STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525586	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Services	1119 N Wisconsin St Port Washington, WI 53074

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure protective placement was obtained for 1 resident (R) (R1) of 3 sampled residents with a Guardian when the resident's nursing home stay exceeded ninety days. R1 was admitted to the facility on [DATE] with the consent of a legal Guardian. The facility did not pursue protective placement when the resident's stay exceeded ninety days. Findings include: State Statute Chapter 55.03(4) indicates court-ordered protective placement should be obtained for any resident admitted to a nursing home who has a legal Guardian and whose nursing home stay exceeds ninety days. State Statute Chapter 55.18 indicates protective placement is reviewed annually. On 3/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including paraplegia, epilepsy, and congestive heart failure. R1's Minimum Data Set (MDS) assessment, dated 12/17/24, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had a court-appointed Guardian. R1's medical record contained guardianship and protective placement documents dated 2/11/98. R1's medical record did not contain the required annual reviews for protective placement to determine if R1 resided in the least restrictive environment. R1's medical record indicated the facility updated R1's Guardian on R1's changes in condition and R1's Guardian made decisions regarding R1's healthcare needs. On 3/11/25 at 11:37 AM, Surveyor interviewed Social Worker (SW)-C who indicated the county sends updated annual reviews to the facility every year and the documents are uploaded into residents' electronic medical records. SW-C indicated SW-C would search for R1's most recent annual review documentation. On 3/12/25 at 10:13 AM, Surveyor interviewed SW-C who indicated R1's managed care organization (MCO) had been trying to contact the county since 2024 regarding protective placement. SW-C indicated SW-C made a referral to Adult Protective Services (APS) on 3/11/25 and was told by APS they would conduct an emergency review. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed a message from R1's MCO, dated 3/11/25, that indicated R1's MCO had (starting in April of 2024) been routinely contacting the county requesting updates on the status of the protective placement order for R1. On 3/12/25 at 10:23 AM, Surveyor interviewed SW-C who indicated SW-C received an an email from APS that indicated R1's protective placement was discontinued in 2003. SW-C indicated if protective placement is discontinued by the court system, there is no need for protective placement when a resident is admitted to a skilled nursing facility. Surveyor reviewed an undated email from APS that indicated R1's protective placement was discontinued by the court system on 2/19/03. On 3/12/25 at 11:54 AM, Surveyor interviewed [NAME] President of Success (VPS)-D who indicated the facility's legal department informed VPS-D the facility does not have a policy that addresses guardianship and protective placement. VPS-D indicated facility should follow state regulations.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff interview, and record review, the facility did not provide the necessary care and treatment to promote healing and/or prevent impaired skin integrity for 1 resident (R) (R1) of 15 sampled residents. R1 was diagnosed with a rare skin condition. R1's care plan indicated staff should not use incontinence briefs for R1. During an observation of care on 3/11/25, staff removed an incontinence brief from R1 and applied a clean brief. Findings include: On 3/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including paraplegia, epilepsy, obsessive compulsive disorder, and excoriation disorder (also known as chronic skin-picking or dermatillomania; a mental illness related to obsessive-compulsive disorder characterized by repeated picking at one's skin resulting in areas of swollen or broken skin). R1's Minimum Data Set (MDS) assessment, dated 12/17/24, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had a court-appointed Guardian who was responsible for R1's healthcare decisions. Surveyor reviewed R1's care plan and Kardex (an abbreviated care plan used by nursing staff). Both indicated staff should not use incontinence briefs for R1. The care plan indicated staff should use union suits, boxer shorts, long pants, tall socks, and/or wrap R1's body with a bath blanket to prevent self-trauma. On 3/11/25 at 9:48 AM, Surveyor observed Licensed Practical Nurse (LPN)-E provide wound care for R1 with the assistance of Certified Nursing Assistant (CNA)-F. Surveyor observed LPN-E and CNA-F remove an incontinence brief to provide wound care to R1's bilateral buttocks. Surveyor observed multiple open areas on R1's bilateral buttocks and noted the skin surrounding the areas was red. Surveyor noted a reddened area covered almost all of R1's bilateral buttocks and was the same area of skin covered by the incontinence brief. R1 denied pain in the area. LPN-E indicated R1's skin had been like that for years. LPN-E indicated sometimes R1's skin almost heals and then somehow (R1) gets down there and the areas open again. Following wound care, Surveyor observed LPN-E and CNA-F put a clean incontinence brief on R1. LPN-F indicated staff used hypoallergenic soap on R1's skin. (Note: R1's care plan did not indicate what type of soap staff should use on R1's skin.) On 3/11/25 at 11:13 AM, Surveyor interviewed LPN-E who indicated the facility tried different medications to help R1 stop itching, including an anti-itch cream for R1's arms. LPN-E indicated nothing seemed to help. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 9:07 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R1's psychiatric provider tried different medications to help R1 stop itching. When asked if any non-pharmacological interventions were tried, DON-B indicated R1's wound care provider tried different lotions. DON-B indicated whenever staff were not with R1, R1 itched R1's skin open. DON-B indicated DON-B started employment at the facility in November of 2024 and was unsure if different soaps or laundry detergents had been tried. DON-B verified staff should not use incontinence briefs for R1 because the briefs hold in too much moisture. DON-B was unaware staff were using incontinence briefs for R1. DON-B indicated when DON-B conducted wound rounds with R1's wound provider, R1 had a shower just prior to wound care and all dressings were off before the assessment began. DON-B indicated the wound provider used a small amount of tape on the skin to hold R1's dressings in place or wrapped R1 in a blanket to prevent R1 from itching R1's skin open.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49010 Based on observation, staff interview, and record review, the facility did not ensure food was stored and served in a sanitary manner. This practice had the potential to affect all 25 residents residing in the facility. The kitchen cooler and dry storage area contained multiple open and undated food items. Staff did not follow appropriate hand hygiene procedures in the kitchen and while serving food. Findings include: On 3/10/25 at 9:35 AM, Surveyor and Account Manager (AM)-G began an initial kitchen tour. AM-G indicated the facility follows the Food and Drug Administration (FDA) Food Code. Food Labeling/Storage: The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (Celsius) (41 F) (Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. The 2022 FDA Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition: (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). The facility's Labeling and Dating policy, dated 2/2017, indicates: All foods should be dated upon receipt before being stored Food labels must include: The food item name; The date of preparation/receipt/removal from freezer; The use-by date as outlined in the attached guidelines .Items that are removed from a labeled case in the freezer and placed in the refrigerator for thawing should be labeled with the date of removal from the freezer and the use-by date. Leftovers must be labeled and dated with the date they are prepared and the use-by date .Use-By Dating Guidelines: .Day of preparation or opening is considered day 1 when establishing the use-by date . Guidelines apply, regardless of storage location (e.g., kitchen, pantries, etc.) . During an initial kitchen tour that began at 9:35 AM on 3/10/25, Surveyor and AM-G observed the following: Dry Storage: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ A bag of Toasted Oats (opened 3/7/25) with no use-by date ~ A container of Cheerios (opened 3/7) with no use-by date ~ A container of Corn Flakes (opened 3/28) with no use-by date ~ A container of [NAME] Krispies (opened 2/28) with no use-by date ~ A container of Bran Flakes (opened 2/22) with no use-by date ~ An unsealed 50 pound bag of flour (received 10/25/24) with no open or use-by dates ~ A package of Chinese noodles (opened 1/13/25) with no use-by date ~ A 25 pound bag of dry milk (received 10/25/24) with no open or use-by dates ~ A bag of coconut flakes (opened 3/4/25) with no use-by date ~ A container of flour (dated 11/20/24) with no use-by date ~ A container of sugar (dated 11/10/24) with no use-by date ~ A bulk container of unidentified material (dated 11/20/24) with no use-by date. (At 11:52 AM, Regional Manager (RM)-H labeled the container as flour.) Cooler: ~ A container of cream of chicken prepared 2/3/25 with a use-by date of 2/6/25. AM-G discarded the item. ~ A container of hot dogs (opened 3/3/25) with no use-by date ~ A container of hard boiled eggs (opened 1/7/25) with no use-by date ~ A container of orange juice mix labeled orange (prepared 2/23/25) with no use-by date Freezer: ~ An open, resealed package of English muffins (dated 1/4/25) with no use-by date ~ Two unopened, unlabeled packages of pound cake (per AM-G) (dated 2/24/25) with no use-by dates Surveyor interviewed AM-G who indicated staff should date food with a received date, an opened or prepared date, and a use-by date. On 3/11/25 at 11:52 AM, Surveyor interviewed RM-H who indicated food should be properly labeled and dated and should include a use-by date. RM-H indicated staff should be familiar with and follow the facility's food dating policies. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hand Hygiene: The 2022 FDA Food Code documents at 2-301.14: Food employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. The 2022 FDA Food Code documents at 3-301.11 Preventing Contamination From Hands: (A) Food employees shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. The facility's Hand Hygiene policy, dated 11/2/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations in the facility .6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing them. The Facility's Culinary Professionals Training-Glove Usage policy indicates: When to change or remove your gloves: When they are dirty, torn, damaged, discolored, or contaminated; When taking one step away from your work area; Before going to the restroom; Before starting another job .You must remember to always wash your hands in between gloves .Gloves do not give you the right to not wash your hands .do not keep them on, reuse them or anything else. On 3/10/25 at 12:18 PM, Surveyor observed AM-G serve food to residents. Surveyor observed AM-G pick up residents' plates with bare hands and touch food serving utensils. AM-G then served food on the plates AM-G had touched with bare hands. AM-G repeated the process for all lunch plates served. On 3/10/25 at 12:37 PM, Surveyor observed [NAME] (CK)-I enter the kitchen from the back door. CK-I went through the kitchen, opened a drawer, and applied a beard restraint. CK-I then continued through the kitchen and started kitchen tasks. CK-I did not complete hand hygiene. On 3/11/25 at 1:07 PM, Surveyor observed CK-I enter the kitchen from the hallway door. CK-I went to the stove and began working. CK-I did not complete hand hygiene. On 3/11/25 at 1:08 PM, Surveyor interviewed CK-I who indicated CK-I was in the hallway donning on a beard restraint prior to re-entering the kitchen. When asked if CK-I should have performed hand hygiene upon entering the kitchen, CK-I stated CK-I would perform it now if it would make Surveyor happy. On 3/11/25 at 1:18 PM, Surveyor interviewed AM-G who indicated hand hygiene should be performed after tasks and when changing gloves. AM-G indicated staff should be aware of when to use gloves. AM-G indicated staff should wash hands upon entering the kitchen. AM-G indicated staff should be familiar with and follow the facility's hand hygiene and food dating policies.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49010 Based on staff interview and record review, the facility did not ensure the required members of the Quality Assurance and Performance Improvement (QAPI) committee met at least quarterly. This practice had the potential to affect more than 4 of the 25 residents residing in the facility. The facility did not ensure the required members of the QAPI committee met at least quarterly from March 2024 through February 2025. Findings include: The facility's Quality Assurance and Performance Improvement (QAPI) Committee policy, dated 7/11/22, indicates: The Executive Director and the Director of Nursing are responsible and accountable for the development, implementation, monitoring, and leadership of the center's QAPI program. A core team of individuals will be appointed to spearhead the QAPI program and will engage in monthly QAPI meetings which will include the creation/modification of performance improvement plans (PIPs). The center's QAPI Committee may include the following team members: the Executive Director, Director of Nursing, Medical Director, Infection Preventionist, Life Enrichment Director, Social Services Director, Maintenance Director, Housekeeping Director, Business Office Manager, Human Resources Director, Dietary Manager/Registered Dietician, Minimum Data Set (MDS) Coordinator and at least one non-licensed direct care staff. On 3/11/25, Surveyor requested attendance sheets for the previous year (March 2024 through February 2025) of QAPI meetings. Surveyor reviewed the facility's sign-in sheets which included six pages labeled QAPI agenda and meeting minutes for the designated time period. The sheets were dated March 2024, April 2024, June 2024, August 2024, January 2025, and February 2025. There were no QAPI sign-in sheets provided for May, July, September, October, November or December of 2024. Surveyor reviewed the sign-in sheets to ensure each of the following members attended a QAPI meeting at least quarterly: Medical Director (MD), Nursing Home Administrator (NHA) (Executive Director), Director of Nursing (DON), Infection Preventionist (IP), and two additional staff. The March 2024 meeting had signatures for the NHA and two additional staff. The MD participated via phone. The DON and IP were missing. The April 2024 meeting had signatures for the MD, NHA, DON and one additional staff. The IP and one other staff were missing. There was no sign in sheet for May 2024. The June 2024 meeting had signatures for the NHA, DON, IP, and two additional staff. The MD was missing. There was no sign-in sheet for July 2024. The August 2024 meeting had signatures for the NHA, DON, and two additional staff. The MD participated via Teams. The IP was missing. There were no sign-in sheets for September, October, November or December of 2024. The January 2025 meeting had signatures for the NHA, DON, IP, and two additional staff. The MD was missing. The February 2025 meeting had signatures for the NHA, DON, IP, and two additional staff. The MD was missing. On 3/12/25 at 9:29 AM, Surveyor interviewed DON-B who indicated there was not a QAPI meeting in November or December of 2024 because there was no Executive Director/NHA. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 10:52 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A could not locate sign-in sheets for the May, July, September, October, November, or December 2024 monthly QAPI meetings. NHA-A indicated the MD attended the meetings via phone for January and February 2025, however, NHA-A was unable to provide proof of attendance. NHA-A indicated there should be signatures of the QAPI meeting attendees. On 3/12/25 at 10:54 AM, Surveyor interviewed [NAME] President of Success (VPS)-D who indicated VPS-D could not locate sign-in sheets for the May, July, September, October, November, and December 2024 monthly QAPI meetings. VPS-D indicated it is difficult to show proof of meetings without attendance sheets and indicated the facility could not locate any sign-in sheets at that time.

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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** 49010 Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect all 25 residents residing in the facility. The facility did not maintain infection surveillance logs to assist with the recognition of trends and patterns of infection. In addition, the facility did not monitor residents for signs and symptoms of infection. Hand hygiene was not offered or completed for residents prior to dining. Licensed Practical Nurse (LPN)-E did not complete appropriate hand hygiene during wound care for R1. Findings include: The facility's Infection Prevention and Control Program policy, revised 7/23/24, indicates: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection per accepted national standards and guidelines .3. Surveillance: a. A system of surveillance is used for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement .b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility .c. Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff .for notification of changes and in-house reporting of communicable diseases and infections . The facility's Infection Outbreak Response and Investigation policy, dated 2/26/23, indicates: .h3. Outbreak investigation: .c. A case definition may be developed in order to identify other staff and residents who may be affected. Criteria for developing a case definition include: Person - key characteristics the patients share in common. Place - the location associated with the outbreak. Time - period of time associated with illness onset for the cases under investigation. Clinical features - objective signs and symptoms, such as sudden onset of fever and cough. d. A line list for the outbreak will be maintained. e. The incubation period, period of contagiousness, and date of most recent case will be used in making the determination that the outbreak is resolved . According to the (Centers for Disease Control and Prevention) CDC.Gov website 3/2025: .Key times to wash hands. You can help yourself and your loved ones stay healthy by washing your hands often, especially during these key times when you are likely to get and spread germs: Before, during, and after preparing food; Before and after eating food .Washing hands with soap and water is the best way to get rid of germs in most situations. If soap and water are not readily available, you can use an alcohol-based hand sanitizer that contains at least 60% alcohol . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Hand Hygiene policy, dated 11/2/22, indicates: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations in the facility .2. Hand hygiene is indicated and will be performed .after handling contaminated objects; before applying and after removing personal protective equipment (PPE), including gloves; before and after handling clean or soiled dressings, linens, etc.; before performing resident care procedures; when, during resident care, moving from a contaminated body site to a clean body site; and when in doubt. 1. During the entrance conference on 3/10/25, Nursing Home Administrator (NHA)-A indicated Infection Preventionist (IP)-K was in the process of leaving the position but agreed to stay until the position was filled. NHA-A confirmed IP-K was the facility's IP. From 3/10/25 to 3/12/25, Surveyor was unable to interview IP-K who was not in the facility and was unavailable. On 3/12/25 at approximately 8:30 AM, Surveyor interviewed [NAME] President of Success (VPS)-D who indicated Surveyor should interview Director of Nursing (DON)-B in IP-K's absence regarding infection control surveillance and protocol. Surveyor requested staff and resident line lists used for infection surveillance for the previous 120 days. On 3/12/25 at 9:29 AM, Surveyor interviewed DON-B who indicated the facility did not have an IP. DON-B indicated IP-K stepped down a week prior and DON-B had assumed some infection control tracking while the facility figured out who would replace IP-K. On 3/12/25 at 10:16 AM, VPS-D provided Surveyor with resident line lists. Surveyor interviewed VPS-D who indicated DON-B misspoke. VPS-D indicated IP-K was still the acting IP, however, IP-K was ill and not available. On 3/12/25, Surveyor reviewed the resident line lists which were incomplete and missing data needed to document and track infections and identify trends. The missing data included: ~ November: The form did not indicate the year and contained six resident entries. For dates of infection: There were no start dates. For dates of precautions used (contact precautions, airborne precautions, etc.): There were no start or end dates and the form did not contain a spot for the information. For organism identified (i.e., fungal, COVID-19, etc.): It was not listed for four of the six entries. There were also no symptoms or not applicable (NA) listed for five of the six entries. There was no test tracking (i.e., a urinalysis), testing criteria (i.e., McGeer's), results, or test dates and no spot on the form to record the information. In addition, the number of antibiotic-resistangt organisms and the date reported to the Quality Assessment and Assurance (QAA) committee were blank. (continued on next page)

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	525586	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Services	1119 N Wisconsin St Port Washington, WI 53074

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ December: The form contained eight resident entries. For dates of infection: Start dates were listed but no end dates. There were not spots to record end or well dates. For dates of precautions used: There were no start or end dates and the form did not contain spots for the information. For organism identified: It was not recorded for seven of the eight entries. There were no symptoms listed (or NA) for seven of the eight entries. There was no test tracking, testing criteria, results, or test dates and no spot on the form to record the information. The number of antibiotic-resistant organisms and the date reported to the QAA committee were blank. The number of resident days was not recorded and the infection incidence rate was blank. ~ January: The form did not indicate the year and contained thirteen resident entries. For dates of infection: There were start dates but no end dates. The form did not contain spots to record end or well dates. For dates of precautions used: There were no start and end dates and no spot to record them. For organism identified: It was not recorded for eleven of the thirteen entries. There were no symptoms listed (or NA) for seven of the thirteen entries. There were no test tracking, testing criteria, results, or test dates recorded and no spot to record them. The number of antibiotic-resistant organisms and the date reported to the QAA committee were blank. ~ February: There were eleven resident entries. For dates of infection: There were start dates but no end dates and no spot to record end or well dates. For dates of precautions used: There were no start or end dates and no spot to record them. There were no symptoms listed (or NA) for five of the eleven entries. There was no test tracking, testing criteria, results, or test dates and no spot to record them. The number of antibiotic-resistant organisms and the date reported to the QAA committee were blank. The number of resident days was not recorded and the infection incidence rate was blank. ~ March (through 3/12/25): There was one resident entry. For dates of infection: There were start dates but no end dates and no spot to record end or well dates. For dates of precautions used: There were no start or end dates and not spot to record them. For organism identified: There were no entries. There was no test tracking, testing criteria, results, or test dates and no spot on the form to record them. On 3/12/25 at 12:08 PM, Surveyor interviewed DON-B who indicated the line lists should have start and end dates. DON-B indicated it was not possible to know how long residents were on precautions with the information provided. DON-B indicated the IP should be tracking the information and indicated there was no way to effectively track the etiology of infections and infection rates due to the missing information. When asked about the number of resident days and infection incidence tracking, DON-B indicated the information should come from the IP because DON-B had not completed IP training. Surveyor again asked for staff lines lists. On 3/12/25 at 1:12 PM, Surveyor reviewed the staff line lists which were incomplete and missing data needed to document, track, and identify trends in infections, including outbreaks. Surveyor noted the following: ~ November 2024: There was no line list provided. ~ December 2024: There was no line list provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ January 2025: A resident tracking form contained seven entries with staff listed under the resident area. Dates of infection and start dates were listed, however, the form did not contain a spot for well or return to work dates. ~ February 2025: A blank resident tracking sheet was provided. There were no staff entries. ~ March 2025: A blank resident tracking sheet was provided. There were no staff entries. On 3/12/25 at 1:12 PM, Surveyor interviewed DON-B and VPS-D. VPS-D indicated the staff line lists were incomplete. DON-B verified the staff line lists for February and March 2025 were blank and indicated staff call-ins must have been related to car and child issues. 2. On 3/10/25 at 12:14 PM, Surveyor observed lunch and noted there were twelve residents in the main dining room. Staff in the dining room included an LPN, NHA-A, [NAME] (CK)-J, and Regional Manager (RM)-H. Surveyor observed dining service from start to finish and noted there was no hand hygiene offered to residents, including no verbal reminders prior to or after dining. Surveyor noted one dining room table contained a few individual hand sanitizing wipes with sugar packets on the table. On 3/10/25 at 12:32 PM, Surveyor interviewed R15 who indicated staff did not offer hand hygiene prior to the meal. On 3/11/25 at 8:04 AM, Surveyor observed breakfast and noted there were ten residents in the main dining room. Surveyor observed DON-B and CK-J in the dining room. Surveyor did not observe DON-B or CK-J offer hand hygiene to residents or hear DON-B or CK-J ask residents if they washed hands or needed assistance with hand hygiene. On 3/11/25 at 8:20 AM, Surveyor observed an eleventh resident enter the dining room. DON-B assisted the resident with beverages and set up but did not offer hand hygiene. On 3/11/25 at 8:27 AM, Surveyor interviewed R15 who indicated staff did not offer hand hygiene prior to the meal. R15 indicated there was a hand wipe in the sugar dish with packets of sugar. R15 indicated no one asked if R15 washed hands prior to the meal or if R15 needed assistance. On 3/11/25 at 8:32 AM, Surveyor interviewed R9 who indicated staff did not offer hand hygiene prior to the meal. R9 indicated there used to be hand wipes in the dining room. R9 indicated no one asked if R9 washed hands prior to the meal or if R9 needed assistance. On 3/11/25 at 8:33 AM, Surveyor interviewed R25 who indicated staff did not offer hand hygiene prior to the meal. R25 agreed with R9 that there used to be hand wipes on the table. R25 indicated no one asked if R25 had washed hands prior to the meal or if R25 needed assistance. 40342 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On 3/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including paraplegia, epilepsy, obsessive compulsive disorder, and excoriation disorder (also known as chronic skin-picking or dermatillomania; a mental illness related to obsessive-compulsive disorder characterized by repeated picking at one's own skin resulting in areas of swollen or broken skin). R1's Minimum Data Set (MDS) assessment, dated 12/17/24, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had a court-appointed Guardian. On 3/11/25 at 9:48 AM, Surveyor observed LPN-E provide wound care to R1 with the assistance of Certified Nursing Assistant (CNA)-F. During wound care, Surveyor observed LPN-E cleanse multiple open areas on R1's right lower leg and apply ointment and a clean dressing with gloved hands. LPN-E then removed gloves. Without completing hand hygiene, LPN-E opened a drawer in the treatment cart, obtained a dressing, and donned gloves. LPN-E opened the dressing, applied the dressing to an open area on R1's right lower leg, and dated the dressing with a pen that was on top of the treatment cart. LPN-E then removed gloves and completed hand hygiene. Surveyor also observed LPN-E cleanse and apply a clean dressing to an area on top of R1's left foot with gloved hands. LPN-E then opened a drawer in the treatment cart with the same gloved hands to obtain a dressing. LPN-E opened the dressing and applied the dressing to an area on top of R1's left foot. LPN-E then removed gloves, completed hand hygiene, and donned new gloves. Surveyor also observed LPN-E apply clean dressings to multiple open areas on R1's bilateral buttocks with gloved hands and put a clean incontinence brief on R1 with the assistance of CNA-F. LPN-E then removed gloves. Without completing hand hygiene, LPN-E donned new gloves and applied ointment and a dressing to an open area on R1's left forearm, LPN-E then removed gloves and completed hand hygiene. On 3/11/25 at 11:13 AM, Surveyor interviewed LPN-E who verified LPN-E missed hand hygiene opportunities during wound care. LPN-E verified staff should complete hand hygiene immediately following glove removal and should not touch objects without completing hand hygiene. On 3/12/25 at 9:07 AM, Surveyor interviewed DON-B who verified LPN-E missed hand hygiene opportunities during wound care. DON-B indicated staff should complete hand hygiene before and after dressing changes as well as before applying and after removing gloves.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff interview and record review, the facility did not ensure vaccinations were offered or administered for 5 residents (R) (R1, R5, R7, R19, and R21) of 5 sampled residents. The facility did not offer R1, R5, R7, R19, or R21 the PCV20(R) vaccine. Findings include: Abbreviations (www.cdc.gov): PCV13: 13-valent pneumococcal conjugate vaccine (Prevnar13(R)) PCV15: 15-valent pneumococcal conjugate vaccine (Vaxneuvance(R)) PCV20: 20-valent pneumococcal conjugate vaccine (Prevnar 20(R)) PPSV23: 23-valent pneumococcal polysaccharide vaccine (Pneumovax23(R)) The most recent Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccinations indicate: For adults [AGE] years or older who have only received PPSV23, the CDC recommends: Give 1 dose of PCV15 or PCV20. The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For those who have received PCV13 and 1 dose of PPSV23, the CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine. For adults [AGE] years or older who have received PCV13, give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. The facility's Pneumococcal Vaccine (series) policy, revised 9/18/24, indicates: It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations .1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. 3. Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization with the education documented in the clinical record .4. The resident/representative retains the right to refuse the immunization. Refusals should be documented in the medical record along with what education was provided and a risk versus benefit discussion . 1. On 3/12/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including paraplegia, epilepsy, and congestive heart failure. R1's Minimum Data Set (MDS) assessment, dated 12/17/24, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had a court-appointed Guardian. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's medical record indicated R1 did not receive the PCV13 vaccine. R1 received the PPSV23 vaccine on 4/11/2019. Based on the facility's policy and CDC recommendations, R1 was due to receive the PCV20 vaccine on or after 4/11/20 and should have been offered the vaccine. 2. On 3/12/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including dementia, acute respiratory failure with hypoxia and hypercapnia, and hemiplegia and hemiparesis following cerebral infarction. R5's MDS assessment, dated 12/28/24, indicated R5 was rarely/never understood. R5 had a Guardian. R5's medical record indicated R5 received the PCV13 vaccine on 12/19/16. R5's medical record did not indicate R5 received the PPSV23 vaccine. Based on the facility's policy and CDC recommendations, R5 was due to receive the PCV20 on or after 12/19/17 and should have been offered the vaccine. 3. On 3/12/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease, mild cognitive impairment, and obesity. R7's MDS assessment, dated 12/16/24, had a BIMS score of 15 out of 15 which indicated R7 had intact cognition. R7's medical record indicated R7 received the PCV13 vaccine on 3/15/16. R7's medical record did not indicate R7 received the PPSV23 vaccine. Based on the facility's policy and CDC recommendations, R7 was due to receive the PCV20 vaccine on or after 3/15/17 and should have been offered the vaccine. 4. On 3/12/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including mild cognitive impairment, history of cerebral infarction, and cluster headaches. R19's MDS assessment, dated 1/9/25, had a BIMS score of 15 out of 15 which indicated R19 had intact cognition. R19's medical record indicated R19 received the PCV13 vaccine on 11/15/22. R19's medical record did not indicate R19 received the PPSV23 vaccine. Based on the facility's policy and CDC recommendations, R19 was due to receive the PCV20 vaccine on or after 11/15/23 and should have been offered the vaccine. 5. On 3/12/25, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including necrotizing fasciitis, abdominal abscess, and chronic pain. R21's MDS assessment, dated 2/24/25, had a BIMS score of 14 out of 15 which indicated R21 had intact cognition. R21's medical record indicated R21 received the PPSV23 vaccine on 4/25/13 and the PCV13 vaccine on 7/6/15. Based on the facility's policy and CDC recommendations, R21 was due to receive the PCV20 vaccine on or after 7/6/20 and should have been offered the vaccine. On 3/12/25, Surveyor requested vaccination records including offer/declination paperwork for R1, R5, R7, R19, and R21. On 3/12/25 at 9:29 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did not have an Infection Preventionist (IP). DON-B indicated IP-K had stepped down the week prior to and DON-B had assumed some of the IP duties while the facility looked for a new IP. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 10:16 AM, Surveyor interviewed [NAME] President of Success (VPS)-D who indicated DON-B was new and misspoke. VPS-D confirmed IP-K was still the acting IP, however, IP-K was ill and not available during the survey. VPS-D indicated IP-K was transitioning to another position but agreed to stay on as IP for the facility. On 3/12/25 at 12:04 PM, Surveyor interviewed VPS-D regarding the facility's infection control program. VPS-D indicated in the absence of IP-K, Surveyor should direct infection control questions to DON-B. On 3/12/25 at 12:08 PM, Surveyor interviewed DON-B who indicated residents are offered vaccines per the facility's policy. DON-B indicated the facility offers the PCV 20 vaccine to residents. DON-B indicated records are kept of vaccines administered or declined. On 3/12/25 at 12:48 PM, Surveyor interviewed VPS-D who indicated staff should follow the facility's vaccination policies for administration and record keeping. On 3/12/25 at 1:12 PM, Surveyor reviewed resident vaccination tracking sheets provided for R1, R5, R7, R19, and R21. The tracking sheets did not indicate the PCV20 vaccine was offered to R1, R5, R7, R19, or R21. In addition, Surveyor was not provided with offer or declination paperwork for R1, R5, R7, R19, or R21.