08/14/2024. On 02/26/25, at 10:05 AM, Surveyor observed two staff in R13's room doing ADLs (activities of daily living) with R13. One staff then stepped out of room and went to get the Hoyer to get R13 out of bed for day. On 03/03/25, at 10:00 AM, Surveyor observed R13's door shut, Surveyor knocked on door and was told staff were doing R13's cares to get up for the day. Surveyor notes R13's care plan and sign on R13's door state resident likes to be up at 6:30 AM. On 03/03/25, at 01:06 PM, Surveyor interviewed R13 about what time R13 likes to get up. R13 stated by 6:30 AM and that has not happened since R13 came back from the hospital on 2/24/2025. R13 stated that when R13 can be up in power wheelchair R13 can maintain independence and that is R13's goal. When in wheelchair R13 has ability to get food, water and medications otherwise R13 just lays in bed unable to get needs met. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25, at 09:30 AM, Surveyor interviewed R13 again and asked if was up at 6:30 am today. R13 stated yes they were, but not up properly. R13 does not have seat cover on seat and there was no teeth brushing among other things, R13 is working on getting that accomplished. On 03/04/25, at 09:39 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K and asked what time R13 got up. CNA-K replied it was before they got here so must be before 6:30 AM. CNA-K stated that they finished helping R13 get ready today. On 03/04/25, at 10:10 AM, Surveyor interviewed Director of Nursing (DON)-B about R13's desire to get up by 6:30 AM. DON-B stated that there is a sign on the door and R13's desired time is on the get up list CNA get. Per DON-B R13 refuses sometimes if staff ask and it should be documented but it's not. Surveyor let DON-B know this is a concern as a resident has the right to get up at the time desired. No additional information was provided.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review the Facility did not ensure that residents are free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms and document ongoing re-evaluation of the need for restraints for 1 (R13) of 1 residents reviewed for restraints. R13 has an abdominal binder in place which cannot be removed easily by R13 and restricts R13's freedom of movement or normal access to body. The Facility did not have a Physician order or signed consent form, did not provide evidence that the use of the abdominal restraint is the least restrictive alternative, did not document scheduled time binder should be on and did not document on-going evaluation of the need for the abdominal binder. Findings include: R13 was originally admitted to the facility on [DATE] and most recently readmitted [DATE] after a hospital stay. R13's pertinent diagnoses include methicillin resistant staphylococcus aureus (MRSA), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Parkinsonism, type 2 diabetes mellitus with diabetic nephropathy, and neuromuscular dysfunction of bladder. R13's 5 day Minimum Data Set (MDS), completed 2/27/25, documents R13's Brief Interview for Mental Status (BIMS) score to be 15, indicating R13 is cognitively intact for decision making. R13's MDS also documents Patient Health Questionnaire (PHQ-9) score to be 00, indicating no depression. R13 has no behavior concerns. R13 is assessed as making self understood and understands others. Per MDS R13 has a catheter and an ostomy for bladder and bowel function. The MDS assesses that physical restraints are not used. Surveyor's review of R13's medical record revealed no Physician's order, assessment, care plan, consent or ongoing monitoring of an abdominal binder. R13 does have a care plan for indwelling catheter and one approach listed is Abdominal Binder to maintain placement of tubes. Created: 01/07/2025. Surveyor notes that it is not documented why the abdominal binder was needed to maintain placements of tubes in use, how long the abdominal binder should be used and alternative interventions that had previously been used that may have been less restrictive. Surveyor notes the abdominal binder is not a regularly prescribed intervention with nephrostomy tubes. Surveyor notes there are no instructions given on times binder should be put on or off of R13. Surveyor notes the medical record does not contain a Physician's order, care plan or consent for the binder restraint and there is no evidence of ongoing monitoring of the restraint on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/25, at 01:50 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-F regarding R13's nephrostomy tubes getting dislocated by staff during cares and was told they started an intervention of using an abdominal binder to hold the tubes in place. They discussed with the Nurse Practitioner today if there are other ideas on how to keep the tubes from not getting pulled out. (Cross-reference F684). On 03/04/25, at 09:30 AM, Surveyor interviewed R13 regarding the abdominal binder, R13 stated they are not using it now because it is so tight that R13 got a rash. R13 decided on own that they did not want the rash so have asked staff not to put the binder on. On 03/04/25, at 09:39 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K who finished helping R13 get ready that morning and asked about R13's abdominal binder to which CNA-K responded ya he wear it. On 03/04/25, at 09:58 AM, Surveyor interviewed Director of Nursing (DON)-B regarding steps taken to prevent pulling of nephrostomy tubes by Facility. Per DON-B the first couple times it happened it was during Hoyer transfers so DON-B got an abdominal binder to hold tubes in place. DON-B admits not being aware R13 is not wearing the binder due to rash, stated will have to talk to R13 about skin protection options. On 03/04/25, at 03:34 PM, Surveyor asked DON-B if the abdominal binder was assessed and was told that it was not assessed or considered a restraint. The Nursing Home Administrator was also in the room. Surveyor reiterated that this is a concern. As of the time of exit, no additional information was provided as to why the Facility did not comprehensively assess the use of the physical restraint (abdominal binder) and then develop a plan of care based on the outcome of the assessment for its continued use.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not complete a Pre-Admission Screening & Resident Review (PASARR) assessment for 1 (R37) of 1 residents reviewed. R37 was admitted to the facility on [DATE], and did not have a PASARR Level I completed at time of admission. Findings include: The facility's Policy and Procedure titled Admission Criteria, not dated, documents: All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. R37 was admitted to the facility on [DATE] with a diagnosis that includes Bipolar disorder, Depression, Anxiety, and Post Traumatic Stress Disorder (PTSD). R37's hospital documentation dated 12/20/24, documents R37 with a history of chronic bipolar, depression, anxiety, and PTSD. On 2/27/25, at 1:39 PM, Surveyor interviewed Medicaid Pending Manager (MPM)- C who states she is notified by the facility of new admissions and will read through the referral to see if there are any medications or diagnoses to fill out the Level I PASARR. MPM- C indicates a Level I PASARR is required on every resident, and she will download in the Electronic Medical Record (EMR). MPM- C states she will complete a Level 2 PASARR if it is required and will send a notification to the facility's Director of Nursing (DON) if a Level 2 PASARR is required. Surveyor asked MPM- C if a Level I PASARR was completed on R37 and MPM- C states she completed the Level I PASARR today on 2/27/25. Surveyor notes R37 was admitted on [DATE]. Surveyor asked why the Level I PASARR was completed on 2/27/25 and MPM- C states she works in 6 other facilities and sometimes doesn't catch everything. MPM- C indicates R37's Level I PASARR was completed and submitted on 2/27/25 and the Level 2 PASARR is not completed but is requested. On 2/27/25, at 3:02 PM, Surveyor notified Nursing Home Administrator (NHA)- A, Assistant Nursing Home Administrator (ANHA)- D, and DON- B of concerns with R37 not having a Level I PASARR completed on admission. NHA- A, ANHA- D, and DON- B acknowledge concerns.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents received care consistent with professional standards of practice to prevent development of pressure injuries or received care to promote healing and prevent new ulcers from developing for 6 (R17, R47, R34, R19, R26, and R36) of 6 residents reviewed with pressure injuries or at risk for developing pressure injuries. *R17 did not have a comprehensive skin assessment on admission on 7/19/2024. On 7/26/2024, wound documentation included a Deep Tissue Injury (DTI) to the right lateral foot, a DTI to the right Achilles and heel, a DTI to the coccyx, a DTI to the left heel, and a DTI to the left Achilles. The Right lateral foot, and the coccyx pressure injuries progressed to Unstageable, and the right Achilles and heel progressed to a Stage 4. All areas healed. R17 developed a DTI to the right medial foot on 8/2/2024 that progressed to a Stage 3 and healed. R17 developed Moisture Associated Skin Damage (MASD) on 2/7/2025 to the right and left buttocks that worsened with pressure and are still present. The pressure injury documentation was not accurate, and the wounds were not comprehensively assessed weekly. The Registered Dietician recommendations were not implemented for 2 months. *R47 did not have a comprehensive skin assessment on admission on 10/18/2024. On 10/25/2024, wound documentation included a Stage 2 pressure injury to the right lateral ankle, an Unstageable pressure injury to the right lateral foot, and MASD to the sacrum and medial thighs. Documentation was conflicting as to the right lateral ankle and right lateral heel being assessed as the same area or two separate areas. R47 was readmitted after hospitalization four times with skin assessments not being completed upon return to the facility. The sacrum and medial thighs MASD healed. The right lateral ankle/heel progressed to Unstageable. On 2/7/2025, R47 developed MASD to bilateral buttocks that worsened with pressure and was not staged as a pressure injury. The pressure injury documentation was not accurate, and the wounds were not comprehensively assessed weekly. The Registered Dietician recommendations were not implemented for 2 months. *R34 developed a Stage 3 pressure injury to the right heel on 11/26/2024 that was not comprehensively assessed on discovery. Interventions to prevent the pressure injury to the heel were not in place. The pressure injury documentation was not accurate, and the wounds were not comprehensively assessed weekly. Observations were made of R34's heels on the mattress and the air mattress was not plugged in. The Registered Dietician recommendations were not implemented. *R19 developed a DTI to the right heel on 11/1/2024 that progressed to an Unstageable pressure injury. The pressure injury documentation was not accurate, and the wounds were not comprehensively assessed weekly. Observations were made of interventions not in place. *R26 developed wounds to the abdominal fold that were not comprehensively assessed. *R36 was admitted to the facility on [DATE] with limited mobility related to a left femur fracture. R36 was Non-Weight-Bearing (NWB) to Left Lower Extremity (LLE). R36 was prescribed an immobilizer brace to her LLE to be worn at all times. There is no evidence the facility was removing R36's immobilizer brace and performing skin checks to prevent injuries to the skin. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Findings include: The facility policy and procedure titled Prevention of Pressure Injuries from MED-PASS (C) 2001 revised 4/2020 documents: Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly for one month a total of 4 assessments, upon any changes in condition and with each MDS assessment. 2. Under observations use the standardized assessment titled Skin Risk Assessment with Braden Scale to determine and document risk factors, help you identify and initiate preventive interventions and initiate plan of care. 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. 2. During the skin assessment, inspect: a. Presence of erythema. b. Temperature of skin and soft tissue; and c. Edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care of ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). for darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e. Reposition resident as indicated on the care plan. 4. A weekly skin prevalence will be conducted each week over a 24-hour period. See Skin Prevalence process and form. Skin prevalence should be completed the day prior to wound rounds. 5. Weekly RN assessment and documentation completed. Wound rounds must be completed at a minimum of at least once every 7 days. 6. Measurements and documentation to support treatment, interventions, type of wound must be part of the weekly documentation. 7. There must be a current PI care plan in place to support the wound status and all interventions and goals. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	8. MD must be notified with any changes in wound. 9. Residents and or their representative must be notified of the status of the wound and current interventions at least weekly and as needed. Prevention: . Nutrition: 1. Conduct nutritional screenings for residents at risk. 2. Conduct a comprehensive nutritional assessment for any resident at risk of pressure injury who is screened to be at risk for malnutrition, and for all adult residents with a pressure injury. 5. Monitor the resident for weight loss and intake of food and fluids. 6. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Mobility/Repositioning: 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Support Surfaces and Pressure Redistribution: 1. Select appropriate support surfaces based the [sic] resident's risk factors, in accordance with current clinical practice. Device-Related Pressure Injuries: 1. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device. 2. Monitor regularly for comfort and signs of pressure-related injury. 3. For prevention measures associated with specific devices, consult current clinical practice guidelines. Monitoring: 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. 1.) R17 was admitted to the facility on [DATE] with diagnoses of cellulitis of the right and left lower limbs, chronic obstructive pulmonary disease, venous insufficiency (peripheral), congestive heart failure, adult failure to thrive, and xerosis cutis (a skin condition characterized by excessive dryness, roughness, and flaking). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R17's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented R17 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and had no impairment to the arms or legs. R17 was always incontinent of bowel and bladder, had one Unstageable pressure injury due to a non-removable dressing or device that was present on admission, and four Unstageable pressure injuries that were present on admission. The Pressure Ulcer/Injury Care Area Assessment (CAA) associated with the MDS documented R17 had recently transitioned to hospice care and remains bed bound most of the time. R17 transfers with a Hoyer lift and is dependent in the wheelchair. R17 had skin concerns on the coccyx that was present on admission and the wound nurse continues to monitor. R17 was rotated every two hours and lays on a pressure relieving mattress. R17 had a BIMS of 15 and could state any concerns or needs. R17 did not have an activated Power of Attorney. Prior to admission to the facility, R17 was hospitalized from 7/15/2024 to 7/19/2024 with failure to thrive and worsening bilateral foot wounds. On 7/15/2024, R17 was evaluated by the hospital wound Registered Nurse (RN) and documented R17 had an Unstageable pressure injury to the coccyx that measured 1.3 cm x 0.4 cm x unable to determine with 100% slough, a venous ulceration to the right lateral ankle that was red and moist with a few scattered open areas, and a venous ulceration to the left posterior ankle that was red and moist with one small open area. The RN documented R17 reported not being able to cleanse the legs and only has a bathtub so has not showered in quite some time. R17 had thick build up of epithelial cells and drainage on bilateral ankles/lower extremities; hair was cleansed from the right leg wound. Thick scaly skin was removed with mechanical debridement with cleansing and cocoa butter was applied to help moisten the areas that could not be removed. An Unstageable pressure injury was discovered on the coccyx. R17 was positioned to the right side lying with pillow support as well as placement of a waffle cushion. R17 should be turned every two hours left to right and limit supine/sitting position as much as possible. A photograph of the right lateral ankle wound was included in the hospital documentation. On 7/19/2024 (date of admission to the facility) on the Head-to-Toe Assessment form, the nurse hand wrote See RN document under the skin section for pressure ulcer. The form was not signed. The Skin Condition on the Admission form documented R17 had a bruise to the top of the right hand, a bruise to the left wrist, and a bruise to the left antecubital from blood draws. No areas were circled on the body diagram. This form was not signed. On 7/20/2024 at 3:19 PM in the progress notes, an RN documented R17 was admitted on [DATE] with diagnoses of venous stasis dermatitis with infected ulceration to the right foot and a wound to the coccyx. No documentation of an assessment was found. On 7/22/2024 at 6:00 PM in the progress notes, an RN documented an admission skin assessment was done by the RN and Director of Nursing (DON)-B and R17 had bilateral lower extremity venous stasis dermatitis. The wounds were cleansed with normal saline, patted dry, and xeroform was applied to the affected areas. No measurements or description was documented, and no assessment of the coccyx was documented. On 7/22/2024, R17 got a treatment order to cleanse area with warm water and soap daily. Surveyor noted no location was documented as to where the treatment was to be applied and, if this was for the coccyx wound, the coccyx wound was not treated for three days since admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	R17's At Risk for Skin Breakdown Care Plan was initiated on 7/25/2024 with interventions: -Assess for presence of risk factors; treat, reduce, eliminate risk factors to the extent possible. -Avoid shearing skin during positioning, transferring, and turning. -Check for incontinence episodes often. -Conduct a systemic skin inspection on admission, with cares, and on bath days. -Cushion in wheelchair for protection. -Document episodes of refusals to reposition in progress notes. -Educate on the risk vs benefits of sleeping in recliner vs bed for off loading and pressure relief if indicated. -Educate on the risk vs benefits of staying in bed vs getting up for offloading and position changes to prevent breakdown if indicated. -Encourage fluids every shift. -Encourage physical activity, mobility, and range of motion to maximal potential. -Encourage/assist to make frequent position changes while in chair. -Encourage/assist to turn and reposition frequently. -Float heels to reduce the risk of pressure and friction. -Heel boots on at all times while in bed. -Keep clean and dry as possible; minimize skin exposure to moisture. -Keep linen clean, dry, and wrinkle free. -Provide cushion in recliner if (R17) prefers to sleep in recliner to reduce the risk of skin breakdown. -Report any signs of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	On 7/26/2024 at 8:46 AM in the progress notes, an RN documented wound rounds were done with Nurse Practitioner (NP)-N and R17 did not have any open areas to bilateral lower extremities. The RN documented R17 had multiple deep tissue injuries (DTIs): 1.) the right heel measured 8.5 cm x 1 cm with intact skin that was deep purple and appeared to be an old injury unseen related to the thick covering of stasis dermatitis; 2.) the right Achilles measured 14 cm x 5 cm with intact skin that was deep purple and an old wound as stated above; 3.) the coccyx had an open wound measured 4 cm x 9 cm that was 90% dark purple and 10% slough; 4.) the left heel had a DTI that measured 1 cm x 1 cm; 5.) skin discoloring 1.5 cm x 12 cm related to R17 lying on catheter tubing. Surveyor noted the coccyx wound was not staged and did not have a depth measurement, and no location was identified where the skin was discolored from the catheter tubing. On 7/26/2024 at 12:21 PM in the progress notes, DON-B documented an alternating air mattress had been ordered for R17 due to R17's condition. On 7/27/2024, R17 got a treatment order for the coccyx wound to be cleansed with warm water and soap, pat dry, and apply zinc cream to the area twice daily and to turn R17 every two hours to relieve pressure. On 8/4/2024 at 10:44 AM in the progress notes, an RN documented wound rounds were completed on 8/2/2024 with NP-N and R17 had Prevalon boots on but refused to have them Velcro closed. R17 had DTIs to the right thigh, the left heel, the left thigh, the left Achilles and the right thigh (listed twice). -The right heel/Achilles DTI measured 15 cm x 5 cm. -The wound to the coccyx measured 5 cm x 7 cm with 50% epithelial tissue, 10% granulation tissue, and 40% deep purple. -The right medial foot DTI measured 4 cm x 1 cm. -The right calf DTI measured 0.7 cm x 15 cm. -The left lateral foot/Achilles DTI measured 8.5 cm x 7 cm and was boggy and blanchable. Surveyor noted the right heel wound and the right Achilles wound were combined to one measurement, the coccyx pressure injury was not staged and did not have a depth measurement, and multiple new areas had deep tissue injuries that did not include measurements: the right thigh, the left heel, and the left thigh. Surveyor noted the right medial foot wound and the right calf wound were new DTIs. On 8/9/2024 at 5:05 PM in the progress notes, an RN documented wound rounds were done with NP-N and R17 had the following pressure injuries: -The right heel/Achilles DTI measured 13 cm x 4 cm and was now Unstageable with 50% eschar and 50% epithelial tissue. Surveyor noted no depth measurement was documented. -The Coccyx DTI measured 2.5 cm x 2.5 cm and was now Unstageable with slough. Surveyor noted no depth measurement or percentage of slough was documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-The right medial foot DTI measured 3 cm x 0.9 cm. -The right posterior calf DTI, related to the catheter tubing, measured 0.5 cm x 12 cm. -The left Achilles DTI measured 0.5 cm x 0.5 cm. -The left heel DTI measured 1 cm x 1 cm. -The right lateral foot DTI measured 7.9 cm x 0.5 cm. Surveyor noted the right thigh and the left thigh DTIs from the previous week were not documented on, the left Achilles wound did not include the left lateral foot wound as it did from the previous week, and the left heel wound and right lateral foot wound were new DTIs. On 8/16/2024 at 4:38 PM in the progress notes, an RN documented wound rounds were done with NP-N and R17 had the following pressure injuries: -The right heel/Achilles DTI measured 12 cm x 3.5 cm with eschar. Surveyor noted the pressure injury did not meet the definition of DTI, and no depth measurement or percentage of eschar was documented. -The Coccyx pressure injury measured 3.5 cm x 2 cm with slough. Surveyor noted the pressure injury was not staged, and no depth measurement or percentage of slough was documented. -The right medial foot DTI measured 1.5 cm x 0.4 cm. -The right posterior calf DTI measured 0.5 cm x 10 cm. -The left Achilles DTI resolved. -The left heel DTI resolved. -The right lateral foot DTI measured 2 cm x 0.5 cm. On 8/23/2024 at 3:48 PM in the progress notes, an RN documented wound rounds were done with NP-N and R17's wounds to the left lateral ankle, the left heel, and the left Achilles/heel, and the left lateral ankle had healed. R17 had the following pressure injuries: -The right heel/Achilles pressure injury measured 12 cm x 3.5 cm x unable to determine with 50% eschar and 50% epithelial tissue. Surveyor noted the pressure injury was not staged. -The Coccyx pressure injury measured 2.5 cm x 1.5 cm with 50% slough and 50% epithelial tissue. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. -The right medial foot DTI measured 1 cm x 0.3 cm and was now Unstageable with 100% eschar. Surveyor noted no depth measurement was documented. -The right posterior calf DTI measured 0.5 cm x 10 cm with 100% epithelial tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-The right lateral foot DTI measured 2 cm x 0.5 cm and was now Unstageable with eschar. Surveyor noted no depth measurement or percentage of eschar was documented. No documentation for wounds was found from 8/23/2024 until 9/6/2024, two weeks later. R17's Moisture Associated Skin Damage (MASD) on Bilateral Buttocks Care Plan was initiated on 9/2/2024 with the interventions: -Turn every two hours to off load wound area. -treatment to the wound will be done according to provider orders. Surveyor noted no documentation was found in R17's record of having MASD to the buttocks. A timeline of the wound progression is listed for each pressure injury site: the right heel/Achilles, the coccyx, the right medial foot, the right posterior calf, and the right lateral foot. RIGHT HEEL/ACHILLES On 9/6/2024 at 1:31 PM in the progress notes, an RN documented wound rounds were done with NP-V and the right heel pressure injury measured 2.7 cm x 4 cm x unable to determine with dry eschar. Surveyor noted the pressure injury was not staged, and no percentage of eschar was documented. The right Achilles pressure injury measured 5 cm x 1.5 cm x unable to determine with 90% dry eschar and 10% epithelial tissue. Surveyor noted the pressure injury was not staged. On 9/13/2024 on the Wound Management Detail Report, RN-M documented the right Achilles/heel pressure injury measured 11 cm x 3.5 cm x 0 cm with 40% epithelial tissue, 30% eschar, and 30% slough. Surveyor noted the pressure injury was not staged. The right heel and the right Achilles were measured as one. NP-N assessed R17's right heel/Achilles Unstageable pressure injury and documented weekly from 9/20/2024 - 10/11/2024. On 10/18/2024 at 5:40 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the pressure injury measured 11.5 cm x 4 cm with 40% epithelialization, 20% eschar, and 20% slough. Surveyor noted the pressure injury was not staged, and no depth was documented. The percentage tissue type did not equal 100%. On 10/25/2024 at 6:00 PM in the progress notes, RN-M documented wound rounds were done with NP-V and R17 had a venous stasis ulcer to the right lateral calf that measured 3.5 cm x 2 cm x 0.1 cm. No pressure injuries were assessed or documented. No wound documentation of the pressure injury was found from 10/18/2024 until 11/8/2024. On 11/8/2024, NP-N assessed R17's right heel/Achilles Unstageable pressure injury and documented the wound measured 11 cm x 3.2 cm x unable to determine with 40% epithelial tissue, 20% slough, and 40% granulation and the measurements are post-debridement. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	On 11/15/2024, NP-N assessed R17's right heel/Achilles Stage 4 pressure injury and documented the wound measured 10.4 cm x 3.2 cm by unable to determine with 40% epithelial tissue, 10% tendon, and 50% granulation. NP-N had debrided the area by removing the eschar on the heel. On 11/22/204 on the Wound Management Detail Report, RN-M documented the pressure injury measured 10.3 cm x 3.0 cm with 40% epithelialization, 50% granulation, and 10% slough. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. No wound documentation of the pressure injury was found from 11/22/2024 until 12/11/2024. On 12/11/2024 on the Wound Management Detail Report, RN-M documented the pressure injury measured 10.4 cm x 2.9 cm x 0 cm with slough. Surveyor noted the pressure injury was not staged, and no percentage of slough was documented. On 12/13/2024 on the Wound Management Detail Report, RN-M documented the Stage 2 pressure injury measured 10 cm x 2.4 cm x 0 cm with 30% epithelialization tissue, 60% granulation, and 10% slough. Surveyor noted the pressure injury was not staged appropriately. NP-N documented the pressure injury was a Stage 4. On 12/20/2024 and 12/27/2024 on the Wound Management Detail Report, RN-M did not document the stage of the pressure injury. On 1/3/2025 on the Wound Management Detail Report, RN-M documented the pressure injury was Unstageable Deep Tissue injury with 100% granulation tissue. The staging did not match the wound description. On 1/10/2025 on the Wound Management Detail Report, RN-M documented the pressure injury was a Stage 3 which was not appropriate staging; a wound cannot get downgraded. RN-M assessed and documented on R17's Stage 4 pressure injury on 1/17/2025. R17's Stage 4 pressure injury was not assessed or documented on from 1/17/2025 until 1/31/2025. RN-M assessed and documented on R17's Stage 4 pressure injury weekly from 1/31/2025 until 2/21/2025 when the wound healed. COCCYX On 9/6/2024 at 1:31 PM in the progress notes, an RN documented wound rounds were done with NP-V and the Stage 3 pressure injury measured 2.5 cm x 2.5 cm x 0.1 with 50% slough and 50% epithelial tissue. Surveyor noted this was the first comprehensive assessment of the wound since admission on 7/19/2024. On 9/13/2024 at 6:34 PM in the progress notes, DON-B documented wound rounds were done with NP-N and the Stage 3 pressure injury measured 0.7 cm x 0.5 cm with dry slough. Surveyor noted no depth measurement or percentage of slough was documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	On 9/20/2024 at 3:20 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the Stage 3 pressure injury measured 0.8 cm x 0.6 cm with 100% granulation tissue. Surveyor noted no depth measurement documented. On 10/1/2024 at 12:52 AM in the progress notes, RN-M documented pressure injury assessments from 9/27/2024: the Stage 3 pressure injury measured 0.8 cm x 0.6 cm with 100% granulation tissue. Surveyor noted no depth measurement documented. On 10/4/2024 at 5:05 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the Buttock/Coccyx pressure injury measured 3 cm x 2 cm. Surveyor noted the pressure injury was not staged, and no depth measurement or description of the wound bed was documented. On 10/11/2024 at 6:25 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the Buttock/Coccyx pressure injury measured 0.7 cm x 1 cm with 100% smooth pink tissue. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. On 10/18/2024 at 5:40 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the Buttock/Coccyx pressure injury resolved. RIGHT MEDIAL FOOT On 9/6/2024 at 1:31 PM in the progress notes, an RN documented wound rounds were done with NP-V and the pressure injury measured 0.3 cm x 0.3 cm with dry eschar. Surveyor noted the pressure injury was not staged, and no depth measurement or percentage of eschar was documented. On 9/13/2024 at 6:34 PM in the progress notes, DON-B documented wound rounds were done with NP-N and the pressure injury measured 1 cm x 0.7 cm with 100% granulation. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. On 9/20/2024 at 3:20 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the Stage 3 pressure injury measured 0.8 cm x 0.6 cm with 100% granulation. Surveyor noted no depth measurement was documented. On 10/1/2024 at 12:52 AM in the progress notes, RN-M documented pressure injury assessments from 9/27/2024: the right medial/anterior foot pressure injury measured 1 cm x 0.7 cm with 100% granulation. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. On 10/4/2024 at 5:05 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the medial/anterior foot pressure injury was not assessed or documented. NP-N documented the right medial/anterior pressure injury resolved. RIGHT POSTERIOR CALF On 9/6/2024 at 1:31 PM in the progress notes, an RN documented wound rounds were done with NP-V and the pressure injury measured 1 cm x 12 cm and was determined to no longer be a DTI, even though the description of the area was dark purple. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	On 9/13/2024 at 6:34 PM in the progress notes, DON-B documented wound rounds were done with NP-N and the Stage 3 pressure injury healed. Surveyor noted this was the first documentation of the pressure injury being a Stage 3. RIGHT LATERAL FOOT On 9/6/2024 at 1:31 PM in the progress notes, an RN documented wound rounds were done with NP-V and the pressure injury measured 2 cm x 0.6 cm x unable to determine was scabbed over with 100% eschar. Surveyor noted the pressure injury was not staged. On 9/13/2024 at 6:34 PM in the progress notes, DON-B documented wound rounds were done with NP-N and the pressure injury was not assessed or documented. On 9/20/2024 at 3:20 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the pressure injury measured 2.4 cm x 1.3 cm with 80% eschar and 20% slough. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. On 10/1/2024 at 12:52 AM in the progress notes, RN-M documented pressure injury assessments from 9/27/2024: the right lateral foot pressure injury measured 2.4 cm x 1.3 cm with 80% eschar and 20% slough. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. On 10/4/2024 at 5:05 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the pressure injury measured 2.4 cm x 1.7 cm x 1.1 cm. Surveyor noted the pressure injury was not staged, and no description of the wound bed was documented. On 10/11/2024 at 6:25 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the pressure injury measured 2.4 cm x 1.4 cm x 1.1 cm. Surveyor noted the pressure injury was not staged, and no description of the wound bed was documented. On 10/18/2024 at 5:40 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the pressure injury measured 2.5 cm x 1.5 cm. Surveyor noted the pressure injury was not staged, and no depth measurement or description of the wound bed was documented. On 10/25/2024 at 6:00 PM in the progress notes, RN-M documented wound rounds were done with NP-V and R17 had a venous stasis ulcer to the right lateral calf that measured 3.5 cm x 2 cm x 0.1 cm. No pressure injuries were assessed or documented. No wound documentation of the pressure injuries was found from 10/18/2024 until 11/8/2024. On 11/8/2024 at 6:34 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the Stage 3 pressure injury measured 1.6 cm x 0.9 cm. Surveyor noted no depth measurement or description of the wound bed was documented. On 11/15/2024 at 4:17 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the pressure injury measured 1.4 cm x 0.8 cm with granulated tissue throughout. Surveyor noted the pressure injury was not staged, and no depth measurement was documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	On 11/22/204 at 4:42 PM in the progress notes, RN-M documented wound rounds were done with NP-N and the pressure injury was not assessed or documented. On 12/13/2024, NP-N assessed R17's right lateral foot Stage 3 pressure injury. NP-N assessed R17 weekly, and the pressure injury resolved on 1/10/2025. This documentation was not available to facility staff and was not in R17's medical record until Surveyor requested a copy of NP-N's notes on 2/27/2025 at 3:01 PM. NUTRITION On 8/8/2024 at 7:54 AM in the progress notes, the Registered Dietician (RD) documented a nutritional assessment was completed and due to the coccyx wound, multiple DTIs, and foot ulceration, R17 had increased nutrient needs and suggested a wound healing supplement like Arginaid daily. Surveyor noted Arginaid was not initiated. On 9/11/2024 at 11:25 AM in the progress notes, the RD documented at previous review, RD recommended Arginaid for wound healing. RD continued to suggest Arginaid to support wound healing. Surveyor noted Arginaid was not initiated. On 10/9/2024 at 11:17 AM in the progress notes, the RD documented a recommendation for Arginaid daily would aid in wound healing. Surveyor noted this was the third month in a row the RD had made that recommendation, and it was not followed up on. On 10/30/2024, R17 had an order for Arginaid initiated. Surveyor noted this was initiated greater than two and a half months after it had been recommended by the RD. In a phone interview on 3/3/2025 at 2:02 PM, Surveyor asked Registered Dietician (RD)-W, the regional supervisor for the dieticians, how the RD was notified of residents with pressure injuries. RD-W stated the RD would receive a wound report form the DON or the wound nurse, and depending on the severity of the situation, the RD would put in a progress note within 24 hours of the notification. Surveyor asked RD-W how often the RD documented in resident records. RD-W stated the RD would document once a month with the weight status and how much the resident was eating as well as the status of the wounds. RD-W stated the RD would make a recommendation to address the nutrition and wound status and then would follow up to see if the recommendation was in place within 48 hours. RD-W stated the RD would be in person at the facility two to three times a month, so their voice was not always being heard. Surveyor shared with RD-W the concern the RD recommendations for R17 were not followed up for over two months. RD-W stated the RD that had been assigned to the facility did not have confidence in getting their recommendations in place. CURRENT WOUNDS - MASD On 2/3/2025 at 4:02 PM in the progress notes, RN-M documented R17 was assessed due to a report of MASD to bilateral buttocks. Inspection revealed two areas of denuded skin bilaterally with a dermatitis related ulcer at the twelve o'clock position of the left MASD wound. The ulcer has 80% granulated tissue with 20% slough, wound edges are irregularly shaped, however firmly attached to the wound bed. Surrounding skin is MASD, denuded, partial thickness wound with blanchable erythema. MASD wound edges are rolled back measuring 3 cm x 2.5 cm, no exudate noted. The right buttock has a partial thickness MASD wound measuring 4 cm x 3.3 cm with irre [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not always ensure that 1 (R44) out of 3 residents reviewed for accident hazards, received the care and services to prevent a further accident from happening. R44 had a history of swallowing difficulties and experienced a choking episode. The facility did not get a referral for R44, immediately following the incident, to identify the cause of the choking and provide supervision and assistance devices to prevent further choking incidents from happening. Findings include: R44 was originally admitted to the facility on [DATE] with diagnoses that included neuropathy, dementia, muscle weakness, hypothyroidism, gastroesophageal reflux disease (GERD), anxiety disorder and depression, The most recent significant change of condition MDS (Minimum Data Set) dated 1/14/25, indicates that R44 does not have any swallowing disorders or oral concerns. R44 did not participate in the BIMs (brief interview for mental status) assessment but is documented to have long and short-term memory concerns. The MDS indicates R44 is assessed as needing supervision or touching assistance by staff while eating, no signs or symptoms of a swallowing disorder, but is on a mechanically altered diet as a resident. R44's 11/17/24 quarterly MDS indicates R44 requires set up assistance from staff for eating. R44 shows signs and symptoms of coughing and choking while eating or taking medications and is on a mechanically altered diet as a resident. R44's 8/17/24 quarterly MDS indicates R44 requires set up assistance for eating, has no signs or symptoms of swallowing issues, and is on a mechanically altered diet. A nursing note dated 11/12/24 at 10:03 a.m. indicates; (R44) was in main dining room eating breakfast and c/o (complained of) having chest discomfort, (R44) sounded nasally, (R44) has hx (history of) gerd and receives scheduled Famotidine q (every) am which writer administered (R44's) meds this am. (R44) did eat her whole breakfast and drank most fluids. (R44) had a coughing spell in dining room and a copious amount of clear phlegm came up on (sic) (R44) stated she had felt better, and her nose did not feel as stuffed up. Writer performed COVID test on (R44) and it is negative for COVID. (R44) currently sleeping in recliner in back lounge. Writer to update MD and ask for CXR (chest Xray) to rule out URI (upper respiratory infection). Nursing note dated 11/22/2024 at 8:38 a.m. indicates; Staff called for nursing to the dining room. (R44) complaining of feeling full in her throat or like something is stuck. Writer noting mucous production, (R44) making attempts to clear throat. Denies heart burn, however states pain. Tablemate stated that this has been happening every so often, and (R44) confirmed. Updated NP (nurse practitioner) and requested ST (speech therapy) eval/treat. On 11/22/2024 the NP approved ST eval/treat and notified therapy staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R44 did receive speech therapy from 11/25/24 to 12/2/24. Upon discharge from therapy, the recommendations were for thin liquids and regular texture solids. The recommendation was to also give appropriate redirection with R44 and pre-cut large solids. R44's plan of care was updated at this time. A nutrition note dated 12/05/2024 at 9:41 a.m.; Wt. (weight) has been stable past 3 months. Wt. gain over past 6 months is desirable given that BMI (body mass index)/wt. were low for age. Her (R44) current BMI is now indicative of overweight but remains appropriate for advanced age. She (R44) had recent episode for concern for difficulty w (with)/swallowing and getting food stuck. She was evaluated by SLP (speech language pathologist) with recommendations for continued general diet w/regular texture and thin liquids. Her po (by mouth) intake is typically at 76-100% majority of meals which is appropriate. She does receive house supplements at all meals which is appropriate to keep weight stabilized at approp (appropriate) amount given advanced age. No new recommendations. Surveyor noted the nutrition note did not include ST recommendations to pre-cut large solids. Nursing note date 12/19/2024 at 2:51 p.m.; During breakfast (R44) started to choke on her sausage as she could not swallow it or chew it all the way. (R44) had a small emesis after choking on the sausage, vitals were taken and were stable. At lunch time (R44) was complaining of feeling like her chest way full (sic) resident was given Mylanta to see if that would clear up some of the full feeling in her chest. Writer called the doctor, and the doctor said to call the POA (Power of Attorney) and ask if they would like (R44) to go to the emergency room to get a workup. The resident's (R44) POA said to call him back after a while to see if the Mylanta would settle some of the discomfort. Writer checked back after an hour and (R44) said that her chest did not hurt anymore, and she seems much more relaxed and calmed down. Surveyor conducted further review of R44's medical chart and noted that there was no additional follow-up about the choking incident on the morning of 12/19/24. The facility staff did not notify the physician immediately following the incident. There was no update to the plan of care for further supervision and no referral to the Dietician regarding concerns with meal textures. In addition, there was no follow-up by the facility to ensure that R44's breakfast meal which consisted of larger food items (breakfast sausage) were cut-up before consumption. Nursing note dated 12/21/2024 at 3:56 p.m.; no issues with swallowing noted this shift. On 12/26/2024 at 10:34 a.m., the IDT (interdisciplinary team) spoke with NP and requested video swallow study due to Dysphagia, oropharyngeal phase. Voicemail left for POA to return phone call. Scheduling staff made aware of need for appointment. On 12/27/24 the facility obtained a physician order for R44 to have a Video Swallow Study. On 12/30/24, an order was written to monitor R44 for swallowing complications at every meal followed up with documentation. With Meals 08:00 AM, 12:00 PM, 05:00 PM On 1/8/25, R44 received a speech therapy evaluation for the treatment of swallowing dysfunction and /or oral function for feeding. Patient (R44) goals to reach least restrictive diet needs. The reason for the referral was a change in overall status since a recent fall. R44 was presenting with decreased awareness and ability to self-feed, reason, and swallow itself marked. The assessment noted that R44 was seen by Speech Therapy in the fall of 2024 and able to be discharged on regular thin liquids and self-feeding after set-up for help with cutting of foods. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted that there was a Notice of care plan change, dated 1/8/25, from Speech Therapist that R44 is to have a dietary change: downgraded to puree. Advise increased supervision and support at mealtimes. Copies given to nurse on unit, DON (Director of Nursing), CNA (Certified Nursing Assistants), Binder. Nursing note dated 01/14/2025 at 5:21 p.m.; CARE PLAN UPDATE: Dietary change: downgrade to puree, advise increased supervision and support at mealtimes. On 1/17/25, an additional Notice of Care Plan Change from Speech Therapist to upgrade to mech (mechanical) soft and ground meats. Continue thin liquids. Nurse to remind CNA's that R44 needs quiet setting, pre-cut large items to finger food size. Indirect supervision after set-up. Nursing note dated 01/21/2025 at 10:20 a.m.; (R44) continues to be monitored for diet change to mech soft, (R44) ate all her scrambled eggs and toast, and about half of her oatmeal, drank all fluids offered, no coughing or choking present during breakfast. Nursing note dated 01/30/2025 at 03:36 p.m.; (R44) was seen by Speech therapy and new orders to upgrade diet to regular solid texture. Continue swallow guidelines per order. POA called and updated. A physician order was obtained on 1/30/25 ; DIET: Regular solid diet and thin liquids. Instructions: Nurse to remind CNAs that R44 needs quiet setting, pre-cut large items to finger food size. Indirect supervision after set-up. Before Meals 08:00 AM, 12:00 PM, 04:00 PM On 03/04/25 at 08:00 a.m., Surveyor interviewed DON (Director of Nursing)-B regarding R44's choking incident on 12/19/24. DON- B stated that she verified that the nurse on that shift did not notify the physician of the incident. DON- B stated she would have expected the nurse to call the physician immediately and discuss the need for further evaluation and treatment. On 03/04/25 at 11:01 a.m., Surveyor interviewed RD-W (Registered Dietician) regarding R44's choking incident on 12/19/24. RD-W stated the previous RD was at the facility that day and upon her review of the progress notes, there was no documentation that she was alerted of R44's choking incident. RD-W stated that she definitely would want to get the referral to Speech Therapist, make dietary changes if needed and add supervision at meals. RD-W stated that the Dietician or any nurse can downgrade a diet until we can get them a swallow evaluation and diagnosis. RD-W stated that she would expect that facility staff would have notified Dietary just so we can look at weights and if resident has had trouble eating previously and needs diet consistency changes. On 03/04/25 at 01:12 p.m., Surveyor interviewed SP (Speech therapist)-X regarding R44's choking episode on 12/19/24. SP-X stated that she was not made aware of that incident and had previously worked with R44. Surveyor went over the nursing notes and the time it took for R44 to get an order for a swallow study and for Speech Therapy to evaluate and treat her. SP-X stated that it seems like odd intervals in between the incident and the orders, and she cannot say where communication broke down. SP-X stated that she has been treating R44 since January and she has been doing well. SP-X stated that she was the staff that wrote the referral for speech services as she noticed a change in R44's cognition, it was not due to the choking incident in December 2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R44 was noted to have a history of swallowing concerns and after the choking incident on 12/19/24 nursing staff did not ensure R44 received additional assessments of her swallowing to ensure R44's safety. It was not until SP-X noted a change in R44 that led to the 1/8/25 evaluation of R44's swallowing and changes to R44's diet were initiated until further assessments and therapies could be completed related to R44's swallowing abilities. The facility did not do a thorough review to determine if R44 received the correct sized food when she had swallowing concerns. The lack of assessment immediately following the choking incident caused a potential for R44 to choke again without further assessment of her capabilities to eat safely.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents received appropriate treatment to restore continence to the extent possible for 1 (R47) of 2 residents reviewed for bladder incontinence. R47 had an indwelling urinary catheter that was removed while at the facility. The facility did not comprehensively assess R47's bladder pattern to develop a toileting program to restore R47's urinary continence. R47's Care Plan was not revised when the catheter was removed. Findings include: The facility policy and procedure titled Behavioral Programs and Toileting Plans for Urinary Incontinence from MED-PASS (C) 2001 revised 10/2010 documents: The purpose of this procedure is to provide guidelines for the initiation and monitoring of behavioral interventions and/or a toileting plan for the resident with urinary incontinence. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. 2. Conduct a thorough assessment of the resident and his or her environment to determine factors that may have contributed to any recent decline in urinary continence. 3. Provide treatment and services to address factors that are potentially modifiable. For example: a. managing pain; b. providing adaptive equipment for residents with mobility problems; c. removing or improving environmental impediments (lighting, distance to toilet or commode, etc.); and d. reviewing medication regimen and notifying the physician with any concerns. 4. Monitor, record and evaluate information about the resident's bladder habits, and continence or incontinence, including: a. voiding patterns .; b. associated pain or discomfort .; c. type of incontinence (stress, urge, mixed, overflow, functional, etc.); d. level of incontinence .; and e. response to specific interventions. 5. Assess the resident for appropriateness of behavioral programs which promote urinary continence. General Guidelines: 1. Options for managing urinary incontinence include primarily behavioral programs, toileting plans and medication therapy. 3. Toileting Plans that are relatively more dependent on staff involvement and assistance as opposed to resident function include: a. prompted voiding; and b. habit training/scheduled voiding. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Toileting Plans: 1. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence and/or behavior modification, the staff will initiate a toileting plan. 2. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. Documentation: 1. The staff will document the results of behavioral/toileting trial in the resident's medical record. 2. If the resident responds well, behavioral/toileting programs will be continued. 1. R47 was admitted to the facility on [DATE] with diagnoses of left femur fracture, right pubis fracture, diabetes, congestive heart failure, lumbar disc degeneration, and morbid obesity. R47's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R47 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and had an indwelling urinary catheter. R47 did not have an activated Power of Attorney. R47's Indwelling Catheter Care Plan was initiated on 10/29/2024. On 2/15/2025 at 11:22 AM in the progress notes, nursing documented R47 was voiding freely with no difficulty in urination after the indwelling urinary catheter was removed on 2/14/2025. R47's Indwelling Catheter Care Plan was not resolved or revised after the catheter was removed. R47 did not have a care plan in place to address urinary incontinence. On 2/26/2025 at 10:08 AM, Surveyor observed R47 lying in bed. R47 had on a nightgown that was pulled up exposing R47's abdomen and incontinence brief. Surveyor noted an odor of urine. Surveyor asked R47 if R47 had been provided incontinence care recently. R47 stated R47 had urinated in the incontinence brief, and no one had changed her since the previous night. R47 stated R47 had just urinated in the brief and was waiting until Certified Nursing Assistant (CNA)-K was done helping R47's roommate with cares. R47 stated R47 wanted a bedside commode in the room so R47 could get up to use it instead of urinating in the incontinence brief. On 3/3/2025 at 3:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R47 did not have a comprehensive bladder assessment completed after the indwelling catheter had been removed and R47's Care Plan still indicated R47 had an indwelling urinary catheter in place. In an interview on 3/4/2025 at 10:49 AM, Surveyor asked Certified Nursing Assistant (CNA)-J how often R47 had incontinence cares completed. CNA-J stated R47 tells staff when R47 is wet and needs to be changed. CNA-J stated staff also check R47 as well to see if R47 had been incontinent. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/4/2025 at 8:07 AM, Surveyor asked Director of Nursing (DON)-B if R47 had a bladder assessment completed after the indwelling urinary catheter was removed on 2/14/2025. DON-B provided CNA documentation that was completed hourly from 2/14/2025 to 3/4/2025 to establish if R47 had voided and had incontinence care provided. Surveyor asked DON-B if a nurse or nurse manager had reviewed the documentation to establish a toileting program such as prompted voiding. DON-B stated nothing was done with the information and no toileting program had been developed. In an interview on 3/4/2025 at 8:16 AM, Surveyor asked R47 if R47 was aware of the need to urinate before voiding. R47 stated R47 knows when R47 has to go but the staff do not offer R47 anything to go to the toilet. R47 stated R47 uses a mechanical lift so it does not fit in the bathroom, but the staff could put a bedside commode next to the bed and R47 could be lifted to the commode. Surveyor asked R47 if the staff offered R47 a bed pan. R47 stated they tried to use a bed pan once, but it caused R47 pain because the bed pan was not straight underneath R47. On 3/4/2025 at 3:32 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and DON-B the concern R47 did not have a comprehensive bladder assessment completed after the urinary catheter was removed to determine a toileting program to meet R47's needs.

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F 0691 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review, the Facility did not ensure a resident received treatment and care in accordance with professional standards of practice to prevent the need for repeated medical interventions. This was discovered with 1 (R13) of 14 residents reviewed for quality of care. In the last 120 days R13 has been sent to the emergency department six times for complications related to nephrostomy tubes (thin, flexible tubes inserted directly into the kidney to drain urine when the natural urinary tract is blocked). Findings include: R13 was originally admitted to the facility on [DATE] and most recently readmitted [DATE] after a hospital stay. R13's pertinent diagnoses include methicillin resistant staphylococcus aureus (MRSA), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Parkinsonism, type 2 diabetes mellitus with diabetic nephropathy, and neuromuscular dysfunction of bladder. R13's 5 day Minimum Data Set (MDS), completed 2/27/25, documents R13's Brief Interview for Mental Status (BIMS) score to be 15, indicating R13 is cognitively intact for decision making. R13's MDS also documents Patient Health Questionnaire (PHQ-9) score to be 00, indicating no depression. No behavior concerns are noted. R13 is assessed as making self understood and understands others. The MDS indicates R13 has a catheter for bladder and an ostomy for bowel function. R13 has a care plan for indwelling catheter which started on 06/26/2024. The problem reads R13 requires an indwelling catheter (Bilateral Nephrostomy Tubes) r/t (related to) Neuromuscular dysfunction of bladder and BPH (benign prostate hyperplasia) with the following pertinent interventions: -Abdominal Binder to maintain placement of tubes Created: 01/07/2025 -Assess drainage. Record amount, type, color, odor. Observe for leakage. Keep closed system as much as possible to reduce the risk of infection. Created: 06/26/2024 -Monitor output q (per)/ shift. Flowsheet: I&O (intake & output). Created: 06/26/2024 -Observe for s/s (signs/symptoms) of infection. Document and promptly report s/s. Follow McGeer's unless specified per MD (medical doctor) order with education. Created: 06/26/2024 -Provide catheter care Q shift and as needed. Created: 06/26/2024 -Provide education to reduce the risk of trauma. Created: 06/26/2024 (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	Surveyor notes the following interventions remained on the care plan and should have been updated/removed: -16 FR foley with 10mL balloon. Created: 06/26/2024 -Attempt voiding trial per facility protocol or MD order, unless otherwise specified per MD. Created: 06/26/2024 -Change catheter per facility protocol or MD order. Created: 06/26/2024 Surveyor reviewed the electronic medical record (EMR) and found the following orders related to R13's nephrostomy care: Bilateral Nephrostomy Tubes. Special Instructions: Assess bandages and change if soiled. Imperative to be changed if soiled. Once An Evening 03:00 PM - 07:00 PM start date 01/06/2025. Nephrostomy tubes: Cleanse with NS (normal saline), pat dry, cover with spilt gauze. Change Q 2-3 days and PRN (as needed). Once A Day Every Other Day 06:00 PM - 10:00 PM start date 11/19/2024. Surveyor reviewed the EMR for past 120 days and found six occurrences when R13 was sent out for complications with Nephrostomy tubes. 1st time sent out On 11/28/2024, at 12:34 AM, a progress note was written ambulance arrived to take resident to (name of) hospital for R (right) nephrostomy tube placement. VSS (vital signs stable). No signs of pain at this moment. No s/s of infection from nephrostomy tube insertion site. A second progress note gives more details to the dislocation written on 11/28/2024, at 12:46 AM, writer entered room to perform wound care to find that resident's Nephrostomy had been torn from the stop-cock during transfer via Hoyer lift. Leaving urine to leak freely from the Neph (nephrostomy)-tube. Writer attempted to identify a resolution and without success, called . DON (Director of Nursing). DON had suggested to contact (name of nurse practitioner group) to update and ask to advise. (Name of nurse practitioner group) had advised patient go to the ED (emergency department) for eval (evaluation) and treat. To stop the urine from freely flowing on to patient, a Foley catheter was cut and attached to a leg bag to allow the Nephrostomy tube to be inserted directly inside the Foley to drain into the collecting bag until patient could be transported to the ED for eval and treat . On 11/28/2024, at 04:00 AM, a progress note was written resident returned from (name of) hospital. Hospital stated resident will need to go to (name of different) hospital for new nephrostomy tube. Tube remains to drain but is partially dislodged. VSS (vital signs stable) . The After Visit Summary dated 11/28/24, reads right sided nephrostomy tube partially dislodged internally, but still functional. Continue to empty the bag as per normal protocol. Use caution in transferring the patient to prevent further dislodgement or tubing . An After Visit Summary dated 11/29/2024, contains discharge instructions for the procedure of percutaneous nephrostomy being completed. 2nd time sent out (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	A progress note written on 12/29/2024, at 08:54 AM, reads left nephrostomy tubing stick line is 2 Inches off the insertion site, no c/o (complaints of) pain to site, blood is noted to the tubing about 50 cc of sanguinis (sic) drainage noted, notified (nurse practitioner group) gave order to send out to (name of hospital) in [NAME] to be reinserted ., paramedics arrive at 0916 . On 12/29/2024, at 01:30 PM, a progress note reads pt (patient) back from ED for nephrostomy displacement vitals stable and charted no complaints, IR (interventional radiology) could not place nephrostomy today but referral to IR in place they will be calling us tomorrow but call back tomorrow if they don't reach out, stated to keep it covered, N.O. (new order) for cephalexin 500mg cap (capsule), take 1 cap PO (by mouth) in the AM, noon and evening x10 days per paperwork appear pt received first dose at ED, pt does not meet UTI (urinary tract infection) McGeer criteria, called (nurse practitioner group) to clarify if she would like to continue with ABT (antibiotic) due to pt not meeting criteria . (nurse practitioner group) gave order to continue with ABT prophylactic due to pt having leukocyte in UA (urinary analysis) and for upcoming procedure tomorrow, all order in. pt placed on 24 hour board to keep insertion site covered and to call IR tomorrow . The After Visit Summary dated 12/29/2024, has a diagnosis for visit of nephrostomy tube displacement. The After Visit Summary dated 12/30/2024, shows the nephrostomy tube being replaced. 3rd time sent out A progress note written on 01/28/2025, at 10:18 AM, reads at 0745 (am) CNA (Certified Nursing Assistant) called RN (Registered Nurse) to look at nephrostomy bag. Left nephrostomy tubes attached to the patient and dressing dry and intact. Adaptor where tubing is attached to intact but catheter tubing was out and looks like its clogged with a white object. No other tubing available . On 01/28/2025, at 01:26 PM, the return from ED progress note reads patient returned from (hospital location) BL (bilateral) nephrostomy tubes in place with clear yellow urine. Per patient replaced both tubes . The After Visit Summary dated 1/28/2025, has diagnosis of malfunction of nephrostomy tube. 4th time sent out A progress note written on 02/11/2025, at 02:04 PM, reads CNA found left nephrostomy tube out. RN applied dressing no drainage noted at this time some redness noted. Call placed to NP (nurse practitioner) order to send to (hospital location) ED. The After Visit Summary dated 2/11/2025, has diagnosis listed as nephrostomy tube displacement. 5th time sent out On 2/16/2025, at 01:08 PM, a progress note was written that reads blood tinged urine noted in nephrostomy as well as unequal output. Urine leaking through penis as well with strong foul odor. (Name of medical group) gave orders for resident to be sent to ED for evaluation . (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	Surveyor notes R13 was hospitalized on the 16th and returned to the facility on [DATE]. R13 was kept at the hospital to receive intravenous antibiotics due to a urinary tract infection. The After Visit Summary dated 2/24/25, has a diagnosis of urinary tract infection associated with nephrostomy catheter. A right nephrostomy catheter exchange was ordered on 2/17/25. 6th time sent out A progress note written on 03/01/2025, at 05:57 AM, reads resident returned from hospital this shift. Sent out on PMs for dislodged urostomy tube. Tube remains dislodged. Left tube functioning properly. Instructions sent to make an appointment to schedule urostomy placement. The After Visit Summary dated 3/1/2025 has diagnosis of nephrostomy tube displacement. On 02/26/25, at 12:35 PM, Surveyor interviewed R13 and learned that R13 returned from the hospital Monday (2 days before). R13 was there over a week due to nephrostomy tube being pulled out, R13 got a bacterial infection in the kidneys. On 03/03/25, at 01:11 PM, Surveyor interviewed R13 again regarding the number of times sent out to hospital due to nephrostomy tube issues. Per R13 staff don't take the time to do the job correctly. Some are just not conscientious, R13 will give them instructions if needed to prevent issues with nephrostomy tubes but some just are not willing to learn. On 03/03/25, at 01:50 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-F regarding R13's nephrostomy tubes and asked about training given to staff. Per ADON-F there is a nurse and CNA meeting every other week, and training on how to transfer R13 with a Hoyer has been discussed. Surveyor asked about interventions to keep nephrostomy tubes in place and was told the Facility had started using an abdominal binder to hold tubes in place. Also, discussed with NP today if there are other ideas on how to keep tubes in so not pulled out. (Cross-reference F604). On 03/04/25, at 09:30 AM, Surveyor interviewed R13 regarding the abdominal binder, R13 stated they are not using it now because it is so tight that R13 got a rash. R13 decided on own that they did not want the rash so have asked staff not to put it on. On 03/04/25, at 09:39 AM, Surveyor interviewed CNA-K regarding the care used for R13's nephrostomy tubes. CNA-K stated they have gotten a little training from Facility on how to clean around the nephrostomy tubes. It is kinda the same as cleaning the penis. CNA-K stated that when R13 first got the nephrostomy tubes it was discussed at a staff meeting, topics like precautions when transfer with Hoyer, always use a two assist with R13 and both staff should watch the cords. Surveyor asked about R13's abdominal binder and was told ya he wear it. (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	On 03/04/25, at 09:58 AM, Surveyor interviewed Director of Nursing (DON)-B regarding steps taken by facility to prevent pulling of nephrostomy tubes on R13. Per DON-B the first couple times it happened it was during Hoyer transfers, so DON-B got an abdominal binder and stat locks to hold tubes in place. DON-B admits not being aware R13 is not wearing the binder due to rash, stated will have to talk to R13 about skin protection options. Surveyor asked what type of staff training had occurred since R13 got the nephrostomy tubes. DON-B replied that they had talked to staff verbally about transfers and checking tubing so not in a place where the tubes can get pulled out. Surveyor told DON-B this is a concern because R13 has been sent to ED six times in the last 120 days, with some requiring hospitalization . Surveyor notes the Facility Assessment was reviewed and there is no staff competency to care for Nephrostomy tubes included as being assessed. On 03/04/25, at 03:34 PM, Surveyor told DON-B and Nursing Home Administrator-A that there is a serious concern related to R13's nephrostomy tubes and being sent to the ED six times for care issues where R13 developed infections and requiring hospitalization .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on record reviews and interviews, the facility did not adequately address Nutrition needs for 1 (R19) of 1 residents reviewed for Nutrition. *R19 sustained a 9.2% weight loss from October 2024 to December 2024. The facility did not monitor R19's weight or implement proper interventions per RD (Registered Dietician) recommendations. Findings include: *R19 was admitted to the facility on [DATE] with diagnoses including left femur fracture, hemiparesis of left side, polyneuropathy and cerebrovascular disease. R19's Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/30/24 indicated that R19 has a Brief Interview for Mental Status (BIMS) score of 12, indicating that R19 is moderately cognitively impaired. R19's Admission MDS with ARD of 10/30/24 indicated that R19 is dependent upon staff for bed mobility, transfers, bathing, dressing and toileting. R19's Admission MDS with an ARD of 10/30/24 indicates that R19 did not have any pressure injuries or an active risk for pressure injuries. R19's Quarterly MDS with ARD of 1/13/25 indicated that R19 is dependent upon staff for bed mobility, transfers, bathing, dressing and toileting. R19's Quarterly MDS with an ARD of 1/13/25 indicates that R19 was assessed with a stage 3 pressure injury and at active risk for pressure injuries. Surveyor reviewed R19's electronic medical record including nursing progress notes, physician orders, Registered Dietician progress notes and comprehensive care plan. On 10/25/2024, R19's weight was documented at 148.7 lb. On 10/27/2024, R19's weight was documented at 147.9 lb. On 11/7/2024, R19's weight was documented at 149.2 lb. On 12/27/2024, R19's weight was documented at 135.0 lb. On 2/24/2025, R19's weight was documented at 140.4 lb. Surveyor did not identify any documented weight for R19 for January 2025. From 10/25/2024 to 12/27/2024, R19 sustained a 9.2 % weight loss. Surveyor reviewed R19's nutrition care plan with an initiation date of 12/20/2024. R19's nutrition care plan documents the following: Problem: I (R19) am on a Regular diet, with thin liquids. No straws. R19's nutritional care plan included the following interventions: House stock supplement beverage daily .Obtain dietary consultation as needed .monitor and record weight, notify the health care provider and family of significant weight change .provide supplements as ordered . Surveyor reviewed R19's dietary progress notes from Reg (Registered) Dietician-Y from 10/30/2024 to present. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 11:23 AM Reg Dietician-Y documented the following: RD new admit assessment. Ht (Height): not recorded, Wt (Weight)147.9 lb, BMI (Body Mass Index) unable to calculate. Resident admits post fall with L (left) hip fx (fracture) . (surgical repair). PMH (Primary Medical History): hemiplegia/hemiparesis, COPD (Chronic Obstructive Pulmonary Disease, PVD (Peripheral Vascular Disease), HTN (Hypertension, HLD (Hyperlipidemia), polyneuropathy, pre diabetes, CHF (Congestive Heart Failure). Receiving regular diet which is appropriate. PO (by mouth) intake appears to be > (greater than) 50% at meals which is adequate. No reports of any recent significant weight changes .Suggest obtaining height. No further recommendations. Resident (R19) is low nutritional risk. RD to follow as consult. On 11/21/2024 at 11:28 AM, Reg Dietician-Y documented the following: RD review. Ht 70, Wt 149.2 lb, BMI 21.41 . DTI (Deep Tissue Injury) to R (Right)-heel, being treated by wound nurse. He (R19) receives a regular diet w/thin liquids. He (R19) has snacks/food items brought in from family at times. Recorded po intake does varying depending on day/meal. Does tend to have at least 1 smaller meal each day. His (R19) weight is stable without any recent changes. Would suggest offering 30ml pro-source daily for additional protein to support healing of DTIs. Resident is high nutritional risk r/t wounds. RD to follow as consult. On 12/19/2024 at 12:46 PM, Reg Dietician-Y documented the following: RD review. Ht 70, Wt 149.2 lb (11/7/24), BMI 21.41. Most recent weight available from November, unable to assess any recent weight changes. He continues with a DTI to R-heel which has a scab intact .He (R19) is on a general diet order with varying po intake. He is receiving a multivitamin to support wound healing. Would suggest offering a house supplement at least 1x day due to varying po intake and low BMI/wt. Also suggest obtaining recent weight to better assess any weight changes. Resident is high nutritional risk r/t wounds. RD to follow as consult. On 1/29/2025 at 10:44 AM, Reg Dietician-Y documented the following: RD review. Ht 70, Wt 135 lb (12/27/24), BMI 19.37. Most recent weight available from December and indicates a -9.2% weight loss since October. Receives regular diet w/thin liquids. Po intake appears adequate around 76-100% majority meals. Skin reviewed: PI (Pressure Injury) to R heel, improving. Would suggest offering a house supplement at least 1x day due to varying po intake and low BMI/wt, increased needs for wound healing. Also suggest obtaining recent weight to better assess any weight changes and weekly weights therefore after given significant weight loss. Resident is high nutritional risk r/t wounds and weight. RD to follow as consult. On 2/27/2025, Surveyor requested to conduct interview with Reg Dietician-Y. Nursing Home Administrator (NHA)-A informed Surveyor that Reg Dietician-Y is no longer employed by the facility. The facility has a newly appointed dietician and offered to ask them to speak to Surveyor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/2025 at 2:05 PM, the Survey team conducted a group interview with Reg Dietician-W. Surveyor asked Reg Dietician-W what their expectation would be for how often residents should be weighed upon admission to the facility. Reg Dietician-W told Surveyor that usually each facility has their own procedure for obtaining weights for new admissions and that they are not sure what procedure the facility has been following. Surveyor asked Reg Dietician-W if they are familiar with R19. Reg Dietician-W responded that they are not familiar with that resident and that they are currently covering for another dietician who is on vacation. Surveyor asked Reg Dietician-W what their expectation would be regarding the facility's time frame to carry out dietary recommendations by a dietician, such as supplement orders or recommendations for weekly weights. Reg Dietician-W responded that as a dietician that they would expect no more than a 24 hour turn around time for facility to initiate dietician recommendations and share those with resident's physician and power of attorney if applicable. Reg Dietician-W added that they had been made aware by Reg Dietician-Y that the facility was not timely following up on Reg Dietician-Y's recommendations and sometimes not responding to recommendations at all. On 3/3/2025 at 3:40 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R19 had sustained a documented 9.2 % weight loss from October 2024 to December 2024. Surveyor shared concerns that Reg Dietician-Y had made recommendations including a liquid protein supplement and weekly weights for R19 that were not carried out by the facility. The facility did not provide any additional information at this time.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review the Facility did not ensure residents who require dialysis receive such services, consistent with professional standards of practice, including the ongoing communication with the dialysis center before and after dialysis treatments for 1 (R46) of 1 residents reviewed for dialysis. R46 has a physician order for dialysis on Tuesday, Thursday and Saturday. Communication between the Facility and the dialysis center was not being shared with each visit. Findings include: The Facility Policy titled Dialysis Policy and Procedure last reviewed 9/17/2024 documents (in part): Procedure .: -Communicate with dialysis facility before and after treatment via the Dialysis Communication form . R46 was admitted to the facility on [DATE], pertinent diagnoses include dementia, pleural effusion, end stage renal disease, and dependence on renal dialysis. R46's Quarterly Minimum Data Set (MDS) with an assessment reference date of 1/7/25 indicated R46 had a Brief Interview for Mental Status score of 99, which indicates severe cognitive impairment. R46 uses a wheelchair for mobility. Dialysis was selected in Section O of the MDS. On 02/27/25, at 08:27 AM, Surveyor reviewed the electronic medical record and for January and February only found two dialysis communication forms dated 1/25/25 and 1/28/25. Surveyor requested January and February communication forms regarding dialysis for R46. On 02/27/25, at 09:47 AM, Surveyor interviewed Director of Nursing (DON)-B who stated that the Nursing Home Administrator (NHA)-A had talked to dialysis regarding a hiccup in getting communication forms back from dialysis, NHA-A would be in to discuss. Surveyor reviewed Dialysis Communication forms provided. None were provided for: 1/4/25, 1/7/25, 1/9/25, 1/14/25, 1/16/25, 1/18/25, 1/21/25, 2/8/25, and 2/22/25. On 02/27/25, at 01:27 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-Q regarding the process of sending R46 to dialysis. LPN-Q stated that when transportation gets here, they are given an orange folder. There is a paper inside that has who is doing transport along with vitals etc. about R46. The nurse signs the form and sends it with R46. (Name of dialysis center) will send pertinent information back on that form. LPN-Q states this happens each time R46 goes out. On 02/27/25, at 03:00 PM, Surveyor interviewed NHA-A who stated they talked to (name of dialysis center) before Christmas regarding the missing forms, will get Surveyor an exact date. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/25, at 08:15 AM, NHA-A followed up with Surveyor that they spoke with (name of dialysis center) originally on [DATE] then followed up with them on January 6, 2025. Surveyor notes eight dialysis communication forms were not on record after the NHA-A followed up with dialysis. No additional information was provided regarding the missing dialysis communication forms.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49011 Based on interview and record review, the Facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident potentially affecting 53 of 53 residents in the Facility. * The Facility did not designate a charge nurse for each tour of duty on each daily nursing schedule. Findings include: On 02/27/25, at 10:58 AM, Surveyor reviewed 30 days of nursing staff schedules. Surveyor noted that the Facility's nursing staff schedules did not designate who the charge nurse was for each tour of duty. On 02/27/25, at 01:25 PM, Surveyor interviewed Nursing Scheduler-R regarding how to know who the charge nurse is at any given time. Nursing Scheduler-R replied that during the day the Director of Nursing (DON) or Assistant DON are in the building. On PM shift the Nurse Educator is usually in the building otherwise there is an on-call person listed at the bottom of the schedule page who is reachable by phone. Surveyor then asked who is in the building that is labeled as charge nurse during each shift, the answer was staff know to call the on-call person. On 02/27/25, at 03:08 PM, Surveyor informed the Nursing Home Administrator-A, DON-B and Assistant Nursing Home Administrator-D of the concern related to the Facility's schedules not designating who the Facility charge nurse would be for each shift on the Facility's nursing staff schedules. The Facility did not provide any additional information as to why it did not ensure there was a designated charge nurse for each tour of duty.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49011 Based on observation, interview, and record review the Facility did not ensure they posted the nurse staffing data to include the date, resident census, and the total actual hours worked by Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides, on a daily basis. This has the potential to affect all 53 residents currently residing in the Facility. * The Facility did not have Nurse Staff Posting forms posted daily in a visible location in the Facility and has no record of Nurse Staff Postings being completed or maintained for 18 months. Findings include: On 02/27/25, at 10:58 AM, Surveyor reviewed 30 days of nursing staff schedules provided by Facility. However, noted that there were no Nurse Staff Postings included which had been requested. On 02/27/25, at 12:30 PM, Surveyor observed no Nurse Staff Postings in the reception area of the Facility when looking around for the posting. On 02/27/25, at 01:25 PM, Surveyor interviewed Nursing Scheduler-R and asked where the Nurse Staff Posting is located, which the response was it is posted in the nurses' stations to keep confidential. Nursing Scheduler-R then walked with Surveyor to one of the nurse stations where we had to enter a room through a closed door to see the posting. What Nursing Scheduler-R showed Surveyor was the nursing staff schedule. On 02/27/25, at 01:36 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-F regarding the Nurse Staff Posting. ADON-F stated putting the posting in the nurse station is not the correct way, it should be on the outside of both nurses' stations and in the receptionist desk area. On 02/27/25, at 03:08 PM, Surveyor discussed with the Director of Nursing-B, Nursing Home Administrator (NHA)-A and Assistant Nursing Home Administrator-D the concern of no Nurse Staff Posting displayed daily in a visible spot for visitors and residents to see. Surveyor explained what is needed on the form and which tag to refer to. It was also explained that the nursing staff schedule that is posted in the nurse stations is not visible and lacks pertinent information. On 03/03/25, at 10:52 AM, NHA-A shared they have a form they used to use, will start using again and it will be posted on the scheduler's door which is adjacent to the lobby area.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not ensure that 5 out of 5 residents (R44, R26, R16, R34 and R5) drug regimen was free from unnecessary medications. R44, R26, R16, R34 and R5 received recommendations from the Pharmacy Consultant via the monthly review and the facility did not address the recommendations by having the physician review and sign acknowledge of receiving the recommendations and if they accept or want to modify the recommendation for each individual resident. Findings include: Policy review: Medication Regimen Reviews , revised 5/2019 Policy statement: The consultant pharmacist reviews the medications regimen of each resident at least monthly. Policy Interpretation and Implementation: 8.) Within 24 hours of the MRR (medication regimen review), the consultant pharmacist provides a written report to the attending physicians for each resident identified as having non-life-threatening medication irregularity. The report contains the resident's name, the name of the medication, the identified irregularity and the pharmacist's recommendation. 11.) If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator. 12.) The attending physician documents in the medical record that the irregularity has been reviewed an what (if any) action was taken to address it. 14.) The consultant pharmacist provides the director of nursing services and medical director with a written, signed copy of all medication regimen reports. 15.) Copies of the medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. 1.) R44 was originally admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder, and depression. Surveyor conducted a review of the monthly pharmacy consultant reviews and noted the following: On 11/27/2024 at 10:54 a.m., med review complete; see report. On 12/28/2024 at 08:56 a.m. med review complete; see report. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/24/2025 at 10:33 a.m., med review complete; see report. On 03/03/25 at 08:31 a.m., DON- B stated that she will need to print the pharmacy recommendations but she does not have any of them signed off or notations if they followed up on them. On 03/03/25 09:05 a.m., Surveyor was provided with the pharmacy consultation report/ recommendations for R44, dated 11/27/24, and 12/28/24 These reports had to be downloaded and printed prior to being available for review and were not part of R44's medical record. The 11/27/24 pharmacy consultation report indicated that R44's PRN (as needed) order for Desitin paste has not been used within the previous 60 days. Recommendation is to consider discontinuing due to lack of use. The facility was unable to provide evidence that they followed-up on this recommendation by obtaining the Physician's response. The 12/28/24 pharmacy consultation report states that R44 receives 2 or more medications known to prolong the QT interval (length of time it takes for the ventricles of the heart to depolarize & repolarize as measured on an electrocardiogram): Ondansetron ODT (Zofran-anti-nausea), Escitalopram Oxalate (Lexapro), quetiapine (Seroquel). Recommendation to reevaluate continued use of these medications and consider decreasing dose of the escitalopram from 20 mg each day to 10 mg each day. The facility was unable to provide evidence that they followed-up on this recommendation by obtaining the Physician's response. On 03/04/25 at 08:00 AM Surveyor interviewed DON (Director of Nursing)-B who stated that the facility did not respond to the pharmacy recommendations for R44 for those dates. DON- B stated that there was a break in the system and not all of the communication was made to the physician. 2.) R26 was originally admitted to the facility on [DATE] with diagnoses that included adjustment disorder with mixed anxiety and depressed mood. Surveyor conducted a review of the monthly pharmacy consultation reports and noted the following: On 10/26/2024 at 01:20 p.m., med review complete; see report. On 12/28/2024 at 09:23 a.m., med review complete; see report. On 03/03/25 at 08:31 a.m., DON- B stated that she will need to print the pharmacy recommendations but she does not have any of them signed off or notations if they followed up on them. On 03/03/25 09:05 a.m., Surveyor was provided with the pharmacy consultation report/ recommendations for R26, dated 10/26/24 and 12/28/24. These reports had to be downloaded and printed prior to being available for review and were not part of R26's medical record. The 10/26/24 pharmacy consultation report documented that R26 receives a medication containing an inhaled corticosteroid, Wixela Inhub. The recommendation is to reduce the risk of thrush, please update the order to include the directions: Rinse mouth with water after use. Do not swallow. The facility was unable to provide evidence that they followed-up on this recommendation by obtaining the Physician's response. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/28/24, the same recommendation was made as on 10/26/24. R26 receives a medication containing an inhaled corticosteroid, Wixela Inhub. Recommendation to reduce the risk of thrush, please update the order to include the directions: Rinse mouth with water after use. Do not swallow. The facility was unable to provide evidence that they followed-up on this recommendation by obtaining the Physician's response. On 3/4/25 at 10:30 a.m., Administrator-A confirmed that there is no behavior monitoring for R26. In addition, there has been no follow-up on the pharmacy recommendations. Administrator- A stated that they are going to start having behavior meetings to discuss these types of issues. 3.) R16 was originally admitted to the facility on [DATE] with diagnoses that included major depressive disorder and anxiety. Surveyor conducted a review of the monthly pharmacy consultation reports and noted the following: On 11/29/2024 at 12:28 p.m., med review complete; see report. On 01/26/2025 at 03:35 p.m., med review complete; see report. On 03/03/25 at 08:31 a.m., DON- B stated that she will need to print the pharmacy recommendations but she does not have any of them signed off or notations if they followed up on them. On 03/03/25 09:05 a.m., Surveyor was provided with the pharmacy consultation report/ recommendations for R16, dated 11/29/24 and 1/26/25. These reports had to be downloaded and printed prior to being available for review and were not part of R16's medical record. The 11/29/24 pharmacy consultation/ report documented that R16's PRN (as ordered) orders below have not been used within the previous 60 days- miconazole powder. Recommendation: Please consider discontinuing due to lack of use. The facility was unable to provided evidence that they followed-up on this recommendation by obtaining the Physician's response. The 1/26/25 pharmacy consultation/ report; (R16) receives two antiplatelets, Aspirin low dose and Plavix and does not have a CBC (complete blood count) documented in the medical record within the previous 6 months. Recommendation: Please monitor a CBC on the next convenient lab day and every 6 months thereafter. Consider fecal occult blood tests if clinically indicated. Ongoing surveillance for bleeding is recommended. The facility was unable to provided evidence that they followed-up on this recommendation by obtaining the Physician's response. Further review of R16's electronic record did not show an order for CBC drawn following the 1/26/25 recommendation. On 03/04/25 at 08:00 AM Surveyor interviewed DON (Director of Nursing)- B who stated that the facility did not respond to the pharmacy recommendations for R16 for those dates. DON- B stated that there was a break in the system and not all of the communication was made to the physician. 42037 4.) R34 was admitted to the facility on [DATE]. R34's current diagnoses include Atrial Fibrillation, Cerebral Infarction and Hyperlipidemia. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R34's Quarterly MDS (Minimum Data Set) Assessment with ARD (Assessment Reference Date) of 2/17/25 indicates that R34 is receiving a Antidepressant and Anticoagulant medication. Surveyor reviewed R34's electronic medical record including physician orders, and comprehensive care plans. An anticoagulant care plan with an initiation date of 8/6/24 documents: (R34) is at risk for bleeding and bruising d/t (due to) use of Eliquis (an anticoagulant medication). The following interventions are documented: Administer anticoagulants as ordered by MD .Monitor for bruising .monitor lab work as ordered by MD .Observe for signs of active bleeding. A psychosocial care plan with an initiation date of 8/6/24 documents: (R34) receives Fluoxetine (an antidepressant medication) d/t depression. The following interventions are documented: Assess/record effectiveness of drug treatment, Monitor (R34's) mood and response to medication, Pharmacy consultant review. Surveyor could not identify monitoring for R34's anticoagulant or antidepressant medications in R34's medical record. On 2/27/25 at 2:47 PM, Surveyor requested R34's monthly pharmacy reviews from Director of Nursing (DON)-B. DON-B told Surveyor that they do not have resident's pharmacy recommendations available at the facility and have requested additional documentation from the pharmacy. DON-B told Surveyor that they are unable to verify if R34's pharmacy recommendations have been followed up upon. On 3/3/25 at 3:24 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A that R34 does not have any documented evidence of monitoring for anticoagulant medication, antidepressant medication and no evidence of monthly pharmacy reviews. No additional information was given by the facility at this time. 5.) R5 was admitted to the facility on [DATE]. R5's diagnoses include aphasia, diabetes mellitus and traumatic brain injury. On 2/27/25 at 2:47 PM, Surveyor requested R5's monthly pharmacy reviews from Director of Nursing (DON)-B. DON-B told Surveyor that they do not have resident's pharmacy recommendations available at the facility and have requested additional documentation from the pharmacy. DON-B told Surveyor that they are unable to verify if R5's pharmacy recommendations have been followed up upon. On 3/3/25 at 3:24 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A that R5 does not have any documented evidence of monthly pharmacy reviews. No additional information was given by the facility at this time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review the Facility did not ensure 1 (R13) of 1 residents were free from significant medication errors. R13 had a physician order to receive one 100 mg Amantadine HCl capsule (Per Drugs.com Amantadine is used to treat Parkinson's disease and Parkinson-like symptoms such as stiffness or tremors, shaking, and repetitive uncontrolled muscle movements that may be caused by the use of certain drugs) one time a day. It was documented that R13 did not receive three administrations of Amantadine between 2/28/2025 and 3/3/2025. Findings include: The Facility's Policy and Procedure titled, Adverse Consequences and Medication Errors, last revised February 2023 documents, in part: Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services . 2. Examples of medication errors include: a. Omission - a drug is ordered but not administered . R13 was originally admitted to the facility on [DATE] and most recently readmitted [DATE] after a hospital stay. R13's pertinent diagnoses include methicillin resistant staphylococcus aureus (MRSA), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Parkinsonism, type 2 diabetes mellitus with diabetic nephropathy, and neuromuscular dysfunction of bladder. R13's 5 day Minimum Data Set (MDS), completed 2/27/25, documents R13's Brief Interview for Mental Status (BIMS) score to be 15, indicating R13 is cognitively intact for decision making. R13's MDS also documents Patient Health Questionnaire (PHQ-9) score to be 00, indicating no depression. No behavior concerns are documented. R13 is assessed as making self understood and understands others. Per MDS R13 has a catheter bladder function and an ostomy for bowel function. R13 has a care plan with diagnosis of Parkinsonism, start date 6/26/2024. A pertinent intervention is provide medications as ordered by MD (medical doctor) Start date 6/26/2024. R13 has a physician order that started 11/19/2024 for Amantadine HCl 100mg, once a day for Parkinsonism. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R13's Medication Administration Record (MAR) and saw that Amantadine HCl was documented as not given three times between 2/28/25 to 3/3/25. Surveyor notes on 3/1/25 the medication was signed out as given, however, the three missed doses are coded as drug/item unavailable so unsure how it was available to be given on 3/1/25. On 03/03/25, at 01:06 PM, Surveyor interviewed R13 and was told that at least three times a week the improper medication or dose is given. R13 must be vigilant and watch each medication given. On 03/03/25, at 01:50 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-F regarding the missed doses of Amantadine HCl. ADON-F stated they will look into this. Surveyor asked if the Facility has a contingency supply of medications and was told they do, ADON-F will see if Amantadine HCl is included in contingency. On 03/03/25, at 02:25 PM, ADON-F followed up with Surveyor and stated that the Amantadine HCl medication was delivered and put into overflow, the nurses did not look there for the medication. ADON-F moved the medication to the medication cart. Also, Amantadine HCl is not available in contingency. ADON-F had contacted the Nurse Practitioner (NP) and was waiting to hear from NP if ok to give Amantadine HCl now. Surveyor notes an order was entered as once-one time for Amantadine HCl on 3/3/2025 to be given between 3:00 PM and 11:00 PM. On 03/04/25, at 10:00 AM, Surveyor interviewed Director of Nursing (DON)-B regarding the missed doses of Amantadine HCl and was told that ADON-F talked to DON-B and it was decided to reach out to doctor to update and get order to give late since it is a once a day medication. On 03/04/25, at 01:29 PM, Surveyor interviewed Agency Licensed Practical Nurse (LPN)-T regarding the Amantadine HCl not being administered on 3/3/24 and that it was coded as drug/item unavailable. Per LPN-T they worked [PHONE NUMBER] AM yesterday, then left. LPN-T does not remember this medication. On 03/04/25, at 01:38 PM, Surveyor interviewed LPN-Q who gave the once-one time dose of Amantadine HCl on 3/3/25. LPN-Q stated they had to call the pharmacy and ask them to resend the order so could be given. No further information was provided as to why the Facility did not ensure that R13 was free from this significant medication error.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48391 Based on observation and interview, the facility did not ensure food was stored, prepared and served in a sanitary manner. This practice had the potential to affect a pattern of the facility 53 residents who receive food served in the facility common dining room. * A dietary staff member was observed taking temperatures and serving food in the common dining room for breakfast service on 3/3/25 and not wearing a hair net. * Food temperatures were not obtained prior to providing breakfast service on 3/3/25 and throughout breakfast serving times, in the common dining room. Findings include: The facility Policy and Procedure titled, Food Preparation and Service with no date, documents: Policy Statement: Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Food Distribution and Service: 2. The temperature of foods held in steam tables are monitored throughout the meal service by food and nutrition services staff. 8. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. On 3/3/25, at 8:08 AM, Surveyor entered the common dining room and reviewed the clip board containing food temperature logs, hanging on the wall next to the warming station. Surveyor notes food temperature entries on 3/1/25 and 3/2/25 with no missed entries or concerns with temperatures. Surveyor notes there are not food temperatures noted for breakfast on 3/3/25 and residents currently eating breakfast in the common dining room. Surveyor observed Dietary Aide-H enter the common dining room with her hair loosely pulled back with a hair tie and no hair net on. Surveyor observed Dietary Aide-H serve food from the warming trays to a resident in the common dining room without a hair net on. Dietary Aide-H returned to the warming tray station and Surveyor asked if staff record food temperatures. Dietary Aide-H responded yes and directed Surveyor to the food temperature clip board hanging on the wall. Surveyor noted to Dietary Aide-H there were no temperatures recorded for breakfast today on 3/3/25. Dietary Aide-H then grabbed the thermometer and proceeded to temp the food in the warming trays. Surveyor asked Dietary Aide-H if food temperatures should be tested prior to serving food and Dietary Aide-H responded, yes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/3/25, at 8:43 AM, Surveyor observed Dietary Aide-H with hair loosely pulled back in a hair tie and a hair net on. Dietary Aide-H was observed in the common dining room assisting residents with food and requests. On 3/3/25, at 9:16 AM, Surveyor interviewed Dietary Aide-H who states she is supposed to wear a hair net at all times while serving food and throughout the common dining room while serving food. Surveyor noted to Dietary Aide-H she was not wearing a hair net when temping food and serving residents food from the warming trays earlier at breakfast. Dietary Aide-H states she was returning from using the restroom and was caught off guard which is why she didn't have a hair net on. Surveyor observed Dietary Aide-H wearing a hair net at the time of the interview. On 3/3/25, at 11:09 AM, Surveyor went back into the common dining room to review the clip board containing food temperatures. Surveyor notes there was one temperature log from 3/3/25 breakfast that was obtained earlier with Dietary Aide-H and Surveyor. No further temperatures for 3/3/25 breakfast were noted. Cook- G walked into the common dining area where Surveyor was reviewing the food temperature log. Surveyor asked Cook- G if he serves food in the common dining room and if temperatures of food are obtained. Cook- G states yes, he serves lunch from the warming trays in the common dining room and food temperatures are to be completed and documented on the clip board, prior to serving food and in the middle of passing lunch. Cook- G pointed to the food temperature log on the clip board and states this is where temperatures are recorded. Surveyor asked Cook- G if he would expect additional entries for 3/3/25 breakfast time and Cook- G indicates yes. On 3/3/25, at 3:05 PM, Surveyor notified Nursing Home Administrator (NHA)- A of concerns listed above. NHA- A acknowledged concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not develop an infection prevention and control program that included preventing, identifying, reporting, and controlling infections and communicable diseases potentially affecting all 53 residents, and providing a sanitary environment to help prevent the development and transmission of communicable diseases and infections for 4 (R47, R34, R17, and R19) of 12 residents in Enhanced Barrier Precautions (EBP). *Facility outbreaks did not have complete surveillance data on the residents and staff affected. *Monthly infection surveillance data did not have infection rates calculated. *The Water Management Plan did not have a detailed description and diagram of the water system in the facility identifying control measures and how the control measures are monitored. *R47 was in EBP. Observations were made of staff not wearing appropriate Personal Protective Equipment (PPE) when performing cares and wound care. *R34 was in EBP. Observations were made of staff not wearing appropriate PPE when performing wound care. *R17 was in EBP. Observations were made of staff not wearing appropriate PPE when performing wound care. *R19 was in EBP. Observations were made of staff not wearing appropriate PPE when performing wound care. Findings include: The facility policy and procedure titled Surveillance for Infections from MED-PASS (C) 2001 revised 9/2017 documents: Policy Interpretation and Implementation: 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. Gathering Surveillance Data: 1. The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI committee may be involved in interpretation of the data. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. In addition to collecting data on the incidence of infections, the surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted; for example, focused surveillance data may be gathered for residents with a high risk for infection or those with a recent hospital stay. Data Collection and Recording: 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a. Identifying information .; b. Diagnoses; c. admitted , date of onset of infection .; d. Infection site .; e. Pathogens; f. Invasive procedures or risk factors .; g. Pertinent remarks Also, record if the resident is admitted to the hospital, or expires; and h. Treatment measures and precautions . 4. For targeted surveillance sing facility-created tools, follow these guidelines: a. DAILY (as indicated): Record detailed information about the resident and infection on an individual infection report form b. MONTHLY: Collect information from individual resident infection reports and enter line listing of infections by resident for the entire month (e.g., Line Listing of Infections by Resident or similar form). c. MONTHLY: Summarize monthly data for each nursing unit by site and by pathogen d. MONTHLY/QUARTERLY: Identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends . e. MONTHLY/QUARTERLY: Compare incidence of current infections to previous data to identify trends and patterns. Use an average infection rate over a previous time period (for example, over the past 12 months) as the baseline. Compare subsequent rates to the average rate to identify possible increases in infection rates. Calculating Infection Rates: 1. Obtain the month's total resident days from the business office. The following data is used as the denominator to calculate the monthly infection rate: a. Total resident days (daily census of each day in the designated time period added together). 2. To determine the incidence of infection per 1000 resident days, divide the number of new healthcare associated infections for the month by the total resident days for the month (obtained from the business office) X 1000. Interpreting Surveillance Data: 1. Analyze the data to identify trends. a. Compare the rates to previous months in the current year and to the same month in previous years, to identify seasonal trends. b. Consider how increases or decreases might relate to recent process changes, events, or activities in the facility 2. Surveillance data will be provided to the infection control committee regularly. 3. The infection control committee will determine how important surveillance data will be communicated to the physicians and other providers, the administrator, nursing units, and the local and state health departments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy and procedure titled Enhanced Barrier Precautions from MED-PASS (C) 2001 revised 8/2022 documents: 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bating/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 1.) On 2/26/2025 at 8:00 AM, Surveyor entered the facility and observed a sign on the front door stating the facility was in a COVID-19 outbreak and anyone entering the facility needed to wear a mask. Surveyor asked for a list of residents in COVID-19 isolation and was told by facility staff that no residents currently have any positive COVID-19 tests, and the facility staff and visitors are wearing masks for the ten days beyond the last symptom to prevent future spread of COVID-19. On 2/26/2025 at 3:00 PM, Surveyor requested from Nursing Home Administrator (NHA)-A and Director of Nursing (Don)-B all outbreak summaries and line lists since the last recertification survey. DON-B stated Assistant DON (ADON)-F is the facility infection preventionist and would provide that information to Surveyor. On 2/27/2025, ADON-F provided Surveyor with two COVID-19 outbreak packets consisting of resident and staff line lists and a summary of the outbreak, two respiratory line lists, and two gastrointestinal line lists. Surveyor noted the gastrointestinal line lists each had one resident listed and therefore did not meet the definition of an outbreak. Surveyor noted the respiratory line list that had current dates of infection was an Influenza outbreak and not a COVID-19 outbreak as was documented on the sign at the facility entrance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the outbreak packet for COVID-19 that started on 10/26/2024 when a staff member tested positive. Another staff member and one resident tested positive on 10/28/2024. Per the line lists, 7 staff members tested positive and 17 residents tested positive totaling 24 individuals being affected by COVID-19. The last positive collected sample was on 11/4/2024. The summary of the outbreak documented the outbreak began on 10/29/2024 with a total of 20 residents and 7 staff members testing positive. Surveyor noted the number of residents on the summary did not match the number of affected residents on the line list. Surveyor reviewed the outbreak packet for COVID-19 that started on 12/4/2024 when three staff members tested positive. Two staff members tested positive on 12/5/2024. A resident tested positive on 12/18/204, thirteen days after the last staff member tested positive. The outbreak should have been concluded on 12/15/2024, ten days after the last staff member tested positive. 1/6/2025-1/22/2025 had two staff members and eight residents positive. The Outbreak Summary Report documented 17 individuals were affected in the outbreak with testing of residents and staff from 12/4/2024-1/6/2025 with the outbreak conclusion being 1/6/2025. The conclusion date does not match the last resident testing positive on 1/22/2025. On 3/3/2025 at 11:14 AM, Surveyor met with DON-B and ADON-F to discuss the facility Infection Prevention (IP) program. ADON-F stated ADON-F had been responsible for the IP program since 10/2024 and was still learning the process. Surveyor shared with ADON-F the concern the outbreak summaries did not match the information on the line lists. ADON-F agreed. 2.) Surveyor reviewed ADON-F's IP binder for the previous months infection surveillance logs listing the residents and infective processes including the use of antibiotics. The monthly sections included line lists and plot maps of the facility. In an interview on 3/3/2025 at 11:14 AM, Surveyor asked ADON-F if monthly rates of infection were calculated. ADON-F stated no. Surveyor asked ADON-F what information was brought to Quality Assessment and Assurance (QAA) meetings for the infection prevention program. ADON-F stated ADON-F brings the binders with the line lists to QAA. Surveyor shared the concern trends in infection could not be determined if rates of infection were not calculated monthly to compare to previous months/years. ADON-F agreed. On 3/3/2025 at 3:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and DON-B the concern rates of infection were not calculated per infection monthly. DON-B agreed the rates should be calculated. 3.) On 3/3/2025 at 11:14 AM, Surveyor asked ADON-F if ADON-F is part of the Water Management Plan (WMP). ADON-F stated Maintenance Director (MainDir)-L is in charge of the WMP and would have any information Surveyor needed. Surveyor requested ADON-F contact MainDir-L to provide the WMP to Surveyor for review. The facility policy and procedure titled Legionella Water Management Program from MED-PASS (C) 2001 revised 7/2017 documents: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The water management team will consist of at least the following personnel: a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. The director of environmental services. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 4. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program. 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving; (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: (1) storage tanks; (2) Water heaters; (3) Filters; (4) Aerators; (5) Showerheads and hoses; (6) Misters, atomizers, air washers and humidifiers; (7) Hot tubs; (8) Fountains; and (9) Medical devices such as CPAP machines, hydrotherapy equipment; etc. d. The identification of situations that can lead to Legionella growth, such as: (1) Construction; (2) Water main breaks; (3) Changes in municipal water quality; (4) The presence of biofilm, scale or sediment; (5) Water temperature fluctuations; (6) Water pressure changes; (7) Water stagnation and; (8) Inadequate disinfection. e. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. 6. The Water Management Program will be reviewed at least once a year, or sooner if any of the following occur: a. The control limits are consistently not met; b. There is a major maintenance or water service change; c. There are any disease cases associated with the water system; or d. There are changes in laws, regulations, standards or guidelines. On 3/3/2025 at 11:36 AM, MainDir-L provided to Surveyor the facility Legionella Water Management Program policy and procedure. Surveyor asked MainDir-L for the WMP, which should include diagrams of the water system, control measures, and logs of flushes. MainDir-L stated MainDir-L thought Surveyor just wanted the policy for the WMP. MainDir-L stated MainDir-L would get more information for Surveyor. On 3/3/2025 at 1:34 PM, MainDir-L provided to Surveyor a second copy of the facility Legionella Water Management Program policy and procedure, a checklist for developing a legionella water management program that was not dated, a facility policy and procedure titled Legionella Water Management dated 1/10/2024, and a hand-drawn diagram of the facility with no control measures designated. -The facility policy and procedure titled Legionella Water Management dated 1/10/2024 documented: I. OBJECTIVE: The purpose of this policy is to reduce the risk associated with the control of Legionella to the lowest practical level. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	II. DEFINITION: Legionella-the bacterium that causes legionnaires' disease, flourishing in air conditioning and central heating systems. III. POLICY: The Legionella Team consisting of the Administrator, Director of Nursing, Maintenance Director, Dietary Manager and Housekeeping Supervisor are to achieve by improving the standard of existing water, implementing safe operational procedures, and ensuring that the design and installation of all new systems conform to the current standards. IV. PROCEDURES: A. NURSING 1. Make sure medical devices such as CPAP and BIPAP machines are cleaned and sanitized on a daily basis. B. HOUSEKEEPING 1. DAILY TASKS: a. Clean and sanitize all showerheads for a minimum of 3 minutes. b. Clean and sanitize all facets [sic] regardless of use. 2. WEEKLY TASKS a. Run water through every showerhead for a minimum of 3 minutes. b. Run water through every facet [sic] for a minimum of 3 minutes. C. DIETARY 1. Clean/drain and sanitize all steam tables daily. 2. Monitor ice machine filters and notify Maintenance when the filter needs to be replaced. 3. Check water temperatures and chemical dispensers on Dishwasher daily. 4. Notify vendor of and repairs. [sic] D. MAINTENANCE 1. Insure [sic] the water heaters are running within the required WI State code guidelines. 2. Flush when required. Surveyor noted the policy did not include the infection preventionist as part of the team and no documentation showed the appropriate time to flush shower heads and faucets to be 3 minutes. Surveyor reviewed with MainDir-L the facility Legionella Water Management Program policy and procedure. Surveyor asked MainDir-L if there was a more detailed drawing or description of the water system showing where control measures were in the building. Surveyor went through each item listed in 5. The water management program includes the following elements: to clarify with MainDir-L what information Surveyor needed to see to assess the facility WMP that was in place. MainDir-L stated the information provided to Surveyor, the policies, the checklist, and the hand-drawn diagram, was the information provided to MainDir-L by the previous maintenance director. MainDir-L stated MainDir-L would get logs that have been completed by kitchen and housekeeping. In an interview on 3/3/2025 at 1:47 PM, Surveyor asked Nursing Home Administrator (NHA)-A who was part of the Water Management team. NHA-A stated the Regional Maintenance Director, MainDir-L, and ADON-F. Surveyor asked NHA-A if NHA-A was part of the team. NHA-A stated no. Surveyor shared the concern with NHA-A that NHA-A should be part of the team per their policy, and the information provided by MainDir-L was not complete or thorough. On 3/3/2025 at 1:52 PM, MainDir-L provided logs that showed six rooms a week were tested for water temperature coming out of the faucets. Surveyor noted the temperatures logged ranged from 94 degrees to 112 degrees. The Centers for Disease Control and Prevention (CDC) guidelines document Legionella grows best between 77-113 degrees; hot water should be stored at temperatures above 140 degrees and hot water in circulation should not fall below 120 degrees. MainDir-L provided logs from the kitchen that documented daily draining and sanitizing steam tables. Surveyor noted not all the boxes had been filled in indicating the task had been completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 3/4/2025 at 8:04 AM, Surveyor asked NHA-A to explain the water temp logs for resident rooms. NHA-A stated temperatures are gotten from six different rooms every week and the rooms are listed on the logs. Surveyor noted it takes about one and a half months to get the temperatures of every room in the facility. Surveyor shared with NHA-A the concern the temperatures taken in resident rooms were below the recommended 120 degrees by the CDC. Surveyor asked NHA-A if they had a policy to show what temperature should be reached and if there was a measure in place to follow if the temperatures were not at the level indicated. NHA-A provided a facility policy and procedure titled Water Temperatures, Safety of dated MED-PASS (C) 2001 revised 12/2009 that documented: 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 115 degrees F. Surveyor noted 115 degrees was hand-written in the policy where a blank had been left. On 3/4/2025 at 10:57 AM, Surveyor measured the temperature of the water coming out of the faucet in room [ROOM NUMBER]. The temperature measured 124 degrees. On 3/4/2025 at 3:32 PM, Surveyor shared with NHA-A and DON-B the concern staff measuring the temperature of the running water did not keep the thermometer in the water for a long enough period of time to come up with an accurate measurement. Surveyor shared the observation of the temperature of the water coming from the faucet in room [ROOM NUMBER]. Surveyor shared the concern NHA-A was not a member of the WMP team and the WMP did not have a detailed description and diagram of the water system in the facility identifying control measures and how the control measures are monitored. 4.) R47 was admitted to the facility on [DATE] and was in EBP due to wounds to the right heel, right lateral foot, and coccyx. On 2/27/2025 at 11:14 AM, Surveyor was with Registered Nurse (RN)-M who was preparing to provide wound care to R47. A sign was observed outside of R47's room indicating R47 was in EBP. RN-M knocked on R47's door prior to entering and told R47 RN-M was there to do wound care. RN-M did not put on a gown prior to entering R47's room. RN-M brought the treatment cart into R47's room rather than leaving it in the hallway and bringing in only the treatment items needed to provide wound care. R47 informed RN-M that R47 had a bowel movement and needed to be cleaned up. RN-M told R47 RN-M would return after R47 had been cleaned. RN-M pushed the treatment cart back into the hallway. Surveyor observed Certified Nursing Assistant (CNA)-K enter R47's room to provide incontinence care. CNA-K did not put on a gown prior to entering the room. CNA-K came out of R47's room with a bag of garbage which CNA-K deposited into a garbage container in the hallway. Surveyor asked RN-M if gowns should be worn in resident rooms when wound care is performed. RN-M stated yes. Surveyor asked RN-M if RN-M should have put on a gown to provide wound care to R47. RN-M stated yes. In an interview on 2/27/2025 at 11:27 AM, Surveyor asked CNA-K if any special PPE needed to be put on when doing incontinence care for R47. CNA-K stated CNA-K did not think any PPE needed to be worn when caring for R47, but maybe for R47's roommate. CNA-K looked at the sign posted on R47's door and stated R47 was in EBP and next time, CNA-K will wear a gown to do cares with R47. On 2/27/2025 at 11:28 AM, Surveyor observed RN-M put on a gown prior to entering R47's room. RN-M pushed the treatment cart into R47's room. R47 asked RN-M why RN-M was wearing a gown since RN-M had never had a gown on to do wound care before. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/27/2025 at 3:01 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern CNA-K did not wear a gown when performing cares on R47 and RN-M put on a gown after a discussion was had regarding R47 being in EBP. Surveyor shared the concern RN-M brought the treatment cart into the room when providing wound care. 5.) R34 was admitted to the facility on [DATE] and was in EBP due to a wound to the right heel. On 2/27/2025 at 10:39 AM, Surveyor was with RN-M who was preparing to provide wound care to R34. A sign was observed outside of R34's room indicating R34 was in EBP. RN-M knocked on R34's door and entered the room pushing the treatment cart into R34's room. RN-M did not put on a gown prior to providing wound care to R34's right heel. After RN-M completed the wound treatment and pushed the cart into the hallway, Surveyor asked RN-M if RN-M should have worn PPE when doing R34's wound treatment. RN-M stated yes. On 2/27/2025 at 3:01 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern RN-M did not wear a gown when performing wound care on R34 and the concern RN-M brought the treatment cart into the room when providing wound care. 6.) R17 was admitted to the facility on [DATE] and was in EBP due to wounds to the left and right buttocks. On 2/27/2025 at 10:57 AM, Surveyor was with RN-M who was preparing to provide wound care to R17. A sign was observed outside of R17's room indicating R17 was in EBP. CNA-O accompanied RN-M to help position R17 during wound care. RN-M and CNA-O did not put on a gown prior to entering the room to provide wound care. RN-M pushed the treatment cart into R17's room. When RN-M completed R17's wound treatments, RN-M pushed the cart out of R17's room and CNA-O followed. Surveyor asked CNA-O when a resident is in EBP, what PPE should be worn. CNA-O stated they should wear a gown. CNA-O showed Surveyor the bin outside of R17's room that had PPE in the drawers. Surveyor asked CNA-O what would cause a resident to be in EBP. CNA-O stated if a resident has a wound or a catheter, then they are in EBP. Surveyor asked CNA-O if R17 was in EBP. CNA-O stated CNA-O did not know if R17 was on precautions or not so did not wear a gown. On 2/27/2025 at 11:14 AM, Surveyor asked RN-M if gowns should be worn in resident rooms when wound care is performed. RN-M stated yes. Surveyor asked RN-M if RN-M should have put on a gown to provide wound care to R17. RN-M stated yes. On 2/27/2025 at 3:01 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern RN-M and CNA-O did not wear a gown when performing wound care on R17 and the concern RN-M brought the treatment cart into the room when providing wound care. 42037 7.) R19 was admitted to the facility on [DATE] and was in EBP due to a heel wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/27/2025 at 10:29 AM, Surveyor was with RN-M who was preparing to provide wound care to R19. A sign observed outside of R19's room door indicated R19 was in EBP. RN-M knocked on R19's door and entered the room pushing the treatment cart into R19's room. RN-M did not don a gown prior to providing wound care to R19's heel wound. After RN-M completed the wound treatment RN-M pushed the cart back into the hallway, On 2/27/2025 at 3:10 PM, Surveyor shared with NHA-A and DON-B the concern that RN-M did not don a gown prior to performing R19's wound care. Surveyor shared the concern RN-M brought the treatment cart into the room when providing wound care for R19 who is in EBP. No additional information was supplied by the facility at this time.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 38253 Based on interview and record review, the facility did not ensure they implemented their antibiotic stewardship program potentially affecting all 53 residents in the facility. Review of the facility infection surveillance logs for residents on antibiotics indicated antibiotic use without documentation of appropriate use of the antibiotic. Findings include: The facility policy and procedure titled Surveillance for Infections from MED-PASS (C) 2001 revised 9/2017 documents: 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. On 3/3/2025 at 11:14 AM, Surveyor met with Assistant Director of Nursing (ADON)-F to discuss the facility Infection Prevention (IP) program. ADON-F stated ADON-F had been responsible for the IP program since 10/2024 and was still learning the process. Surveyor reviewed ADON-F's IP binder for the previous months infection surveillance logs listing the residents and infective processes including the use of antibiotics. Surveyor asked ADON-F what standard of practice for antibiotic stewardship was used. ADON-F stated they use McGeer, and they are trying to get it in place more frequently. (The McGeer criteria are a set of clinical guidelines used for infection surveillance in long-term care facilities, focusing on identifying potential infections and guiding antibiotic stewardship.) Surveyor asked ADON-F what was meant by that. ADON-F stated they are trying to complete the McGeer form for each resident on an antibiotic and then scanning it into the resident record. Surveyor asked ADON-F if each resident has had a McGeer form completed prior to the use of an antibiotic. ADON-F stated that was their goal, but that had not been done for everyone at that time. Surveyor reviewed the monthly line lists for 1/2025, 2/2025, and 3/2025. 1/2025 had 36 resident entries on the line list, 2/2025 had 29 resident entries on the line list, and 3/2025 had 24 resident entries on the line list. Examples from the line list review: -R1 was diagnosed with a urinary tract infection on 3/1/2025 with a culture taken on 3/1/2025; the antibiotic Macrobid was started on 3/2/2025. No documentation was found of a McGeer criteria review being completed prior to the use of the antibiotic. -R151 was diagnosed with a urinary tract infection on 2/17/2025 with a culture taken on 2/17/2025; the antibiotic ciprofloxacin was started on 2/23/2025. On 2/22/2025 at 9:52 AM in the progress notes, nursing documented a call was received from R151's physician regarding the urine culture results and to stop Keflex immediately and start ciprofloxacin. Surveyor noted R151 had not received Keflex, and no documentation was found of a McGeer criteria review being completed prior to the use of any antibiotic. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/4/2025 at 3:32 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern residents are put on antibiotics without documentation that the use of the antibiotic meets the McGeer criteria. Antibiotic stewardship relies on the use of a standard of practice to prevent unnecessary antibiotic usage. Surveyor shared with NHA-A and DON-B resident records were reviewed and no documentation was found in the medical record of the McGeer criteria checklist being completed prior to the use of antibiotics.