STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525588	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Manor	4545 N 92nd St Milwaukee, WI 53225

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review the Facility did not report 2 (R5 and R77) of 3 allegations of abuse or neglect to the State Survey Agency during the required timeframe. A report of abuse or neglect was not reported to the Nursing Home Administrator (NHA)-A for 1 (R77) of 3 allegations during the required timeframe. * An accusation of abuse was made involving R77 which was not reported to the NHA-A during the required timeframe. * The Facility did not report a resident-to-resident altercation involving R77 to the State Survey Agency. * On 7/9/24, R5 returned to the facility from a hospitalization on [DATE] - 7/9/24. R5 was discovered to have a femur fracture and the facility did not conduct an investigation or report the injury of unknown origin to the State Agency. Findings include: The Facility Policy titled Alleged Incidents of Abuse, Neglect, Exploitation and Mistreatment-Reporting and Investigation revised 2/2020, documents: Purpose -Facility will prohibit and prevent abuse, neglect, exploitation, mistreatment, injuries of unknown sources and resident to resident altercations. -Facility is in compliance with the reporting and investigation guidelines specific to each program area governed by the Division of Quality Assurance (DQA)/Office of Caregiver Quality (OCQ) . -All alleged incidents of abuse, neglect, exploitation, and misappropriation must be reported and investigated in a timely manner per program code requirements . Special Key Points . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An initial review of the allegation prior to reporting to DQA/OCQ may be conducted to determine whether or not the incident needs to be reported to DQA/OCQ. All alleged violations involving mistreatment (including abuse, neglect, exploitation, injuries of unknown source, misappropriation of property, resident-to-resident abuse, and mistreatment by family members, visitors, volunteers or other individuals) must be reported to the Division of Quality Assurance (DQA)/Office of Caregiver Quality (OCQ) as soon as possible, but not to exceed 24 hours from the discovery . Guidelines 1. Protect the Resident a. The safety of the resident(s) is the first priority. The resident(s) must be protected from possible subsequent injury or incidents of misconduct. b. After ensuring the safety of the resident(s), all employees are to immediately report any alleged incidents of abuse, neglect and mistreatment to the Supervisor to ensure that appropriate notification and a timely investigation are initiated. c. The Supervisor immediately assesses the resident's personal safety and potential of harm to other residents. d. The Director of Nursing/Director of Resident and Patient Services and/or designee is to be contacted immediately for all allegations of caregiver misconduct or Resident-to-Resident abuse. The Administrator/CCO will be notified immediately . 1.) R77 was admitted to the facility on [DATE] with diagnoses that includes degenerative disease of nervous system, unspecified dementia with agitation and anxiety, generalized anxiety disorder, major depressive disorder and wandering. R77's Quarterly Minimum Data Set (MDS) dated of 6/19/24 documents a Brief Interview for Mental Status (BIMS) score of 00, indicating that R77 has severe cognitive impairment. R77's MDS documents no impairment to R77's upper and lower extremities. The MDS documents that R77 uses a walker for mobility and is incontinent of both bowel and bladder and that R77 has an elopement alarm. On 08/28/24 at 02:10 PM, Surveyor reviewed the Facility Reported Incident regarding an accusation of abuse that occurred on 8/14/24. Per a written statement from the Nursing Home Administrator (NHA)-A, the facility was aware of the event on 8/15/2024 around 10:30 AM. Surveyor noted that the NHA-A was not notified of the incident until 8/15/24, a day later. On 08/29/24 at 01:55 PM, Surveyor interviewed NHA-A and asked why the delay in reporting the incident to the NHA. NHA-A stated it was because the supervisor on duty at the time of the incident believed it was retaliation between two Certified Nursing Assistants who had a disagreement and the supervisor saw no signs of abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/3/24 at 3:23 PM, during the daily exit meeting, Surveyor informed NHA-A and the Director of Nursing (DON)-B know of the above concern related to this incident not being reported timely to the NHA. No additional information was provided. 2.) R77 was admitted to the facility on [DATE] with diagnoses which include degenerative disease of nervous system, unspecified dementia with agitation and anxiety, generalized anxiety disorder, major depressive disorder and wandering. R77's Quarterly Minimum Data Set (MDS) dated of 6/19/24 documents a Brief Interview for Mental Status (BIMS) score of 00, indicating that R77 has severe cognitive impairment. R77's MDS documents no impairment to R77's upper and lower extremities. The MDS documents that R77 uses a walker for mobility and is incontinent of both bowel and bladder and that R77 has an elopement alarm. R77's progress note dated 7/16/2024 at 21:26 (9:26 PM) documents, Behavior Note. Subjective: The CNA was attempting to take the resident into the room. He did not want to go in his room so he grabbed ahold of the railing to remain in the hallway by his door. Once she got him to let go then he saw another resident go by that tried to help him and then he bit his arm. Objective: The pt. did not appear to have any bleeding gums. The pt. once seen had stopped being aggressive to the other resident and the CNA. Assessment: The pt. was given his HS medications a little later then normal and because of it the other staff stated that they feel this is why he became aggressive. Plan: To redirect the pt. to return to room to deescalate the situation with less sensory stimulation. Assist the pt. to the chair or bed to help him calm down. To make sure he takes his night time medications and give any ativan and/or morphine if he is due. Intervention: The pt. was given Ativan per the nurse and his night time medications. The light was turned off in his room and only the lamp was left on. The door was closed to decrease the noise from the hall. Evaluation: The pt. appears to be calm lying on his right side in the bed. Staff will continue to talk in a calm manner and not disrupt his sleeping while in the bed. R77's progress note written on 7/17/2024 at 09:58 AM documents, IDT Note. Note Text: IDT reviewed resident to resident altercation on 07/16, further investigating root cause and circumstances surrounding the incident, if it meets guidelines to report to DHS, and subsequent interventions. Surveyor noted that the Department of Health Services Form, F-62617, was not submitted to the State Survey Agency regarding this resident-to-resident altercation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/03/24 at 01:54 PM, Surveyor interviewed Director of Nursing (DON)-B who stated that a certified nursing assistant was trying to get R77 into room, R77 was combative, and another resident tried to help to redirect R77. R77 then bit the other resident. The other resident stated no pain, and no mark was left. DON-B and the Nursing Home Administrator (NHA)-A looked at the Department of Health Services algorithm and determined that the incident did not need to be reported. On 9/3/24 at 3:23 PM, during the daily exit meeting, Surveyor asked the NHA-A and the DON-B if this incident had been reported. It was acknowledged that it was not. Surveyor let them know of the above findings. No additional information was provided. 48391 3.) R5 was admitted to the facility on [DATE] with a diagnosis that includes pressure ulcer of sacral region, end stage renal disease (ESRD), hypotension of hemodialysis, anemia, convulsions, vascular dementia, left femur fracture, rheumatoid arthritis and type 2 diabetes. R5's Significant Change MDS (Minimum Data Set) dated 5/24/24 documents that R5 is dependent with toileting, showering, dressing, and transferring. R5 was documented as having a BIMS (Brief Interview for Mental Status) score of 10, indicating R5 has moderate cognitive impairment. R5's care plan documents: ~ R5 has an Activities of Daily Living (ADL) self-care performance deficit related to weakness due to end stage renal disease, chronic pain, and dementia (date initiated 5/20/22, revised 12/29/23). Interventions include: 1. Turn and reposition every two hours and as needed while in bed (date initiated 5/20/22, revised 12/29/23). 2. R5 is dependent on one staff to provide weekly shower and as necessary (date initiated 1/8/24). 3. R5 is dependent on two staff for repositioning and turning in bed (date initiated 9/28/22, revised 1/8/24). 4. R5 is dependent on one staff for dressing (date initiated 1/8/24). 5. R5 requires weekly skin inspections on shower day. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse (date initiated 5/20/22, revised 9/28/22). 6. R5 is dependent on two staff for toilet use. R5 uses a bedside commode (date initiated 1/8/24). 7. R5 requires a Hoyer lift and assistance of two staff for transfers (date initiated 5/2022, revised 5/31/24). ~ R5 has episodes of forgetfulness and confusion related to dementia (date initiated 8/22/22). Interventions include: 1. Ask yes/no questions in order to determine R5's needs (date initiated 8/22/22). 2. Cue and supervise R5 as needed (date initiated 8/22/22). ~ R5 has bowel incontinence related to impaired mobility, requires assistance with transfers and toileting (date initiated 6/8/23, revised 3/3/24). Interventions include: 1. Check and change every 2-3 hours (date initiated 5/31/24). 2. Provide a bedpan as able or requested (date initiated 3/3/24, revised 5/31/24). 3. Provide pericare after each incontinent episode (date initiated 6/8/23, revised 3/3/24). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R5 has potential impairment to skin integrity related to mobility, incontinence, ESRD, and morbid obesity (date initiated 5/20/22, revised 4/8/24). Interventions include: 1. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short (date initiated 9/28/22). 2. Heel lift boots on when in bed (date initiated 9/28/22). 3. Identify and document potential causative factors and eliminate/resolve where possible (date initiated 9/28/22). 4. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc to provider (date initiated 9/28/22). 5. R5 Requires pressure reducing cushion to protect the skin while up in chair (date initiated 6/5/24). 6. R5 Requires pressure relieving/reducing mattress to protect the skin while in bed (date initiated 6/5/24). 7. Turn and reposition every two hours and as needed while in bed (date initiated 5/20/22). 8. Use a draw sheet or lifting device to move R5 (date initiated 9/28/22). 9. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface (date initiated 9/28/22). Surveyor reviewed R5's medical records which documents a hospitalization on [DATE] - 7/9/24. R5 was discharged to the facility on [DATE]. Hospital discharge documents dated 7/9/24, document a left distal femoral fracture. Hospital records indicate R5 had complaints of left knee pain and imaging was obtained. Imaging revealed a displaced impacted distal femoral periprosthetic fracture. Hospital records indicate R5 does not recall any falls or trauma. Palliative care was consulted, and no surgical intervention took place. R5 was discharged to the facility on [DATE] with no immediate surgical plan and instructions to be non-weight bearing (NWB). On 8/29/24 at 3:14 PM, Surveyor requested the facility self-report and investigation into R5's left distal femoral fracture from Nursing Home Administrator (NHA)- A. NHA- A indicated R5 did not fall at the facility and the facility Nurse Practitioner (NP) indicated R5 had an idiopathic fracture due to age. Surveyor requested any facility investigation documentation into R5's left distal femoral fracture and documentation of investigation being submitted to the State Agency. None was provided. On 9/3/24 at 3:21 PM, during daily exit meeting, Surveyor notified NHA- A and Director of Nursing (DON)- B of concerns with no investigation into R5's left distal femoral fracture and injury of unknown origin not being submitted to the State Agency. NHA- A indicated the facility did not investigate into R5's femoral fracture due to it not occurring within the facility. Surveyor expressed concerns of R5 obtaining an injury of unknown origin and the facility not reporting to the State Agency. NHA- A acknowledged the facility is required to report injuries of unknown origin to the State Agency and states the facility did not complete the investigation for R5's left distal femoral fracture or report to the State Agency. Surveyor requested additional information if available. No additional information was provided.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not ensure 2 (R5 and R77) of 3 residents reviewed had thorough investigations into allegations of abuse or injuries of unknown origin. * On 7/9/24, R5 returned to the facility from a hospitalization . R5 was discovered to have a femur fracture and the facility did not conduct an investigation into R5's femur fracture. * An accusation of abuse was made involving R77 which was not investigated thoroughly * A resident-to-resident altercation took place involving R77 which was not investigated thoroughly Findings include: The facility's Alleged Incidents of Abuse, Neglect, Exploitation and Mistreatment Reporting and Investigation policy dated August 1995, last revised on February 2020 documents: ~ The facility is in compliance with the reporting and investigation guidelines specific to each program area governed by the Division of Quality Assurance (DQS)/Office of Caregiver Quality (QOC). ~ All alleged incidents of abuse, neglect, exploitation, and misappropriation must be reported and investigated in a timely manner per program code requirements. 1.) R5 was admitted to the facility on [DATE] with a diagnoses that includes pressure ulcer of sacral region, end stage renal disease (ESRD), hypotension of hemodialysis, anemia, convulsions, vascular dementia, left femur fracture, rheumatoid arthritis, type 2 diabetes, spondylosis, and chronic pain syndrome. R5's Significant Change MDS (Minimum Data Set) completed on 5/24/24 documents that R5 is dependent with toileting, showering, dressing, and transferring. R5 was documented as having a BIMS (Brief Interview for Mental Status) score of 10, indicating R5 has moderate cognitive impairment. R5's care plan documents: ~ R5 has an Activities of Daily Living (ADL) self-care performance deficit related to weakness due to end stage renal disease, chronic pain, and dementia (date initiated 5/20/22, revised 12/29/23). Interventions include: 1. Turn and reposition every two hours and as needed while in bed (date initiated 5/20/22, revised 12/29/23). 2. R5 is dependent on one staff to provide weekly shower and as necessary (date initiated 1/8/24). 3. R5 is dependent on two staff for repositioning and turning in bed (date initiated 9/28/22, revised 1/8/24). 4. R5 is dependent on one staff for dressing (date initiated 1/8/24). 5. R5 requires weekly skin inspections on shower day. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse (date initiated 5/20/22, revised 9/28/22). 6. R5 is dependent on two staff for toilet use. R5 uses a bedside commode (date initiated 1/8/24). 7. R5 requires a Hoyer lift and assistance of two staff for transfers (date initiated 5/2022, revised 5/31/24). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R5 has episodes of forgetfulness and confusion related to dementia (date initiated 8/22/22). Interventions include: 1. Ask yes/no questions in order to determine R5's needs (date initiated 8/22/22). 2. Cue and supervise R5 as needed (date initiated 8/22/22). ~ R5 has bowel incontinence related to impaired mobility, requires assistance with transfers and toileting (date initiated 6/8/23, revised 3/3/24). Interventions include: 1. Check and change every 2-3 hours (date initiated 5/31/24). 2. Provide a bedpan as able or requested (date initiated 3/3/24, revised 5/31/24). 3. Provide pericare after each incontinent episode (date initiated 6/8/23, revised 3/3/24). ~ R5 has potential impairment to skin integrity related to mobility, incontinence, ESRD, and morbid obesity (date initiated 5/20/22, revised 4/8/24). Interventions include: 1. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short (date initiated 9/28/22). 2. Heel lift boots on when in bed (date initiated 9/28/22). 3. Identify and document potential causative factors and eliminate/resolve where possible (date initiated 9/28/22). 4. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc to provider (date initiated 9/28/22). 5. R5 Requires pressure reducing cushion to protect the skin while up in chair (date initiated 6/5/24). 6. R5 Requires pressure relieving/reducing mattress to protect the skin while in bed (date initiated 6/5/24). 7. Turn and reposition every two hours and as needed while in bed (date initiated 5/20/22). 8. Use a draw sheet or lifting device to move R5 (date initiated 9/28/22). 9. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface (date initiated 9/28/22). Surveyor reviewed R5's medical records which documents a hospitalization on [DATE] - 7/9/24. R5 was discharged to the facility on [DATE]. Hospital discharge documents dated 7/9/24, document a left distal femoral fracture. Hospital records indicate R5 had complaints of left knee pain and imaging was obtained. Imaging revealed a displaced impacted distal femoral periprosthetic fracture. Hospital records indicate R5 does not recall any falls or trauma. Palliative care was consulted, and no surgical intervention took place. R5 was discharged to the facility on [DATE] with no immediate surgical plan and instructions to be non-weight bearing (NWB). On 8/29/24 at 3:14 PM, Surveyor requested the facility self-report and investigation into R5's left distal femoral fracture from Nursing Home Administrator (NHA)- A. NHA- A indicated R5 did not fall at the facility and the facility Nurse Practitioner (NP) indicated R5 had an idiopathic fracture due to age. Surveyor requested any facility investigation documentation into R5's left distal femoral fracture. On 9/3/24 at 3:21 PM, during daily exit meeting, Surveyor notified NHA- A and Director of Nursing (DON)- B of concerns with no investigation into R5's left distal femoral fracture. NHA- A indicated the facility did not investigate into R5's femoral fracture due to it not occurring within the facility. Surveyor expressed concerns of R5 obtaining an injury of unknown origin and the facility not completing an investigation. NHA- A acknowledged that the facility is required to investigate injuries of unknown origins and states the facility did not complete the investigation for R5's left distal femoral fracture. Surveyor requested additional information if available. No additional information was provided. 49011 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R77 was admitted to the facility on [DATE] with diagnoses which include degenerative disease of nervous system, unspecified dementia with agitation and anxiety, generalized anxiety disorder, major depressive disorder and wandering. R77's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/19/24 documents a Brief Interview for Mental Status score of 00, indicating that R77 has severe cognitive impairment. The MDS documents no impairment to R77's upper and lower extremities. R77 uses a walker for mobility and is incontinent of both bowel and bladder. R77 has a wander elopement alarm. On 08/28/24 at 02:10 PM, Surveyor reviewed the Facility Reported Incident regarding an accusation of abuse that happened on 8/14/24. Per a written statement from the Nursing Home Administrator (NHA)-A they were informed of the event on 8/15/2024 around 10:30 am. At that time the NHA-A interviewed the Certified Nursing Assistant accused of hitting R77 and afterwards ended their shift. NHA-A then interviewed the supervisor on duty when the incident occurred. The supervisor stated that a quick investigation was done, and it was determined the allegation was not true and was made a couple hours after the accused Certified Nursing Assistant was reprimanded for not helping with cares. Surveyor notes there was a significant delay in the prevention of further abuse by allowing the Certified Nursing Assistant to remain in contact with residents for the remainder of the shift the allegation occurred and the start of a new shift the next day. On 08/29/24 at 01:55 PM, Surveyor interviewed the NHA-A and asked about education for staff after the incident. The NHA-A stated that one on one education to that supervisor regarding the abuse policy was completed, none to other staff. Surveyor asked if interviews with other residents were completed and was told the NHA-A would look for that information. The next day a sheet of paper was provided to the Surveyor labeled with R77's name. The next line states Resident Interview:, after which 3 residents names are typed each with a statement about not hearing anything and feeling safe/no concerns. Surveyor notes there are no dates, times or resident signatures provided on the paper. On 9/3/24 at 3:23 PM, during the daily exit meeting, Surveyor let the NHA-A and the Director of Nursing-B know of the concern related to this incident not being investigated thoroughly. No additional information was provided. 3.) R77 was admitted to the facility on [DATE] with diagnoses which include degenerative disease of nervous system, unspecified dementia with agitation and anxiety, generalized anxiety disorder, major depressive disorder and wandering. R77's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/19/24 documents a Brief Interview for Mental Status score of 00, indicating that R77 has severe cognitive impairment. The MDS documents no impairment to R77's upper and lower extremities. R77 uses a walker for mobility and is incontinent of both bowel and bladder. R77 has a wander elopement alarm. Surveyor was reviewing R77's Electronic Medical Record and discovered a progress note dated 7/16/2024, written at 21:26 (9:26 PM). Behavior Note. Subjective: The CNA was attempting to take the resident into the room. He did not want to go in his room so he grabbed ahold of the railing to remain in the hallway by his door. Once she got him to let go then he saw another resident go by that tried to help him and then he bit his arm. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Objective: The pt. did not appear to have any bleeding gums. The pt. once seen had stopped being aggressive to the other resident and the CNA. Assessment: The pt. was given his HS medications a little later then normal and because of it the other staff stated that they feel this is why he became aggressive. Plan: To redirect the pt. to return to room to deescalate the situation with less sensory stimulation. Assist the pt. to the chair or bed to help him calm down. To make sure he takes his night time medications and give any ativan and/or morphine if he is due. Intervention: The pt. was given Ativan per the nurse and his night time medications. The light was turned off in his room and only the lamp was left on. The door was closed to decrease the noise from the hall. Evaluation: The pt. appears to be calm lying on his right side in the bed. Staff will continue to talk in a calm manner and not disrupt his sleeping while in the bed. A second progress note was written on 7/17/2024, at 09:58 AM. IDT Note. Note Text: IDT reviewed resident to resident altercation on 07/16, further investigating root cause and circumstances surrounding the incident, if it meets guidelines to report to DHS, and subsequent interventions. Surveyor noted that the Department of Health Services Form, F-62617, was not submitted to the State Survey Agency regarding this resident-to-resident altercation. On 9/3/24 at 3:23 PM, during the daily exit meeting, Surveyor asked the NHA-A and the Director of Nursing-B if this incident had been reported. It was acknowledged that it was not. Surveyor requested any investigation records that were compiled as this is a concern. No additional information was provided.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not ensure 3 (R5, R34, and R32) of 3 residents reviewed that required hospitalization s were given written reason for transfer to the hospital and the facility did not send this notification to the Ombudsman. R5 was transferred to the hospital on 8/23/24, 8/12/24, 7/3/24, 5/24/24, and 5/15/24 for changes in condition. R5 or their representative did not receive written notification of transfer to the hospital and the State Ombudsman was not sent a copy of this notice. R34 was transferred to the hospital on 4/6/24 while residing in the facility and evidence was not provided R34 or their representative were given the required transfer notice information including appeal rights. On 8/12/24, R32 had a change in condition and was sent to the hospital. R32 was admitted to the hospital and a bed hold notice was given. R32 did not receive a transfer notice for the hospitalization on [DATE]. Findings include: The facility's policy Transfer and discharge date d 10/2021 documents: the facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: ~ The specific reason and basis for transfer or discharge. ~ The effective date of transfer or discharge. ~ The specific location (such as the name of the new provider or description and/or address if the location is a resident) to which the resident is to be transferred or discharged . ~ An explanation of the right to appeal the transfer or discharge to the State. ~ The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. ~ Information on how to obtain an appeal form. ~ Information on obtaining assistance in completing and submitting the appeal hearing request. ~ The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. (continued on next page)

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	525588	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Manor	4545 N 92nd St Milwaukee, WI 53225

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and email addresses and phone number of the state agency responsible for the protection and advocacy of these populations. 1.) R5's medical record documents that R5 was transferred to the hospital on 8/23/24, 8/12/24, 7/3/24, 5/24/24, and 5/15/24 due to changes in condition. Surveyor was unable to locate any transfer notices for the above transfers in R5's medical record. On 9/3/24 at 11:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)- A and asked who is responsible for providing written documentation of transfer to the hospital for R5 or R5's representative. NHA-A informed Surveyor that the facility nursing staff are responsible for providing this documentation and stated that nursing staff have not been completing the written documentation of transfer to the hospital. Surveyor notified NHA-A of concerns with R5 not having written documentation of transfer to the hospital for R5's hospitalization s on 8/23/24, 8/12/24, 7/3/24, 5/24/24, and 5/15/24. NHA-A indicated that there are no written documentation of transfers to the hospital for R5 due to the facility not completing them. Surveyor requested additional information if available. No additional information was provided. 49011 2.) R34 was admitted to the facility on [DATE]. R34's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/6/2024 indicated R34 had a Brief Interview for Mental Status score of 15 (cognitively intact). R34 has an activated power of attorney. On 08/29/24 at 01:43 PM, Surveyor reviewed R34's electronic medical record which documented that R34 was transferred to the hospital on 4/26/2024 and admitted for sepsis and transverse colitis. R34 later returned to the same room in the facility on 4/30/2024. Surveyor requested evidence from the facility that a transfer notice was provided to R34 and or R34's responsible party when R34 was hospitalized on [DATE]. On 9/3/2024 at 8:04 am, Surveyor reviewed a note from the Nursing Home Administrator (NHA)-A stating that R34 was not given a transfer form when sent to the hospital on 4/26/2024. On 09/03/24 at 11:25 AM, Surveyor interviewed NHA-A about the transfer notice and was told the Facility has no transfer notices as nurses are to do them and have not been providing them to residents upon transfer to the hospital. On 9/3/24 at 3:22 PM, during the daily exit meeting, Surveyor let the NHA-A and the Director of Nursing-B know of the concerns related to no transfer notices being provided to R34 or R34's responsible party. No additional information was provided. 20025 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) R32 was transferred to the hospital on 8/12/24 after experiencing a change in condition. R32's nursing note dated 8/12/24 documents that R32 had a change in condition that required to R32 to be transported to the hospital. The medical record indicates R32 was admitted to the hospital and a bed hold notice was provided to R32. Surveyor could not locate any documentation that a transfer notice was given to R32 or R32's representative after R32 was transferred to the hospital on 8/12/24. On 9/3/24 at 11:25 a.m., Surveyor interviewed NHA-A regarding R32's transfer notice on 8/12/24. NHA-A stated nurses are responsible for the transfer notice and that it has not been completed for R32 on 8/12/24. No additional information was provided as to why R5, R34, and R32 of were not given written reason for transfer to the hospital and why the facility did not send this notification to the Ombudsman.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review, the facility did not ensure the Minimum Data Set (MDS) accurately reflected the resident's status at the time of the assessment for 1 (R77) of 24 residents reviewed. R77's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/19/24, did not accurately reflect R77's occurrence of behaviors. Findings include: The Facility Policy titled MDS 3.0 Completion implemented 10/21, documents (in part): Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan . Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 4. Care Plan Team Responsibility for Assessment Completion: . ii. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections . b. Coding of Assessment: . i. All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment . d. Care Area Assessment (CAA's): . iii. Based on the CAA review, key findings regarding a resident's status are documented, including the nature of the condition, complications and risk factors that affect the care planning decision . 1.) R77 was admitted to the facility on [DATE] with diagnoses which include degenerative disease of nervous system, unspecified dementia with agitation and anxiety, generalized anxiety disorder, major depressive disorder and wandering. R77's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/19/24 documents a Brief Interview for Mental Status score of 00, indicating that R77 has severe cognitive impairment. The quarterly MDS documents that R77's upper and lower extremities have no impairment. R77 uses a walker for mobility and is incontinent of both bowel and bladder. R77 also has a wander elopement alarm. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/03/24, at 11:12 AM, Surveyor conducted a further review of the Quarterly MDS with an assessment reference date of 6/19/24 and noted the behaviors listed below were all coded in section E as Behavior not exhibited by R77: Physical behavioral symptoms directed towards others Other behavioral symptoms not directed towards others Did the resident reject evaluation or care Has the resident wandered? A review of progress notes during the look back period indicated that these behaviors did occur: *6/18/2024, at 23:04, Activity Note Note Text: Some BX's (behaviors) noted near end of shift. PRN given; effect *6/18/2024, at 04:50, Daily Skilled Note Note Text: Behavior update: CNA T.L. completed adl rounds on the resident. Resident did not want to stay in bed. Resident up wandering on the unit. Attempting to go into 2801 room several times. He removed the Stop velcro sign. When placed back up resident attempted to go under the sign. Resident challenging to be redirected. Reproach with another staff. Resident was non compliant with the redirection. No agitation, but some resistiveness noted. Noc supervisor on the unit to assist. Resident given fluids but does not want to leave from the hallway between his room and 2801. CNA S.O. and Supervisor able to direct resident into his room and placed back in his bed. No PRN was given. No further attempts to get up and out of bed. *6/16/2024, at 21:48, Nurse to Nurse Report Note Text: PT (patient) was given a PRN he was wondering around unit going through things and going into others room PT was trying to push other residents around no aggressive behaviors. *6/15/2024, at 22:05, Nurse to Nurse Report Note Text: No behaviors noted on first shift. after dinner PT was wondered unit. Pt was a little agitated PT was give PRN lorazepam. lorazepam was effective. *6/15/2024, at 02:10, Daily Skilled Note Note Text: Bx: Resident restless and agitated in his room. He was incontinent of stool and urine. Tensed and stiffened body when attempting to guide him into the toilet to be cleaned up. Resident snatch back his hand. Re approach effective. Resident was pacing and wandering. PRN MSIR and ativan given at 2330 with effectiveness noted during follow up. *6/13/2024, at 19:11, Orders - Administration Note (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note Text: Lorazepam Tablet 0.5 MG .increased anxiety *6/12/2024, at 22:14, Daily Skilled Note Note Text: PRN administered for increased agitation and wandering episodes, Medication was effective. No instances of striking out. Medication taken without issue . *6/12/2024, at 21:56, Orders - Administration Note Note Text: Weekly skin and shower check performed .Not completed due to increased behaviors *6/12/2024, at 19:26, Orders - Administration Note Note Text: Lorazepam Tablet 0.5 MG .given for increased agitation Surveyor noted that the above progress notes document behaviors that occurred and were treated with PRN medication as necessary during this period. On 09/04/24 at 08:45 AM, Surveyor interviewed MDS Coordinator-I regarding R77's quarterly MDS. MDS Coordinator-I informed Surveyor that she did not complete R77's quarterly MDS. For the behaviors section Surveyor was directed to talk to the social worker. MDS Coordinator-I stated that to complete section E, the individual should look at the progress notes and assessments located in the electronic medical records. On 09/04/24 at 08:56 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and was told that the social worker was not working and so Surveyor was unable to interview them. Surveyor asked NHA-A about the discrepancies found in section E of R77's MDS. NHA-A informed Surveyor that she doesn't know why the social worker didn't answer correctly, other than the social worker did not complete it correctly. NHA-A stated the need to do some training about MDS completion. Surveyor conveyed to the NHA-A that this is a concern. No additional information was provided as to why the facility did not ensure the Minimum Data Set (MDS) accurately reflected R77's behaviors.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview, and record review, the Facility did not develop and implement a comprehensive person-centered care plan for 5 (R34, R49, R59, R64 and R72) of 24 residents to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment. * R34 was assessed to be an independent smoker and did not have a care plan in place with relevant interventions. * R64 has chronic nose bleeds and is a diabetic, there was no care plan created for either condition with interventions for managing the conditions. * R72 does not have a comprehensive person-centered care plan for the use of an antipsychotic and antianxiety medication. * R59 does not have a comprehensive person-centered care plan for specialized communication needs. * R49 does not have a comprehensive person-centered care plan for the use of an anticoagulant medication or the use of a condom catheter. Findings include: The Facility Policy titled Comprehensive Care Plans revised 9/23, documents: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . Policy Explanation and Compliance Guidelines: . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed . 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. The Facility Policy titled Care Plan Revisions Upon Status Change revised 9/23, documents: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: . f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change of status, at the time the change of status is identified, to ensure care plans have been updated to reflect current resident needs . 1.) R34 was admitted to the facility on [DATE] with diagnoses that includes Parkinson's disease without dyskinesia, dementia, anxiety disorder, depression, chronic obstructive pulmonary disease and personal history of nicotine dependence. R34's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/6/2024 documents a Brief Interview for Mental Status score of 15, indicating that R34 is cognitively intact. The MDS documents impairment to one side of the upper extremity and on one side and lower extremities have no impairment. R34 uses a walker or wheelchair for mobility and has an indwelling catheter. On 08/29/24 at 01:17 PM, Surveyor reviewed R34's medical record due to being identified as a smoking resident at the Facility. On 7/11/24 a smoking assessment was completed by the Facility. The smoking status was identified as Resident uses tobacco products. Resident follows the facility's policy on location and time of smoking. Surveyor reviewed R34's care plan and noted there was no person-centered comprehensive care plan to indicate smoking safety needs and interventions. On 09/03/24 at 10:29 AM, Surveyor interviewed Licensed Practical Nurse Unit Manager (UM)-J about having a care plan related to smoking and UM-J stated that she would review R34's medical record and get back to Surveyor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24 at 01:54 PM, Surveyor interviewed the Director of Nursing (DON)-B and asked about care planning for residents who smoke and was told that smoking should be care planned. On 9/03/24 at 3:23 PM, during the daily exit meeting, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to R34 not having a smoking care plan being in place. No additional information was provided. 2.) R64 was admitted to the facility on [DATE] with diagnoses that includes diabetes mellitus type 2. R64's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/25/2024 documents a Brief Interview for Mental Status score of 10, indicating that R64 is moderately cognitive impaired. R64's MDS documents that R64's upper and lower extremities have no impairment. R64 uses a walker for mobility and is always continent of bowel and bladder. NOSE BLEEDS On 08/28/24 at 09:12 AM, Surveyor reviewed R64's electronic medical record (EMR) progress notes. Three progress notes referred to R64 having nose bleeds and interventions being available. On 5/12/2024, at 11:51 PM, a change in condition progress note documents: Resident has nose bleeding can be prevented, resident is non-compliant refused Supervisor and writer to apply nose clip. On 5/12/2024, at 11:00 PM, a transfer to hospital summary progress note documents: Resident has Hx of Nose bleeding. Bell ambulance here to transport resident to St [NAME] Hosp. for Evaluation. Resident is self . On 5/12/2024, at 10:11 PM, a transfer to hospital summary progress note documents: Unit nurse informed writer that resident is experiencing a noise bleed. Writer attempted interventions to stop bleeding. Resident refused all interventions. Resident is insisting to go out to St. [NAME]'s. Bell Ambulance phoned for transport. NPP (Nurse Practitioner) made aware. While reviewing the EMR an order was found from 4/18/24: Afrin Nasal Spray Nasal Solution 1 application in both nostrils as needed for Nosebleed. If patient has nosebleeds apply Afrin to Cotton ball insert into nares and apply pressure. In review of R64's comprehensive care plan, Surveyor was not able to locate a care plan with interventions to address R64's nose bleeds or interventions to use in the event of a nosebleed. On 09/03/24 at 10:27 AM, Surveyor interviewed Licensed Practical Nurse Unit Manager (UM)-J about having a care plan related to nose bleeds. UM-J stated that she would reviewe if having an order for the Afrin is sufficient or if it should be care planned. On 09/03/24 at 01:54 PM, Surveyor interviewed the Director of Nursing (DON)-B and asked about care planning for residents who have chronic nose bleeds and was told that the chronic nosebleeds should be care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/03/24 at 3:23 PM, during the daily exit meeting, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to no nosebleed care plan in place. No additional information was provided. DIABETES MANAGEMENT Surveyor reviewed R64's medication orders in the electronic medical record and noted R64 was prescribed Lantus SoloStar Subcutaneous Solution Pen. (Start: 4/21/2024) R64 has a diagnosis of Diabetes. On 08/28/24 at 09:36 AM, Surveyor reviewed the EMR and could not locate a care plan with interventions in place for diabetes and monitoring. On 09/03/24 at 10:27 AM, Surveyor interviewed Licensed Practical Nurse Unit Manager (UM)-J about having a care plan related to diabetes for R64. UM-J reviewed R64's medical record and stated that UM-K did not see one, but would check with DON (Director of Nursing)-B. On 09/03/24 at 01:54 PM, Surveyor interviewed the Director of Nursing (DON)-B and asked about care planning for residents with diabetes and was told that diabetes management should be care planned. On 09/03/24 at 3:23 PM, during the daily exit conference, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to no diabetes care plan in place. No additional information was provided. 3.) R72 was admitted to the facility on [DATE] with diagnoses which include degenerative disease of nervous system, adult failure to thrive and vascular dementia with agitation and psychotic disturbance. R72's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/5/2024 indicated R72 did not have a Brief Interview for Mental Status done due to resident rarely/never being understood. R72's MDS documents that R72's upper and lower extremities have no impairment. R64 uses a walker for mobility and is always incontinent of bowel and bladder. ANTIPSYCHOTIC R72's medical record was reviewed for unnecessary medications. R72 is taking Olanzapine 2.5 mg at bedtime (antipsychotic) for restlessness. Surveyor was unable to locate a care plan for R72's antipsychotic medication to address individualized targeted behaviors for continued use of an antipsychotic medication and non-pharmacological interventions. On 09/03/24 at 10:28 AM, Surveyor interviewed Licensed Practical Nurse Unit Manager (UM)-J about having a care plan related to antipsychotic medication. UM-J informed Surveyor that she would review R72's medical record and would inform Surveyor of any findings. On 09/03/24 at 01:54 PM, Surveyor interviewed the Director of Nursing (DON)-B and asked about care planning for residents with antipsychotic medication and was told that the use of antipsychotic medication use should be care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/3/24 at 3:23 PM, during the daily exit conference, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to no antipsychotic medication care plan in place. No additional information was provided. ANTIANXIETY R72's medical record was reviewed for unnecessary medications. R72 is taking the antianxiety medication lorazepam on an as needed basis. R72's care plan does not address the use of the antianxiety medication, side effects to monitor for, or non-pharmacological interventions used to assist with alleviating feelings of anxiety. On 09/03/24 at 10:28 AM, Surveyor interviewed Licensed Practical Nurse Unit Manager (UM)-J about having a care plan related to antianxiety medication. UM-J informed Surveyor that she would review R72's medical record and let Surveyor know of any findings. On 09/03/24 at 01:54 PM, Surveyor interviewed the Director of Nursing (DON)-B and asked about care planning for residents with antianxiety medication and was told that the use of antipsychotic medication use should be care planned. On 09/3/24 at 3:23 PM, during the daily exit meeting, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to no antianxiety medication care plan in place. No additional information was provided. 48391 4.) R59 was admitted to the facility on [DATE] with a diagnoses that includes chronic kidney disease, anemia, osteoarthritis, and constipation. R59's Quarterly MDS (Minimum Data Set) dated 8/19/24, documents that R59 has short and long-term memory problems, impairments to both upper extremities, and is dependent with toileting, dressing, and transferring. R59 was documented as not having a BIMS (Brief Interview for Mental Status) evaluation due to R59 is rarely/never understood. R59's care plan, dated 12/15/23, documents: ~ R59 has an Activities of Daily Living (ADL) self-care performance deficit related to impaired mobility and osteoarthritis (date initiated 12/15/23, revised on 8/23/24). Interventions include: 1. Provide appropriate level of assistance for ADL care needs to R59 (date initiated 12/15/23). 2. R59 requires a set up for eating (date initiated 5/22/24). 3. R59 requires max assistance with upper body dressing and is dependent with lower body dressing (date initiated 5/22/24). 4. R59 requires total assistance with bed mobility and bathing (date initiated 5/22/24). 5. Encourage R59 to use bell to call for assistance (date initiated 12/15/23). ~ R59 has limited physical mobility related to osteoarthritis (date initiated 12/15/23, revised on 8/23/24). Interventions include: 1. Provide appropriate level of assistance for ADL care needs (date initiated 12/15/23). 2. R59 is weight-bearing (date initiated 12/15/23). 3. R59 requires assistance by 1 staff member for locomotion using wheelchair (date initiated 8/7/24). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ R59 has episodes of forgetfulness and confusion related to difficulty making decisions (date initiated 4/25/24). Interventions include: 1. Ask yes/no questions to determine R59's needs (date initiated 4/25/24). On 8/28/24 at 9:01 AM, Surveyor interviewed R59. Surveyor notes R59 has a left-hand contracture with her left fingertips contracted and touching into her palm. R59 is dressed in her personal clothes and is up in her wheelchair with her side table in front of her, eating breakfast. Surveyor notes a pad of paper and pen on the side table within reach of R59. Surveyor asked how breakfast was, and R59 gave Surveyor a thumbs up. R59 was pointing to her feet and Surveyor noted heel boots on both feet while up in her wheelchair and R59's right foot was off the wheelchair foot pedal. Surveyor asked if she needed help and R59 continued to point at her feet and gave a slight moan. Surveyor notified R59 that staff will be requested to come in her room for assistance and Surveyor immediately notified a staff member. On 8/28/24 at 3:17 PM, Surveyor interviewed R59 who was up in her wheelchair and appeared comfortable. Surveyor asked R59 how she was feeling and R59 gave a thumbs up to Surveyor. R59 did not offer any additional information or hand gestures during interview. On 9/3/24 at 1:33 PM, Surveyor interviewed R59 who was up in her wheelchair in her room. Surveyor asked how she was doing and R59 consistently put her right hand up to her mouth as if she needed something but was unable to communicate her needs. Surveyor noted a pad of paper and a pen on the sink counter which was out of reach from R59. Surveyor was unable to communicate with R59 and unable to understand what her needs were through hand gestures. On 9/3/24 at 1:34 PM, Surveyor interviewed Certified Nursing Assistant (CNA)- G who indicated that R59 communicates by using a pen and paper and writing down her needs. CNA-G indicated R59 will also point at things for communication but pen and paper works best for communication. CNA-G reported R59 has good handwriting and R59's handwriting is legible for proper communication. Surveyor reviewed R59's medical record which included a Care Conference dated 6/12/24. Surveyor noted that R59 was present for the care conference on 6/12/24 and was communicating with facility staff via pen and paper and writing down her needs. On 9/3/24 at 3:21 PM, during the daily exit meeting, Surveyor notified Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B of concerns with R59 having communication deficits that are not indicated on her Care Plan. Surveyor notified NHA-A and DON-B that Surveyor was unable to locate a comprehensive communication care plan for R59. Surveyor requested additional information if available. No additional information was provided. 50775 5.) R49 was admitted to the facility on [DATE] with diagnosis of hypertensive heart disease with heart failure, unspecified arterial fibrillation. R49's Minimum Data Set (MDS) dated [DATE] documents R49 receives an anticoagulant. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49 Physicians orders dated 1/6/23 documents: Apixaban Oral Tablet 5 MG (Milligrams). Give 1 tablet by mouth two times a day for A-Fib. (Atrial Fibrillation). Anticoagulant medication-monitor for discolored urine, black tarry stools, sudden severe headache, N&V (Nausea/Vomiting), diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or V/S (Vital Signs), SOB (Shortness of breath), nose bleeds. R49's care plan dated 8/23/23 does not include the anticoagulant. Surveyor noted R49's care plan did not address the need for an anticoagulant medication, or the monitoring and care associated with anticoagulant use. On 8/29/24 at 10:41 AM, Surveyor interviewed Registered Nurse Unit Manager (RN UM)-E. Surveyor asked RN UM-E how a resident's admission assessment was completed. RN UM-E stated admission assessments were completed by the Unit Nurse when a Resident first arrives at the facility. When the assessment is completed by the Unit Nurse, it is then reviewed by the Nursing Manager. Surveyor questioned RN UM-E about R49's ordered anticoagulant and if the anticoagulant use should be addressed the care plan. RN UM-E stated she did not see the anticoagulant use documented in the care plan. On 9/4/2024, at the daily exit conference, the NHA-A and DON-B were informed of no care plan for R49's anticoagulant. No additional information was provided as to why the facility did not have an anticoagulant care plan in for R49. CONDOM CATHETER USE R49 was originally admitted to the facility on [DATE] with diagnosis of hypertensive heart disease with heart failure, unspecified arterial fibrillation. R49's Quarterly review Minimum Data Set (MDS) dated [DATE] documents an external (condom) catheter, R49 is always incontinent, not on a toileting program, and R49 is dependent for all toileting needs. On 8/28/24 at 1:30 PM, Surveyor requested R49's care plan from Director of Nursing (DON)-B. Surveyor received R49's care plan dated 08/23/24. Surveyor noted R49's care plan did not include the R49's use of a condom catheter or the care and treatment of the condom catheter. On 8/29/24 at 10:41 AM, Surveyor interviewed Registered Nurse (RN) Unit Manager (UM)-E (RN UM-E) regarding R49's condom catheter. Surveyor asked RN-UM-H how it was determined R49 required the use of a condom catheter. RN UM-E stated it was a preference of the R49 and R49's Power of Attorney (POA). RN UM-E was unable to locate any documentation for such request. RN UM-E stated she didn't understand why the condom catheter was not on R49's care plan. On 9/4/2024, at the daily exit conference, Surveyor informed NHA-A and DON-B of the above findings. No additional information was provided as to why the facility did not have a comprehensive care plan for the use of a condom catheter for R49.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview, and record review the Facility did not update the comprehensive person-centered care plan for 3 (R29, R49, and R64) of 24 residents to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment. * R64's care plan was not updated when foley catheter was removed. * R49's care plan was not updated to address condom catheter use. * R29's care plan was not updated for compression sleeve use. Findings include: The Facility Policy titled Comprehensive Care Plans revised 9/23, documents: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . Policy Explanation and Compliance Guidelines: . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed . 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. The Facility Policy titled Care Plan Revisions Upon Status Change revised 9/23, documents: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. Procedure for reviewing and revising the care plan when a resident experiences a status change: . f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change of status, at the time the change of status is identified, to ensure care plans have been updated to reflect current resident needs . 1.) R64 was admitted to the facility on [DATE] with diagnoses that includes type 2 diabetes mellitus. R64's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/25/2024 documents a Brief Interview for Mental Status score of 10, indicating that R64 has moderate cognitive impairment. The MDS no impairment to the upper and lower extremities for R64. R64 uses a walker for mobility. R64 does not have a catheter and is always continent of bowel and bladder. R64 has a care plan diagnosis of Enhanced Barrier Precautions (EBP) for high contact resident care activities r/t (related to) Indwelling Foley catheter. At high risk for multidrug-resistant organisms (MDRO) transmission. Date Initiated: 07/11/2024 Revision on: 07/11/2024 Interventions: o Dedicate daily care equipment as much as possible. Clean & disinfect nondedicated equipment after use, before using on another resident & before removal from the resident's room. Date Initiated: 07/11/2024 o EBP for high contact resident care activities. Perform hand hygiene & apply personal protective equipment (PPE) gloves, gown and/or goggle/face shield worn if risk of splash/spray. Remove PPE & perform hand hygiene prior to exiting room. Date Initiated: 07/11/2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o EBP will remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical devices. Date Initiated: 07/11/2024 o Educate resident's family members and visitors on helping resident understand the importance of personal hygiene and enhanced barrier/standard precautions. Date Initiated: 07/11/2024 Surveyor noted that as of the 7/25/2024 MDS R64 had no foley catheter. Surveyor notes several observations of R64 on the unit with no foley catheter in place. On 09/03/24 at 10:27 AM, Surveyor interviewed Licensed Practical Nurse Unit Manager (UM)-J about R64 having a foley catheter and was told R64 does not have one. UM-J stated the care plan must not have been updated after the removal of the foley catheter. On 09/03/24 at 01:54 PM, Surveyor interviewed the Director of Nursing (DON)-B and asked about the care plan for R64 documenting a foley catheter being in place. DON-B responded that it needs to be cleaned up and updated. On 09/3/24 at 3:23 PM, during the daily exit meeting, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to a foley catheter in R64's care plan not being updated. No additional information was provided. 48391 2.) R29 was admitted to the facility on [DATE] with a diagnosis that includes hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cognitive impairment, gout, osteoarthritis, and macular degeneration. R29's Quarterly MDS (Minimum Data Set) dated on 5/23/24 documents that R29 has impairment of one side for both her upper and lower extremities, is dependent for toileting, dressing and transferring, and requires substantial/maximal assistance with bathing. R29 was documented as having a BIMS (Brief Interview for Mental Status) score of 12, indicating that R29 has moderate cognitive impairment. R29's care plan documents: ~ R29 has a self-care performance deficit related to stroke with left sided paralysis (date initiated 2/14/23, revised on 11/26/23). Interventions include: 1. R29 requires max/total assistance with bathing (date initiated 6/4/24). 2. R29 requires total assistance of 2 staff to turn and reposition in bed as necessary (date initiated 2/14/23, revised 6/19/23). 3. R29 requires a mechanical lift with 2 staff assistance for transfers (date initiated 2/14/23, revised 6/8/23). 4. R29 requires total assist with 2 staff with personal hygiene and 1 staff with oral care (date initiated 2/14/23, revised on 6/19/23). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R29's orders which include: Tenashape compression sleeve to be applied to left arm in the AM and take off at bedtime every day. And evening shift for edema to left upper extremity applied in the AM and remove at bedtime. R29's Tenashape compression sleeve was ordered on 6/18/24. Surveyor noted R29's care plan was not updated after her Tenashape compression sleeve was ordered on 6/18/24. On 9/3/24, at 11:52 AM, Surveyor interviewed Nursing Home Administrator (NHA)- A. Surveyor asked NHA-A who is responsible for making changes to the care plan if a compression sleeve is ordered. NHA- A indicated that the unit managers are responsible for making changes to the resident's care plan with any new therapies, including a compression sleeve. Surveyor notified NHA-A of concerns with R29 having a Tenashape compression sleeve ordered on 6/18/24 and how R29's care plan was not updated. Surveyor requested additional information if available. No additional information was provided.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Surveyor: [NAME], [NAME] Based on observation, record review and interviews, the facility did not ensure that 1 (R62) of 5 residents reviewed received care, consistent with professional standards of practice to prevent the development of pressure injures and or to promote healing, prevent infection and prevent additional pressure injuries from developing. * R62 developed a pressure injury on the right buttock on 6/30/24 that was not comprehensively assessed and did not have physician notification for a treatment until 7/10/24. R62's pressure injury declined during this time, and on 7/10/24, the wound physician assessed the pressure injury as unstageable. The wound physician ordered a debriding treatment. On 7/17/24, the pressure injury was mechanically debrided to a stage 4 pressure injury. R62 was not assessed for weight loss prior to this pressure injury development. Cross reference F692. The failure of the facility to provide services to prevent pressure injury development and to ensure prompt treatment created a finding of immediate jeopardy that began on 7/17/24. Surveyor notified the (Nursing Home Administrator) NHA-A on 9/04/24 at 9:11 AM. The immediate jeopardy was removed on 9/11/24. The deficient practice continues at a scope of severity of D (potential for harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's policy and procedure dated 6/14/24 and titled Treatment/Services to Prevent/Heal Pressure Ulcer documents: Intent-The facility will ensure that based on a comprehensive assessment of a resident: a.) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and b.) A resident with pressure ulcers receives necessary treatment and services, consistent with a professional standards of practice, to promote healing, prevent infection and prevent new ulcers on developing. The (National Pressure Injury Advisory Panel) NPIAP 2019 Prevention and Treatment of Pressure Ulcers/Injuries state; Recommendations and Good Practice Statements: - Consider the impact of impaired nutritional status. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Develop and implement a risk-based prevention plan for individuals identified as being at risk for pressure injuries. - Develop and implement an individualized nutrition care plan for individuals with, or at risk of, of a pressure injury who are malnourished or who are at risk of malnutrition. - Conduct a comprehensive initial assessment of the individual with a pressure injury. 1.) R62 was admitted to the facility on [DATE] with diagnoses that included severe protein malnutrition, dysphasia and severed dementia. R62 has a (Power of Attorney for Healthcare) POA-HC that is activated. R62 Admission (minimum data set) MDS assessment dated [DATE] documents that R62 is at risk for pressure injury. The assessment does not encompass the diagnosis of severe protein malnutrition for preventative interventions. R62 requires staff assist with mobility, transfers, incontinence care and assist with activities of daily living. R62's Significant Change in Status MDS dated [DATE] documents changes with eating and swallowing. R62 is at a risk for pressure injuries and Surveyor noted that there were no changes made to the plan of care for preventative measures. R62 Quarterly MDS assessment dated [DATE] does not encompass malnutrition and swallowing concerns. There are no changes to the pressure injury risk treatments as documented in the quarterly MDS. R62 had a severe weight loss of 13% from 3/13/24 to 3/20/24. There was not a comprehensive assessment for the development of a pressure injury. On 3/13/24, R62 weighed 125 lbs and 108 lbs on 3/20/24. R62 had a severe weight loss of 28% from 6/6/24 to 7/10/24. R62 on 6/6/24 weighed 102 lbs and on 7/10/24 weighed 73 lbs. R62 Braden Skin Assessments were reviewed. The Braden Skin scale is from 6- 23. The lower the number the higher the risk for pressure injury development. R62's Braden assessments document the following scores: - 2/13/24 a 15 a mild risk. - 2/20/24 a 14 a moderate risk. - 3/11/24 a 13 a moderate risk. - 4/7/24 a 13 a moderate risk. - 6/7/24 a 12 a high risk R62's plan of care Potential impairment to skin integrity related to nutrition, Alzheimer's dementia and decreased mobility date as initiated 2/13/24 documents under the interventions section: - 2/13/24 Encourage good nutrition and hydration in order to promote healthier skin. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 2/13/24 Turn and reposition every 2 - 3 hours and as needed while in bed. The next intervention initiated on 2/27/24 documents: - Apply house barrier cream every shift and/or with incontinence episodes; Keep skin clean and dry. Use lotion on dry skin. This intervention was added a week after R62's skin risk assessment changed from a mild risk to a moderate risk for skin ulcers. The following interventions were subsequently added: - 3/18/24 Use a draw sheet or lifting device to move resident. There is no change to the plan of care to prevent skin impairment with the severe weight loss on 3/20/24. - 6/14/24 Apply heel boots in bed. - 6/14/24 The resident needs pressure reducing EquaGel cushion to protect the skin while up in chair. (There is not documentation of what preventative measure was used in the chair prior to this intervention.) -6/18/24 The resident needs an air mattress to protect skin while in bed. (There is not documentation of the type of mattress.) On 8/28/24 at 2:48 PM, Surveyor interviewed NHA-A. NHA-A indicated the facility changed R62's wheelchair cushion to an EquaGel but stated that NHA-A did not have information on what had been in place prior to this. NHA-A changed the air mattress. NHA-A indicated that they will get the exact dates. NHA-A provided on paper that on 6/28/24 an alternating air mattress was added to the resident for a pressure prevention related to weight loss and poor nutritional intake and that an EquaGel cushion was ordered for the wheelchair. NHA-A stated that on 7/11/24, a Panncea low air loss mattress was put in place and a EquaGel II cushion was added. R62's Progress Note on 6/30/2024 documents: Writer called into room regarding right buttock skin issue. Area is 0.4 cm x 0.4 cm. Wound bed is white with no drainage. Surrounding skin has erythema. Area is on bony prominence. Placed Allevyn for protection until seen by wound care team for further assessment and treatment. R62's Skin Only Evaluation dated 6/30/2024 documents: Skin: Skin warm & dry, skin color WNL (with in normal limits), mucous membranes moist, turgor normal. Resident has current skin issues. Skin Issue: Pressure Ulcer / Injury. Skin Issue Location: right buttocks Pressure Ulcer / Injury Stage: Unstageable. Length: 0.4 cm Width (cm): 0.4 cm Depth: 0.1 Wound Bed: Epithelial. Wound Exudate: None. Peri Wound Condition: Erythema. Dressing Saturation: None. No wound odor. No tunneling. No undermining. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Area found on right buttocks. Area is 0.4 cm x 0.4 cm. Wound bed is white with no drainage. Surrounding skin has erythema. Area is on bony prominence. Placed Allevyn for protection until seen by wound care team. Clinical Suggestions: Evaluated for pain, discomfort. Dressing changes/treatments performed as ordered. Resident is turned, ambulated, moved at least every 2 hours. PRN (as needed) medication administered and effectiveness evaluated. There is no documentation the physician was contacted for treatment on 6/30/24. The description of the wound bed is white with no percentage of coverage. The definition of a white wound bed is necrotic tissue. The necrotic tissue would need to be removed to promote healing of the wound. There is not a comprehensive assessment on 6/30/24 to identify possible causative factors. There were no changes in interventions to promote healing upon discovery. R62's progress note dated 7/2/2024 documents: Skin/Wound Note. This is a late entry from 7/16/24 from NHA-A. The 7/2/24 documents : The (interdisciplinary team) IDT met to discuss the resident's new skin injury. The resident has a diagnosis of Dementia and dysphasia. Due to her diagnosis, she is only consuming 25% of her meals. The resident has a consult for speech therapy and is followed by the dietician. It was recognized that her Braden score moved from a moderate risk to a high risk. An air mattress was in place d/t (due to) the change. The resident was on a turning schedule and had a pressure reduction cushion on her wheelchair. Other skin prevention interventions in place were incontinence care and feeding assistance. Based on the interventions in place, the wound is classified as unavoidable. The IDT team recommends adding heel boots as an extra level of protection. R62 plan of care for ADL (activity of daily living) self-care performance deficit related to Alzheimer's dementia initiated date of 2/13/24. The interventions on 2/13/24 include: - Provide milkshakes or liquid food supplements when the resident refuses or has difficulty with solid food or provide nutritious foods that can be taken from a cup or mug where appropriate. - The resident requires physical assistance by 1 staff to eat. There is no changes to the ADL plan of care related to obtaining appropriate nutrition and assistance to promote wound healing. R62's plan of care Has an unstageable pressure ulcer right buttock. Now a stage 4 (7/17/24) initiated date 6/30/24. This plan of care does not include any preventative interventions related to positioning and nutrition. Surveyor noted that there is not a nutrition assessment until 7/16/24. This assessment by (Registered Dietician) RD- N documents a significant weight loss and severely underweight. A prosource protein supplement was added twice a day. There was no documentation of interventions to increase oral intake. This could include favorite foods, high caloric foods, or other individualized needs. Surveyor also noted that there was not a comprehensive assessment of R62 nutritional needs to implement an individual plan of care to promote wound healing on 6/30/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/3/2024, a Skin Only Evaluation for R62 was completed by NHA-A as a late entry on 7/16/24. The evaluation documents an increase in the pressure injury with a necrotic wound bed. There is not a percentage of necrotic tissue and is classified as an unstageable wound. The assessment documents Skin: Skin warm & dry, skin color WNL and turgor is normal. Resident does not have an external device. New. Issue type: Pressure ulcer/ injury. Location: Right buttock. Length (cm): 2.6 Width (cm): 2.9 Depth (cm): 0.9 Wound bed: Necrotic. Wound Exudate: Serosanguineous - thin, watery, pale, red/pink drainage. Peri wound: Normal. Dressing saturation: None 0%. Wound odor: No. Tunneling: No. Undermining: No. Treatment schedule: Daily. Pressure ulcer staging: Unstageable pressure ulcer / injury - obscured full thickness skin and tissue loss. Painful: No. Skin tissue: Warm. Skin note: Weekly skin assessment There is no documentation the physician was notified of this decline in the wound to implement an appropriate treatment. R62's initial wound physician assessment dated [DATE] documents: The type of wound is a pressure injury. It is assessed as a unstageable wound due to necrosis. The duration of wound is greater than 10 days. The wound size is 2.4 x 2.7 x 0.8 cm (centimeters). There is light serous sanguineous drainage. The characteristics are thick adherent devitalized necrotic tissue: 60 %; Slough: 30 %; Granulation tissue: 10 %. R62's wound physician assessment dated [DATE] is the first comprehensive assessment of this pressure injury since discovery on 6/30/24. The wound physician ordered Santyl apply once daily and as needed; recommended to off-load wound, reposition and group II mattress. Also recommended sharp debridement. The factors complicating wound healing is malnutrition. R62 had a severe weight loss that was discovered on 7/10/24 however, there was no nutritional assessment until 7/16/24. The additional measures were to add prosource protein supplement twice a day. A low air loss alternating mattress was added on 7/11/24. There were no changes in turning/positioning times. There were no additional nutritional interventions to promote oral intake. R62 was admitted to hospice on 7/16/24 with a primary diagnosis of severe protein malnutrition. The 7/17/24 wound physician assessment documents the wound has been debrided. The pressure injury is now a stage 4. There is no change in the treatment plan. R62 pressure injury has been assessed weekly from this point by the wound physician. On 8/28/24 at 2:17 PM, Surveyor observed R62 pressure injury treatment by Wound (Registered Nurse) RN-D. RN-D stated they do not do anything with the care plans. RN-D was not aware how R62 developed the pressure injury or any changes in the mattress. RN-D completed the treatment as ordered by the physician. The pressure injury was observed to be a stage 4 wound. R62 was positioned with pillows off the area. R62 was on the appropriate air mattress. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/28/24 at 2:48 PM, Surveyor interviewed NHA-A. NHA-A stated they noticed a change in R62 before the development of the pressure injury on 6/30/24. NHA-A stated they were rotating time up in the chair with laying down. They put heel boots in place at this time. NHA-A stated the skin is an organ, and with end stage of life there will be deterioration. NHA-A did not know the origin of pressure for the pressure injury. NHA-A did not indicate what nutritional interventions were started when the pressure injury was discovered 6/30/24. On 8/29/24 at 10:40 AM, Surveyor interviewed RN (Registered Nurse Unit Manager) RN UM-E. RN UM-E started this position in May 2024 and is still getting to know the residents. RN UM-E is not sure what was in place prior to weight loss, and pressure injury discovery. RN UM-E stated that towards the end of June R62's appetite decreased, and they would pick at their food. R62 was getting nutritional supplements. RN UM-E does not know anything about air mattress changes. RN UM-E stated that if R62 is not eating they are offered an additional supplement, and that sometimes R62 will drink this. The IDT meeting on 7/2/24 discussed the new pressure injury and to have Speech Therapy assess for not eating. RN UM-E did not have any additional information related to positioning or origin of the pressure injury. On 8/29/24 at 11:22 AM, Surveyor interviewed RD-N. RD-N they were aware of the weight loss right away. RD-N stated they were doing reweighs and could not believe the severe weight loss. R62 is up and down with eating. RD-N stated R62 is affected by their dementia and will eat food at times. R62 was already getting supplements 3 x a day. R62 is in the dining room for meals. On 7/16/24 pro-source supplement was added twice a day. RD-N increased the pro-source today to 3 x a day because the pressure injury is declining. This week R62 has been eating more with fingers. They also added finger foods this week. R62 varies in eating abilities, will use utensils, however, uses hands more. RD-N feels R62 has advanced dementia and has been eating less. RD-N stated they are in the facility 5 days a week. RD-N did not indicate any other nutritional approaches were attempted to promote nutrition. RD-N does not know how the severe weight loss occurred. RD-N was aware of the new wound, however, did not implement any changes in nutritional management until 7/16/24. The new wound was discovered on 6/30/24. R62's nutritional status is a factor in skin integrity. On 8/29/24, at 11:47 AM, Surveyor interviewed Wound (Medical Doctor) MD-O. MD-O stated that R62's pressure injury is an area that can be off-loaded. The facility and hospice take care of the air mattress ordering. R62 is off loaded most of the time. R62's main issue is their decline in health. R62 would develop wounds much faster with poor nutritional status and infections. R62 wound would not improve if they continue to medically decline. On 9/03/24 at 09:57 AM, Surveyor interviewed (Nurse Practitioner) NP-Q. NP-Q stated R62 has dementia and would eat on and off. R62 had a fall, with a hip fracture in February 2024 that was a factor in their decline in health. NP-Q felt R62 dementia behaviors were affecting their eating. R62 behaviors are crying and repetitive statements. They were trying to address the behaviors with medication. R62 had speech therapy on and off for swallowing and coughing. The coughing was more from bronchitis. NP-Q stated a person with dementia, can progress in the disease, for weight loss. The POA-HC did not want any artificial nutrition. NP-Q could not recall if they were notified of the pressure injury discovered on 6/30/24. NP-Q stated the wound MD drives the treatments. NP-Q stated that they can order a wound treatment, however the wound MD oversees it. NP-Q did not have any additional treatment information for the unstageable wound from 6/30/24 - 7/10/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/03/24, at 1:33 PM, Surveyor shared R62 concerns with NHA-A. NHA-A stated they notified the Nurse Practitioner and were using the Allevyn dressing until the Wound MD saw the resident. NHA-A stated they changed to an air mattress in June right before the pressure injury developed. Then they changed to a stronger air mattress after the wound MD saw the resident. NHA-A did not have additional information related to the actual cause of the pressure ulcer and what interventions were revised/implemented to promote skin integrity. On 9/03/24 at 3:00 PM, NHA-A spoke with Surveyor. NHA-A stated they did not actually see R62's pressure injury on 7/3/24. NHA-A was aware it was necrotic through review. The wound MD was off that week. Surveyor queried about the wound being larger on 7/3/24, from 6/30/24, with no changes in treatment or physician notification. On 9/03/24 at 3:15 PM, NHA-A spoke with Surveyor. NHA-A stated they did assess R62's pressure injury on 7/3/24. There was a question on wound bed. NHA-A stated the wound bed was necrotic and needed debridement. The Wound MD-O was off the first week of July and did not assess the wound until 7/10/24. The wound was debrided on 7/17/24 after permission from R62's POA-HC. NHA-A stated there was no change in treatment from 6/30/24 until 7/10/24. On 9/04/24 a 2:01 PM, Surveyor interviewed Wound MD-O in person at the facility. MD-O stated they debrided R62's wound to prevent infection. The goal is to keep infection risk down. The necrotic tissue removal helps with pain as well. MD-O stated that removing the necrotic also resolves inflammation. Surveyor noted that R62 was at high risk for pressure injury due to malnutrition with decreased mobility. The facility did not comprehensively assess R62's risk factors to develop an individualized treatment plan. R62's pressure injury was not comprehensively assessed upon discovery to provide prompt treatment. There were no changes in R62's nutritional, ADL and skin plan of cares. The failure of the facility to provide services to prevent pressure injury development, and prompt treatment created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 7/17/24. The immediate jeopardy was removed on 9/11/24 when the facility implemented the following: 1) All nursing staff (including agency staff) currently working will be re-educated on the facility wound prevention policy, which includes a comprehensive assessment that should include the following: staging of Pressure injuries, location, size, color, type of wound tissue, exudate or drainage amount and type, odor, and peri-wound condition completed by a registered nurse on all newly identified wounds and residents admitted with wounds. 2) All nursing staff currently working (including agency staff) will be re-educated on pressure injury skin prevention and proper notification of changes with skin injury. They will also be educated on the use of proper pressure prevention interventions. 3) All residents with pressure injuries will be seen by the wound physician and a comprehensive assessment will be completed. Based on his wound round notes the resident will be assessed for the proper skin prevention equipment i.e air mattress and heel boots. The care plan will be adjusted to reflect the pressure injury and pressure prevention equipment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4) All residents and braden that are high risk for pressure injury care plan will be reviewed and and necessary adjustment will be made to reflect pressure prevention interventions. 5) All training noted above is to be completed by non-working staff by the beginning of the working shift. Any nurses who do not complete the competency will not be scheduled until completed. Competencies and education will be conducted by the DON, NHA, or Staff Development department. 6) RD was re-educated on the dietician responsibilities to assess residents with risk and pressure injuries for nutritional statues and interventions. 7) On 9/6/2024 the wound program and wound prevention policy were reviewed with the medical director and wound physician to ensure the policy meets current standards of practice. No additional information was provided as to why the facility did not ensure that R62, received care, consistent with professional standards of practice, to prevent the development of pressure injures and or to promote healing, prevent infection and prevent additional pressure injuries from developing.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on observation, record review, and interview, the facility did not ensure that 1 of 3 residents (R62) reviewed, based on a comprehensive assessment, maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range. * R62 was admitted with severe protein malnutrition. R62's nutritional assessments did not include actual weights that were obtained by facility staff and/or individualized interventions to provide adequate nutrition. R62 developed two periods of severe weight loss (130 lbs to 69.2 lbs, a 46.7% weight loss) that factored into the development of a stage 4 pressure injury and R62 being placed on hospice services. The facility's failure to conduct comprehensive assessments, to develop an individualized plan of care, and to provide adequate nutrition created a finding of immediate jeopardy that began on 3/20/24. Surveyor notified the (Nursing Home Administrator) NHA-A on 9/04/24 at 9:11 AM. The immediate jeopardy was removed on 9/9/24, however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its removal plan. Findings include: The facility's policy and procedure dated October 2021 and titled Weight Monitoring documents: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. 1.) R62 was admitted on [DATE] with diagnoses to include severe protein malnutrition, dysphasia, and severe dementia. R62 has an activated Power of Attorney for Healthcare (POA-HC.) R62's Admission MDS (minimum data set) assessment dated [DATE] documents that R62 requires set-up for eating and has had a recent weight gain. The MDS documents that the assessment weight for R62 is 130 lbs. R62's documented weights at the facility for February were as follows: - 2/13/24 130 lbs - 2/14/24 130.4 lbs - 2/15/24 130 lbs (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R62's Nutrition/Dietary Admission assessment dated [DATE] and written by (Registered Dietician) RD-N documents: R62 is on a mechanical soft diet, consuming ~ (approximately) 35% of meals since admit. Weight is 130 lbs on 2/15 (question accuracy of the weights obtained & requested another weight), was 95.7 lbs in the hospital, and R62's niece said R62 is typically ~95# and Froedtert MyChart had a weight of 106 lbs and she was surprised to see a weight that high. BMI (body mass index): 23.8, WNL (within normal limits) - however, R62 appears closer to underweight and weight of 130 lbs does not seem accurate. R62 has her own teeth, which are in poor condition. No oral sores nor pain with chewing noted. Appears to be tolerating mechanical soft diet but ST (Speech Therapy) is ordered with history of dysphasia. Discussed Boost and R62 said chocolate or vanilla would be okay. Can feed self but assist and encouragement/cues are helpful. No pressure injuries noted. Braden: 15, at risk. R62 diagnosis: Alzheimer's dementia, HTN (hypertension), asthma, dysphasia, protein-calorie malnutrition Meds (medications): sertraline, quetiapine. Estimate nutrition needs based on UBW (usual body weight) of 95 lbs: 1295 kcal (kilocalorie) (30 kcal/kg (kilogram) for wt gain), 43 g (grams) protein (1 g/kg), and 1080-1295 mL (milliliter) of fluids (25-30 mL/kg). Nutrition diagnosis: Inadequate oral intake related to poor-fair po (oral) intake, dementia as evidenced by consuming ~35% of meals, Alzheimer's. Intervention: add Boost/house supplement 240 ml BID (twice a day) for 480 kcal, 20 g protein/day. Goals: consume 25%+ of meals/supplement, skin will not break down, no significant wt triggers, no s/s (sign/symptoms) of dehydration. Surveyor noted that R62's nutritional assessment calculations were not based off the weights obtained by facility staff. This assessment did not include vitamins or mineral supplements that could be provided to R62 to maintain R62's nutritional status. This assessment did not include alternate high calorie food choices, fortified foods, favorite foods or snacks, or any other foods that could be offered as part of R62's personalized diet plan. R62's care conference note dated 2/27/24 and written by RD-N documents: R62's family does not believe R62's weight at the facility. R62 was around 100 lbs at home and do not believe R62 gained 30 lbs. R62 only eats 30 % of their meals and nutritional supplement twice a day. R62 family does not want tube feeding, however they do want R62 to be provided assistance at meals, given cues and encouragement to eat, to keep weight above 95 lbs. The family did not want an appetite stimulant medication unless absolutely necessary. (Note: Despite the family's belief that the resident's weight was probably around 100 lbs., repeated weights at the facility thus far had shown R62's weight to be 130 lbs.) R62's nutritional plan of care dated as initiated on 2/16/24 documents: Resident is at nutritional risk related to need for mech (mechanical) soft diet, need for nutritional supplement, poor-fair po intake, Alzheimer's dementia, dysphasia, pro-cal malnutrition, risk for dehydration and risk for malnutrition. Under the interventions section it documents that on 2/16/24 the following interventions were initiated: - Staff to assist with meal set up and eating prn (as needed). - Allow adequate time for R62 to consume food served. - Monitor oral intakes and record in the electronic record. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Offer a minimum of 1400 ml of fluids at meals/day. R62 mainly prefers milk, juice, water and coffee. - Offer house supplements as ordered. - Provide mechanical soft diet. - Weigh monthly and PRN (as needed) as ordered. R62's plan of care dated as initiated on 2/13/24 documents: ADL (activity of daily living) self-care performance deficit related to Alzheimer's dementia. Now on Hospice care. The interventions section documents the following interventions for eating were in place on 2/13/24: - 2/13/24 R62 requires physical assistance of 1 staff to eat. - 2/15/24 an intervention was initiated to provide milkshakes or liquid food supplements when the resident refuses or has difficulty with solid food or provide nutritious foods that can be taken from a cup or a mug where appropriate. R62's documented weights at the facility continued as follows: - 2/19/24 130.2 lbs - 2/21/24 130.2 lbs - 3/6/24 128.6 lbs - 3/12/24 125.9 lbs - 3/12/24 125.9 lbs R62's Significant Change in Status MDS dated [DATE] documents that R62's weight was 126 lbs and there are coughing and swallowing concerns when eating for R62. R62's Nutritional Nutrition/Dietary Note dated 3/12/24 documents: R62 is downgraded to mildly thick liquids per ST (Speech Therapy) recommendation. R62 with swallowing difficulty and working with ST. R62 received ST for an evaluation one time on 3/11/24 for swallowing concerns by (Speech Therapist) ST-P. R62's speech therapy assessment recommendations are: Mechanical soft textures; nectar thick liquids; close supervision; to facilitate safety and efficiency. It is recommended R62 use the following strategies and/or maneuvers during oral intake: alternate liquid/solids, rate modification and bolus size, upright posture during meals and 30 minutes after eating. No further consult or exam indicated. The results would not change clinical management of R62. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R62's nutritional plan of care revised on 3/12/24 documents: mildly thick liquids as ordered. The ST recommendations were not documented in R62's plan of care. R62's documented weights at the facility continued as follows: - 3/12/24 125.9 lbs - 3/13/24 125 lbs - 3/20/24 125 lbs - 3/20/24 108.2 lbs Surveyor noted that from 3/13/24 to 3/20/24, R62 experienced a 13% weight loss. This would be considered severe weight loss. R62's Nutrition/Dietary Note dated 3/28/24 and written by RD-N documents: Weights ranged 125-130 from 2/13/24 to 3/20/24 but weight also obtained at 108.2 on 3/20/24. Weights now 103.2-103.8 for past week. Continues on mechanical soft with nectar liquids. Sertraline increased on 3/22/24. Needs varying level of assistance at meals. Acceptance of meals and supplements somewhat decreased this past week, about 25%. Visited with R62 before dinner, R62 appeared hydrated but frail. Aide noted R62 seemed unchanged, accepted fluids well. RD-N spoke with R62 POA-HC. R62 had swallow study this week, existing diet/liquids was the recommendation. Discussed weights and POA-HC agreed 103 pounds was more consistent with R62 usual body weight recently as an elderly person. The POA-HC said R62 may have gotten up to 120-125 lbs in their younger adulthood. The POA-HC said R62 got as low as 89 pounds in the past few years but would like to see R62 stay above 100 pounds. The POA-HC was agreeable to increasing house supplement to TID (three times a day) and continuing to monitor weight. Boost/Ensure TID will provide 720 kcals and 30 g protein/day. Updated (Nurse Practitioner) NP-Q. Surveyor noted that R62's above nutritional assessment does not include any snacks, favorite foods, fortified foods, high calorie or other food choices that can be offered as part of R62's personalized diet plan. R62's additional documented weights were as follows: - 3/20/24 108.2 lbs - 3/21/24 103.8 lbs - 3/26/24 103.8 lbs - 3/27/24 103.2 lbs - 4/1/24 102.2 lbs - 4/2/24 102.2 lbs - 4/10/24 101.4 lbs (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 4/14/24 99.8 lbs - 5/10/24 101.8 lbs - 5/10/24 101.2 lbs - 6/6/24 102.3 lbs R62's Nutrition/Dietary quarterly assessment dated [DATE] and written by RD-N documents: R62 is on a mech soft diet with mildly thick liquids, consuming ~45% of meals over the last 7 days. Wt: 102.3 lbs on 6/6, 101.2 lbs on 5/10, 130 lbs obtained at facility on 2/13, but the POA-HC reported all R62 doctor appointments and regular weights were ~95-100 lbs so her current weight is about where it usually had been. BMI: 18.7, WNL (within normal limits). R62 has their own teeth, which are in poor condition. No oral sores nor pain with chewing noted. Appears to be tolerating mech soft diet. R62 is offered house supplement 240 mL TID for ~720 kcal, 30 g protein/day to help maintain weight. Can feed self but assist and encouragement/cues are helpful, and at times she is fed at meals depending on her level of engagement. No pressure injuries noted. Estimated nutritional needs: 1162-1395 kcal (25-30 kcal/kg), 47 g protein (1 g/kg), and 1162-1395 mL of fluids (25-30 mL/kg). Fluid intake averages ~1230 mL of fluids/day, which should be meeting est. needs. Nutrition diagnosis: Inadequate oral intake related to poor-fair po (oral) intake, dementia as evidenced by consuming ~45% of meals, need for encouragement/cues/occasionally needs to be fed, Alzheimer's, need for supplements, low BMI of 18.7. Intervention: continue current POC (plan of care). Goals: consume 25%+ of meals/supplement, skin will not break down, maintain weight above 95 lbs. R62's next documented weight on 7/10/24 was 73.2 lbs. Surveyor noted that from 6/6/24 to 7/10/24, R62 suffered a severe weight loss of 28%. Surveyor noted that there were no revisions in the individualized plan of care to provide nutritional support for R62. Surveyor noted that there is no comprehensive assessment to identify causative factors for R62's severe weight loss. Surveyor also noted that there is not a comprehensive assessment to identify additional nutritional measures to provide nutrition for R62. On 7/10/24, R62 was prescribed an antibiotic for bronchitis. R62 was experiencing coughing prior to this being ordered. R62 was placed in droplet isolation for 5 days. Surveyor noted that there were no changes in the plan of care for additional nutritional support with an infection. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R62's Nutrition/Dietary assessment dated [DATE] and written by RD-N documents: Weight/wound note - R62 is on a mech soft diet with mildly thick liquids, consuming ~30% of meals over the last 7 days. Wt: 66.8 lbs on 7/15, 68.4 lbs on 7/12, 75.4 lbs on 7/11, 73.2 lbs on 7/10, 102.3 lbs on 6/6, 101.2 lbs on 5/10, 130 lbs obtained at facility on 2/13, but POA-HC reported all R62 doctor appointments and regular weights were ~95-100 lbs so 130 lbs was likely incorrect. Significant wt loss from 6/6 to 7/10, not desirable. BMI: 12.2, severely underweight. R62 has increased difficulty chewing and swallowing per staff and ST (Speech Therapy) consult ordered. ST recommends VSS (video swallow study). Per therapy director R62 POA- HC does not want R62 sent out for VSS. Writer notified IDT (interdisciplinary team) on 7/11 that R62 needed a reweigh due to significant wt loss from the previous month. Reweigh obtained but requested another reweigh just to confirm due to the amount of weight lost in 1 month. Notified NP-Q regarding the weight loss and that reweighs were requested to confirm. NP-Q recommends discussing goals of care/hospice with POA-HC. R62 is offered house supplement 240 mL TID for ~720 kcal, 30 g protein/day. R62 needs assist with eating, has poor attention and needs encouragement to eat. No pressure injuries noted. Estimated nutrition needs: 1162-1395 kcal (25-30 kcal/kg), 47 g protein (1 g/kg), and 1162-1395 mL of fluids (25-30 mL/kg). Fluid intake averages ~1230 mL of fluids/day, which should be meeting est. needs. R62 is assisted with eating, receiving nutritional supplements, working with ST. Nutrition diagnosis: Increased nutrient needs related to demands of wound healing as evidenced by unstageable PI (pressure injury) to right buttock. Secondary Nutrition diagnosis: Involuntary weight loss r/t dementia, decline, poor po intake as evidenced by skin breakdown, need for assist with meals, need for supplements, working with ST, severely underweight with BMI of 12.2. Intervention: working with ST, add Prosource 30 ml BID for 200 kcal, 30 g protein/day to aid in wound healing. Goals: consume 25%+ of meals/supplement, skin will not break down, no further wt (weight) loss. Surveyor noted that there is no documentation that includes R62's poor nutritional intake with severe weight loss and how it was assessed. The assessment did not include any increased staff assistance with eating, finger foods, drinkable fortified snacks, or high calorie foods. There is not documentation of food likes or dislikes for R62. There is no assessment that includes vitamins or minerals for added nutritional support for R62. R62 had speech therapy from 7/11/24 to 7/15/24. The speech therapy assessment on 7/11/24 by (Speech Therapist) ST-P documents under the Recommendations section: Mechanical soft textures; nectar thick liquids; close supervision; to facilitate safety and efficiency. It is recommended R62 use the following strategies and/or maneuvers during oral intake: alternate liquid/solids, rate modification and bolus size, upright posture during meals and 30 minutes after eating. On 8/29/24 at 1:24 PM, Surveyor interviewed ST-P. ST-P stated there were variances in R62's oral intake. R62 has no physical barriers to eating. R62 has dementia and does not understand how to eat. ST-P assessed R62 due to more swallowing and coughing concerns. R62 had bronchitis and that would cause more coughing. R62 would take additional liquid supplements. R62 would at times take finger foods. Encouragement did not change R62's intake. ST-P felt R62's dementia was the main reason for not eating. R62 developed an unstageable pressure injury on 6/30/24. This pressure injury evolved into a stage 4 pressure injury on 7/17/24. The primary factor is severe protein malnutrition. Cross reference F686. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R62's Nutrition/Dietary note dated 7/16/2024 and written by RD-N documents: Writer spoke with POA-HC regarding the weight loss d/t multiple reweighs confirming the weight loss. POA-HC is adamant that R62 is not 66 lbs and does not believe that R62 has lost that much weight. The POA-HC feels the scales are inaccurate. The POA-HC was just visiting R62 2 weeks ago and would've noticed if R62 had lost that much weight. Writer discussed all the reweighs obtained and that R62 continues with poor po (oral) intake. Discussed that R62 is working with ST (speech therapy) for swallowing, discussed R62 new unstageable wound to right buttock and that Prosource 30 ml BID was added. The POA-HC agreed ProSource is a good idea. The POA-HC is agreeable to hospice for R62 and feels that is what R62 would want, The POA-HC is noticing R62 decline as well. R62's progress note dated 7/17/24 and written by RN UM (Registered Nurse Unit Manager)-E documents: Writer contacted POA-HC regarding requested reweigh of R62 to ensure accuracy. Writer weighted resident today at 69.4 lbs and noted that resident's pants were very loose with at least 4 inches of extra space. Writer provided these updates to POA-HC. On 8/29/24 at 10:40 AM, Surveyor interviewed RN UM-E. RN UM-E stated they started their position in May and are still learning about the residents. RN UM-E was not sure what interventions were in place prior to May regarding R62's weight loss. RN UM-E stated that when R62's weight loss was identified, the POA-HC did not believe it. RN UM-E stated that R62's appetite was decreased and R62 would pick at their food and that this occurred at the end of June. RN UM-E stated that R62 was on house supplements and Boost. RN UM-E stated that if R62 is not eating, R62 is offered another liquid supplement and sometimes drinks it. R62 was not consuming meals and speech therapy was consulted. R62 is also followed by the RD. RN UM-E did not have information on various methods to provide nutrition related to R62's dementia. Surveyor did share there were no changes in the plan of care, no additional information was provided. R62 was admitted to hospice services on 7/19/24 with a primary diagnosis of severe protein-calorie malnutrition. At that time of the survey, R62's weight continues to decrease: - 7/11/24 75.4 lbs - 7/12/24 68.4 lbs - 7/15/24 66.8 lbs - 7/17/24 69.4 lbs - 7/26/24 69.4 lbs - 8/1/24 69.2 lbs On 8/28/24 at 2:48 PM, (Nursing Home Administrator) NHA-A spoke with Surveyor. NHA-A stated that R62 has advanced dementia and that the hospital weight for R62 was different than R62's admission weight. The facility admission weight was 130 lbs and the family said, No way. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NHA-A stated that the facility had calibrated the scales and that R62's weight on 3/6/24 was 128.6 lbs. NHA-A stated that the RD did a reweigh on 3/12/24 of 125.9 lbs and that the RD indicated that R62 was losing weight and RD ordered supplements. The supplements that were added were Pro-cal upon admission for at risk for malnutrition. NHA-A stated that R62's weight on 3/13/24 was 125 lbs and that R62 was on weekly weights. NHA-A stated that on 3/20/24, R62's weight was 125 lbs and R62 was reweighed the same day and found to weigh 108 lbs. Then on 3/21/24, R62 was 103.8 lbs and kept going down in weight. On 7/10/24, there was a significant weight loss. NHA-A stated at that time, the RD did not believe R62 had that much of a weight loss. NHA-A stated that R62 was weighed on 7/10/24 and found to have weighed 73.2 lbs. On 7/11/24, R62 weighed 75.4 lbs. NHA-A stated that the RD was in contact with R62's POA-HC. NHA-A indicated that at the time, the facility needed to complete a significant change assessment as R62 was also having trouble swallowing. NHA-A stated that R62 did not have a change in intake prior to the significant weight loss and that speech therapy notes indicated R62 was not swallowing properly. NHA-A stated that facility staff met with R62's family to pursue hospice services at the time. NHA-A did not have any additional causative factors, or interventions, for the severe weight loss. On 8/29/24 at 11:22 AM, Surveyor interviewed RD-N. RD-N stated they were aware of R62's weight loss right away as a resident weight loss would show as a PCC (Point Click Care) alert. At the time, RD-N stated they wanted a reweigh to confirm the weight loss in R62 and that R62's POA-HC did not believe the weight loss. RD-N stated that R62 is very up and down with oral intakes and that sometimes R62 will drink fluids. RD-N stated that R62 does not want to touch food at times and will eat when they want. RD-N felt R62's dementia affected their eating and that R62's POA-HC did not want any tube feeding put in place. RD-N does not know how someone could lose that much weight and stated that NP (Nurse Practitioner)-Q recommended hospice. RD-N stated that R62 was already getting supplements 3 x a day and that R62 would be in the dining room for mealtimes. RD-N stated on 7/16/24, they added ProSource supplements twice a day and that this morning (8/29/24) the ProSource was increased to 3 times a day due to R62's pressure injury declining. RD-N stated that this week R62 has been eating more with their fingers and that the facility added finger foods. RD-N stated that R62 varies in eating and that R62 will use utensils at times, however uses hands more and that due to R62's advanced dementia, R62 has been eating less. RD-N is at the facility 5 days a week and stated that they have facility meetings every day. RD-N stated that R62's POA-HC does not want any further workup and that on 7/19/24, R62 started hospice services for severe protein malnutrition. RD-N did not have any additional information regarding R62's severe weight loss. There were no revisions to the plan of care to provide resident nutrition related to their dementia diagnosis. On 9/03/24 at 9:57 AM, Surveyor interviewed NP-Q. NP-Q stated R62 had weight loss in the hospital and eating was an issue. NP-Q stated that R62 had dementia and that R62 would eat on and off. NP-Q stated that R62 sustained a hip fracture just after admission to the facility that contributed to R62's decline. NP-Q indicated that R62 had a lot of crying and repetitive behaviors and that the hospital did adjust medication to address behaviors to assist with eating, and that the facility wanted to treat the behaviors first. NP-Q stated that R62 was seen by speech therapy on and off and that R62 was coughing was more related to a bronchitis. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NP-Q felt that R62's dementia contributed to the weight loss and that the POA-HC did not want artificial nutrition. NP-Q stated that the RD will send an email to notify them about a weight loss. NP-Q indicated they were notified of the weight loss on 7/3/24 via email. The RD increased the nutritional supplements on 7/15/24. NP-Q did not have any information related to R62's severe weight loss. NP-Q requested a care conference to discuss hospice. No additional information was provided. On 9/03/24 at 1:33 PM, Surveyor spoke with NHA-A regarding concerns with R62's weight loss. Surveyor informed NHA-A that R62's plan of care was not revised with changes in their clinical status and that there was not a comprehensive assessment to determine potential factors contributing to the severe weight loss, along with individualized interventions to address R62's severe weight loss. On 8/27/24 at 9:23 AM, Surveyor observed R62 in a wheelchair at the dining room table. R62 was drinking from a glass on their own. There were no staff assisting R62 with eating. On 8/28/24 at 8:40 AM, Surveyor observed R62 in a wheelchair at the dining room table. R62 had a breakfast tray in front of them. R62 had thickened liquids. R62 was holding the glass themselves and drinking from it. There was no staff feeding R62. When staff cues R62 to eat solid food, R62 said no no no. R62 continued to talk non-sensical out loud. Surveyor noted that R62 was admitted with known malnutrition with eating concerns. R62's admission assessment did not calculate the resident's actual weight. Surveyor noted that R62's speech therapy recommendations were not implemented in a plan of care. Surveyor noted that R62's dementia, with behaviors, was not encompassed in the nutritional assessments to develop an individualized approach. R62 was noted to not being eating, along with having loose clothing, in June. There were no changes in the plan of care until mid-July when the nutritional supplement was added. This was also due to a new pressure injury development on 6/30/24. The nutritional assessments do not include a personalized plan to promote nutrition. No additional information was provided as to why the facility did not ensure that R62, based on a comprehensive assessment, maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range. The facility's failure to conduct comprehensive assessments, to develop an individualized plan of care, to provide adequate nutrition, created a finding of immediate jeopardy 3/20/24. Surveyor notified the (Nursing Home Administrator) NHA-A on 9/04/24 at 9:11 AM. The immediate jeopardy was removed on 9/9/24 when the facility completed the following: 1) RD (Registered Dietician), DON (Director of Nursing), and IDT (interdisciplinary team) members were reeducated on the facility's weight loss policy, which includes a nutritional assessment. 2) The RD reassessed all residents at risk for weight loss and applied the necessary nutritional interventions according to best practices. 3) Current residents with weight loss were reassessed and care plans were reviewed and/or updated to reflect those interventions. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4) The facility will validate that weights are accurate. Licensed staff will assist with obtaining and verifying the weights and ensure scales are calibrated by manufacture's recommendation. 5) During the nutritional assessment, residents' food preferences and assistance level will be identified and communicated to the caregivers. 6) DON, QA (Quality Assurance) nurse, and NHA will audit residents that trigger for weight loss using PCC (point click care) daily Monday - Friday to ensure proper interventions are applied and care planned. No additional information was provided as to why the facility did not ensure that R62, based on a comprehensive assessment, maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review the facility did not ensure 2 of 2 medication storage rooms did not have expired stock medication and expired & not dated insulin for R11. * Expired 0.9 sodium chloride irrigation 500 ml (milliliter) bottle, stock Systane lubricant eye drops and tear eye drop advanced were observed in the 2900 unit medication storage room. * Expired stock tear eye drop advance and a bottle of Lantus insulin was expired for R11. A second bottle of Lantus, which was open & used, was not dated when opened. This has the potential to affect 9 residents residing on the 2700 unit and 14 residents residing on the 2900 unit who may have eye drops ordered. Findings include: 1.) On [DATE], at 9:35 a.m., Surveyor observed the 2900 unit medication storage room with Med Tech (Medication Technician)-F. On the wire rack Surveyor observed a bottle of 0.9% sodium chloride irrigation usp 500 ml with the expiration date of [DATE]. In the cabinet to the left there is a stock bottle of Systane lubricant eye drops with the expiration date of ,d+[DATE]. In the same cabinet there are two stock bottles of tear eye drop advanced 15 ml with the expiration date of ,d+[DATE] On [DATE], at 9:40 a.m., Surveyor asked Med Tech-F who is responsible for checking for expired medication. Med Tech-F replied we all do. 2.) On [DATE], at 9:51 a.m., Surveyor observed the 2700 medication storage room with DON (Director of Nursing)-B. In the cabinet to the left of the sink, 4th section down there are two bottles of stock tear eye drop advance 15 ml with the expiration date of ,d+[DATE]. On [DATE], at 9:56 a.m., Surveyor observed a gray plastic bin in the refrigerator located in the 2700 medication storage room. In the gray bin is a bottle of Lantus 100 ml insulin for R 11 which is opened & used and not dated when open. There is a second used bottle of Lantus 100 ml expired with an open date of [DATE]. On [DATE], at 9:59 a.m., DON-B stated to Surveyor I see 4 items on there, referring to the expired/not dated items on Surveyor's table. Surveyor asked DON-B who is responsible for checking for expired medication. DON-B informed Surveyor everyone is responsible for checking for expired medication and is mainly the night shift but all nurses and med techs are responsible. Surveyor asked after Lantus is open when is it considered expired. DON-B informed Surveyor always go by 28 days and if not sure verify with the pharmacy, that's the protocol we teach nurses as well. Surveyor asked DON-B if insulin should be dated when opened. DON-B replied always should be dated. Surveyor showed DON-B the expired medication On [DATE], at 10:03 a.m., Surveyor informed DON-B of the expired medication observed in the 2900 medication storage room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided as to why the facility did not ensure that medication storage rooms did not have expired medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not follow up on pharmacist recommendations reports, with the monthly medication reviews for 2 (R62 and R77) of 5 residents reviewed. - R62 and R77's pharmacy irregularities reports documented by the pharmacist for the physician were not acted upon. Findings include: The facility's policy and procedure Pharmacy Services dated 10/22. The policy documents: It is the policy of the facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. 1.) R62 was admitted to the facility on [DATE] with diagnosis of Alzheimer's dementia. R62 had Pharmacy Review on 6/8/24 that documents a pharmacy note was written. There was no documentation in the medical record regarding the pharmacy report. R62 had Pharmacy Review on 7/1/24 that documents a pharmacy note was written. There was no documentation in the medical record regarding the pharmacy report. On 9/04/24, at 9:54 AM, Surveyor requested R62 pharmacy reports for June, and July, from (Nursing Home Administrator) NHA-A. On 9/04/24, at 10:31 AM, NHA-A provided Surveyor R62 pharmacy review notes from June and July. The pharmacy report documents there is not an appropriate diagnosis for the use of the antipsychotic Seroquel. These reports are not acted upon by the physician. There was no additional information provided on why the physician did not acknowledge these reports and why the pharmacist recommendations were acted upon. 49011 2.) R77 was admitted to the facility on [DATE] with diagnoses which include degenerative disease of nervous system, unspecified dementia with agitation and anxiety, generalized anxiety disorder; major depressive disorder and wandering. R77's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/19/24 documents a Brief Interview for Mental Status score of 00, indicating that R77 has severe cognitive impairment. The MDS documented that R77 has no impairment to the upper and lower extremities. R77 uses a walker for mobility and is incontinent of both bowel and bladder. R77 has a wander elopement alarm. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section D (Mood) of the MDS documents a PHQ-9 (Patient Health Questionnaire) score of 00, indicating no depression in R77. Section N (Medications) documents that R77 has indications for and takes antianxiety, antidepressant and antipsychotic medication. Surveyor reviewed progress notes for pharmacy reviews and located the following documentation: R77's pharmacy review note dated 5/13/2024 documents: Pharmacy review. No new irregularities noted. R77's pharmacy review note dated 6/6/2024 documents: Pharmacy review. Note written. R77's pharmacy review note dated 7/1/2024 documents: Pharmacy review. Note written. R77's pharmacy review note dated 8/1/2024 documents: Pharmacy review. Note written. R77's pharmacy review note dated 9/3/2024 documents: Pharmacy review. Note written. On 09/04/24, at 09:59 AM, Surveyor interviewed the Director of Nursing (DON)-B and asked how to know what the note written pertained to for R77. DON-B stated medical records had the paperwork and that she would bring the recommendations to Surveyor. Consultant Pharmacist's Medication Regiment Review forms were provided to Surveyor for the months of April, June, July and August for R77. The form has statement This resident is receiving the antipsychotic agent Seroquel, but lacks an allowable diagnosis to support its use. The following DSM-IV TR are considered appropriate diagnoses/conditions: -Schizophrenia -Schizo -affect disorder -Delusional disorder -Mania, bipolar disorder, depression with psychotic features, treatment -refractory major depression -Schizophreniform disorder -Psychosis NOS -Atypical psychosis -Brief psychotic disorder -Dementing illnesses with associated behavioral symptoms (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medical illnesses/delirium with manic/psychotic symptoms/treatment -related psychosis/mania Please supply an allowable diagnosis. On 09/04/24 at 01:10 PM, Surveyor interviewed DON-B and asked why there are 4 months of the same recommendation. Per DON-B the recommendations were not addressed and there was no follow up. Surveyor then asked DON-B for the policy due to the concern; Surveyor was told to get policy from Nursing Home Administrator. No additional information was provided by DON-B related to the pharmacy recommendations.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not ensure residents on psychotropic medications received monitoring, and dose reductions, to minimize use of these medications. This was observed with 4 (R50, R62, R38 and R49) of 6 resident medication reviews. - R50 receives an antipsychotic medication, and did not have a AIMS (abnormal involuntary movement scale) assessment, to monitor for side effects. - R62 receives an antipsychotic medication, and did not have a AIMS assessment, to monitor side effects. - R38 receives Cymbalta and Sertraline once daily for depression. The facility has no evidence of AIMS (abnormal involuntary monitory scale) monitoring and no evidence of an attempted dose reduction. - R49 receives an psychotropic medication that was not reviewed for a gradual dose reduction. Findings include: The facility's policy and procedure Use of Psychotropic Medication dated 10/22. The procedures include: 6.) Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. 8.) Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, semi-annual, with a significant change in condition, change in antipsychotic medication, as needed or as per facility policy. 1.) R50 was admitted to the facility with a diagnosis of schizoaffective, borderline personality disorder and dementia. The Annual (minimum data set) assessment completed on 1/2/24 documents routine antipsychotic medication use by R50. The Quarterly MDS assessment completed on 4/2/24 documents routine antipsychotic medication use by R50. The Quarterly MDS assessment completed on 7/2/24 documents routine antipsychotic medication by R50. R50's nursing note dated 8/27/24 documents: COMMUNICATION - with Family Note Text: LM (left message)with POA (power of attorney) regarding recommendation to increase R50's Effexor XR to 75 mg (milligrams) po (by mouth) daily +37.5 mg Effexor XR daily=112.5 mg daily for depressed mood and trouble sleeping, awaiting call back. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R50's medical record did not have documentation of an AIMS assessment being completed for R50's antipsychotic medication use. On 8/28/24, at 3:26 PM, at the facility exit meeting with (Nursing Home Administrator) NHA-A. Surveyor requested any AIMS assessment that was completed for R50's antipsychotic medication use. On 8/29/24 at 3:15 PM, NHA-A spoke with Surveyor. NHA-A stated there was not an AIMS assessment completed for R50's antipsychotic medication use that was completed prior to 8/28/24. NHA-A provided an AIMS assessment completed 8/29/24. No additional information was provided. 2.) R62 was admitted to the facility with a diagnosis of Alzheimer's dementia with agitation. The Significant Change in Status (minimum data set) assessment completed on 3/12/24 indicates routine antipsychotic medication use. The Quarterly MDS assessment completed on 6/10/24 indicates routine antipsychotic medication use by R62. The Significant Change in Status assessment completed on 7/26/24 indicates routine antipsychotic medication use by R62. R62's physician orders documents Seroquel use by R62. R62 medical record did not have documentation of an AIMS assessment being completed for R62's antipsychotic medication use. On 9/04/24, at 8:24 AM, Surveyor interviewed (Nursing Home Administrator) NHA-A. NHA-A stated that an AIMS assessment was not triggering in Point Click Care. for R62's antipsychotic medication use. and that the AIMS assessment was not completed. No additional information was provided. 48391 3.) R38 receives Cymbalta and Sertraline once daily for depression. The facility has no evidence of AIMS (abnormal involuntary monitory scale) monitoring and no evidence of an attempted dose reduction. R38 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R38's diagnoses include multiple sclerosis, depression, post laminectomy syndrome, cramp and spam, chronic pain syndrome, neuromuscular dysfunction of bladder, morbid obesity, and dependence on wheelchair. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R38's Annual MDS (Minimum Data Set) completed on 5/31/24 documents that R38 always socially isolates, has daily verbal behaviors, behaviors that interfere with cares and social interactions, and rejection of care that occur 4-6 days within a week. R38's MDS indicates she is taking an Antidepressant. R38 was documented as having a BIMS (Brief Interview for Mental Status) score of 13, indicating that R38 is cognitively intact. R38's physician orders documents: ~ Cymbalta oral capsule delayed release particles 30 mg (Duloxetine HCL). Give 1 capsule by mouth one time a day for depression. Cymbalta was ordered on 8/18/23 with a start date of 8/19/23. ~ Sertraline HCl tablet 100 mg. Give 1 tablet by mouth one time a day for depression. Sertraline was ordered on 8/18/23 with a start date of 8/19/23. Surveyor was unable to locate in the medical record where a dose reduction for Cymblata was attempted. On 9/4/24 at 10:11 AM, Surveyor interviewed Director of Nursing (DON)- B and asked where attempted medication dose reductions would be documented. DON- B indicated attempted dose reductions are mentioned in psychiatric notes. Surveyor notified DON- B of concerns with no documentation of R38 having an attempted dose reduction for Cymbalta and Sertraline. DON- B indicated she will contact the psychiatric provider to discuss attempted dose reductions for Cymbalta and Sertraline. Surveyor requested additional information if available. No additional information was provided for R38. Surveyor reviewed R38's medical record which includes an AIMS, dated 8/30/24. Surveyor is unable to locate any additional AIMS documentation in R38's medical record. On 9/4/24 at 8:30 AM, Surveyor interviewed Nursing Home Administrator (NHA)- A. Surveyor noted the AIMS documentation for R38, dated 8/30/24, and requested additional AIMS documentation. NHA- A indicates AIMS are completed on residents quarterly. NHA- A states AIMS were not being triggered on residents within the facility. NHA- A indicates the facility noticed AIMS were not being performed on residents which prompted the facility to perform an AIMS sweep, and AIMS was performed on all appropriate residents including R38. NHA- A indicated there were not additional AIMS documentation for R38 except for the AIMS on 8/30/24. Surveyor notified NHA- A of concerns with R38 receiving Cymbalta and Sertraline, and R38 does not have side effect monitoring with AIMS consistently. Surveyor requested additional information if available. No additional information was provided for R38. 50775 4.) R49 was originally admitted to the facility on [DATE] with diagnosis of Post Traumatic Stress Disorder. R49's Quarterly Minimum Data Set (MDS) dated [DATE] documents antipsychotic medications were received on a routine basis only. Has a gradual dose reduction (GDR) been attempted? No is checked. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R49's physician orders which include the following: Seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for nightmares. Surveyor reviewed the pharmacy notes from 8/1/24: Pharmacy Review: Note Text: Pharmacy review. No new irregularities noted. On 9/4/2024 at 10:46 AM, Surveyor requested information from DON-B regarding R49's Seroquel use and a gradual drug reduction being completed. Surveyor requested any psychiatric and or physician notes pertaining to R49's Seroquel use for the last three months. On 9/4/24 at 2:11 PM, Infection Preventionist (IP-C) advised Surveyor that the facility had no gradual dose reduction or a psychiatric consult for R49's Seroquel use. On 9/4/24, at the daily exit meeting, NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B were informed of no gradual dose reduction or psychiatric consult for R49's Seroquel use. No additional information was provided as to why the facility did not ensure residents on psychotropic medications received monitoring, and dose reductions, to minimize use of these medications.

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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 (R64) of 1 residents reviewed were free from significant medication errors. *R64 had a physician order to receive Plavix Oral Tablet 75mg (anticoagulant) one time a day. R64 did not receive 6 administrations of Plavix between 7/28/2024 and 8/11/2024. Findings include: The Facility Policy titled, Unavailable Medications last reviewed 6/23, documents: Policy: This facility shall use uniform guidelines for unavailable medications. Policy Explanation and Compliance Guidelines: 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn, and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications. 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. b. Notify physician if inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold . 5. If a resident missed a scheduled dose of medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report and monitoring the resident for adverse reactions to omission of the medication. 1.) R64 was admitted to the facility on [DATE] with diagnoses that includes type 2 diabetes mellitus, unspecified atrioventricular block, atherosclerotic heart disease of native coronary artery without angina pectoris, and essential hypertension. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/25/2024 documents a Brief Interview for Mental Status (BIMS) score of 10, indicating that R64 has moderate cognitive impairment. R64's MDS documents that R64 has no impairment to R64's upper or lower extremities. The MDS documents that R64 uses a walker for mobility and that R64 does not have a catheter and is always continent of bowel and bladder. R64 has a physician order that started 7/24/2024 for Plavix Oral Tablet 75mg, Give one tablet by mouth one time a day related to atherosclerotic heart disease of native coronary artery without angina pectoris and essential hypertension. On 08/28/24, at 09:04 AM, Surveyor reviewed R64's Medication Administration Record (MAR) and saw that Plavix was not given on August 2 with reason of on order and also August 6, 10, and 11 with reason of await pharmacy delivery. Surveyor looked at the July MAR and saw it was not given the 28 th and 30 th. Surveyor noted that there was a total of 6 missed administrations between 7/28/2024 and 8/11/2024 out of 15 opportunities. On 08/28/24, at 10:43 AM, Surveyor interviewed Certified Medication Assistant (CMA)-K and asked about the procedure when a medication is not available in the cart to give to a resident. CMA-K stated they would call the pharmacy and check with them on what is going on. CMA-K would then ask a nurse to help get medication out of contingency. Surveyor noted that the facility has an Omnicell which nurses can access but CMAs cannot. On 08/29/24, at 08:43 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-K and asked when passing pills if a medication is not there what should staff do. LPN-K stated to go to the Omnicell. Should also call the pharmacy to make sure they got the order, otherwise do a clarification order. LPN-K would also call the Nurse Practitioner to let know the resident did not receive, even if just one dose. On 09/03/24, at 10:25 AM, Surveyor interviewed LPN Unit Manager (UM)-J and asked what staff should do if a medication is unavailable to administer. UM-J stated nurses can get medications from the Omnicell. If it is a CMA they should get a nurse and go to Omnicell to pull, then notify the pharmacy. On 09/03/24, at 01:54 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the protocol when a medication is unavailable to administer. DON-B confirmed Plavix is available in the Omnicell. DON-B stated staff should get it from Omnicell. If it is agency worker, they should go to supervisor for help and if it is a CMA they should get a nurse. DON-B will look into why not given on those days and whether it was staff or agency for training purposes. On 09/3/24, at 3:23 PM, during the end of day meeting, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to Plavix not being administered. No further information was provided as to why the facility did not ensure that R64 was free from this significant medication error.

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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** 20025 Based on observation, interview and record review the facility did not ensure the Covid 19 outbreak reflected accurate data, the surveillance of infections were not identified on the infection line list and the monthly infections rates did not accurately identify infections. Visual alerts such as signs at the entrance to notify everyone of the current outbreak and instructions about current recommendations was not done. * CNAs (Certified Nursing Assistants) were observed not using hand hygiene appropriately during meal service. These deficient practices have the ability to affect all 90 residents residing at the facility at the time of the survey. Findings include: 1.) A Covid 19 outbreak was identified on [DATE] when two facility staff members developed symptoms and tested positive for Covid 19. The outbreak line list identified two residents that tested positive for Covid on [DATE]. The last person that tested positive with Covid was a staff member on [DATE]. On [DATE], R65 tested positive for Covid and was placed in isolation but was not identified on the outbreak line list. On [DATE], R36 tested positive for coronavirus and was not identified on the outbreak line list. Surveyor noted that the surveillance of infections in the facility was not accurate. The infection line list identified residents prescribed antibiotics without an indication of the type of infection being treated or any signs or symptoms that required the use of the antibiotics. Due to the inaccurate identification of infections, the monthly infection rates within the facility were found to not be accurate. During the survey, R65 was still in isolation due to Covid and there were no signs posted indicating the facility was experiencing an outbreak. 2.) During the meal service, Surveyor observed CNA's not using hand hygiene appropriately. The facility's Coronavirus Prevention and Response policy (not dated) documents: 5. The facility will establish a process to identify and manage individuals with suspected or confirmed SARS-CoV-2 infection including: a. Ensuring that everyone is aware of the recommended IPC (infection prevention and control) practices in the facility by posting visual alerts (e.g., signs, posters) at the entrance and in strategic places to include instructions about current IPC recommendations. (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 Infection Surveillance policy dated ,d+[DATE] documents: 6. The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: a. Data to be collected, including how often and the type of data to be documented, including: i. infection site, pathogen (if available), signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections: ii. Observations of staff including the identification of ineffective practices, if any; and iii. The identification of unusual or unexpected outcomes, infection trends and patterns. b. How the data will be used and shared and with appropriate individuals (e.g,. staff, medical director, director of nursing, QAA committee) when applicable, to ensure that staff minimize spread of the infection or disease. 7. The facility will communicate via (specify how e.g. written reports, staff meetings, etc.) to staff and/or prescribing practitioners information related to infection rates and outcomes in order to revise interventions/approaches and/or re-evaluate medical interventions as indicated. 8. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends. 9. All resident and infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. Outbreaks will be investigated. On [DATE] at 1:28 p.m. Surveyor observed R65 door to the room closed with a sign indicating droplet and contact precautions to be used. There was a storage container with PPE (personal protective equipment). Infection preventionist-C indicated R65 is in isolation due to Covid. Surveyor did not observe any signage indicating the facility is experiencing a Covid outbreak. Surveyor observed staff using appropriate PPE when entering R65 room. During the Survey, Surveyor was made aware R36 tested and was positive for coronavirus on [DATE]. R36 was on hospice and experiencing a health decline prior to being tested for Covid and expired on [DATE]. Surveyor reviewed the facility's Infection Surveillance Monthly Report. The [DATE] report indicates a total of 8 residents receiving antibiotics without any signs or symptoms noted and without an infectious diagnosis for the use of the antibiotics. The August infection rates indicate 22 residents with other for an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The [DATE] report indicates a total of 23 residents receiving antibiotics without any signs or symptoms noted and without an infectious diagnosis for the use of the antibiotics. The July infection rates indicate 38 residents with other for an infection. The [DATE] report indicates 24 residents receiving antibiotics without any signs or symptoms noted and without an infectious diagnosis for the use of the antibiotics. The [DATE] infection rates indicate 34 residents with other for an infection. The Covid outbreak line list was reviewed. The outbreak line list did not include R36 that tested positive for coronavirus on [DATE] and it did not include R65 who tested positive for Covid on [DATE]. R65 was in the [DATE] Infection Surveillance Monthly Report as testing positive for Covid on [DATE] and receiving Paxlovid. R36 is not in the [DATE] Infection Surveillance Monthly report for testing positive for coronavirus. On [DATE] at 10:02 a.m. Surveyor interviewed Infection Preventionist (IP)-C. Surveyor asked IP-C why does the Infection Surveillance Monthly Report have residents being prescribed antibiotics and there aren't any signs or symptoms listed and there aren't diagnoses listed for the antibiotics. IP-C stated it's the PCC (point click care) program that does this and she is not sure why it doesn't completely fill it out. Surveyor asked IP-C who is responsible for filling the report out in PCC and she stated she is responsible. Surveyor asked IP-C what does Other mean in the infection rates. IP-C stated she wasn't sure. Surveyor explained to IP-C there isn't an Other infection so the infection rates data isn't not accurate and doesn't reflect the actual infections in the facility. Surveyor asked IP-C why wasn't R65 and R36 reflected on the outbreak line list. IP-C stated R36 was positive for coronavirus on a weekend and died on a weekend. IP-C stated she wasn't in the facility during the weekend and because R36 died she didn't think to add her on the outbreak line list or even the monthly surveillance report. IP-C stated she did not correlate R36 testing positive for corona virus to the current outbreak. Surveyor asked IP-C why is R65 not reflected in the outbreak line list. IP-C stated she didn't correlate R65 positive Covid to the current outbreak because the last person to be positive was on [DATE]. Surveyor asked IP-C if any signage was put up near the entrance or near the entrance to the affected unit (s). IP-C stated the individual residents had isolation signs but those were the only signs posted. On [DATE] at 1:30 p.m. Surveyor interviewed NHA (nursing home administrator)-A regarding the infection control program. Surveyor explained the concerns regarding the Surveillance Monthly report and infections not listed when a resident is prescribed an antibiotic. Surveyor explained the infection rates indicate an infection of Other and the infection rates are then inaccurate. Surveyor explained the concern with the documentation of the current Covid outbreak. Surveyor explained R36 and R65 are not reflected on the line list because IP-C did not see the correlation between the current outbreak and these two residents so they were not placed on the outbreak line list. Surveyor also explained there is no signage explaining there is a current Covid outbreak in the facility. NHA-A stated she understood the concerns. NHA-A stated IP-C has been in this position 4 months and is still learning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No additional information was provided. Surveyor: [NAME], [NAME] L. 2.) The Facility's Policy titled, Hand Hygiene dated ,d+[DATE] documents: Policy Explanation and Compliance Guidelines: . 2. Hand Hygiene is indicated and will be performed under conditions listed in, but not limited to, the attached hand hygiene table . 6. Additional considerations: 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 gloves . Hand Hygiene Table . Either Soap and Water or Alcohol Based Hand Rub (ABHR is preferred) . Between resident contacts After handling contaminated objects . Before applying and after removing personal protective equipment (PPE), including gloves . Surveyor observed breakfast service in the second-floor home dining room. On [DATE], at 08:22 AM, Surveyor observed Certified Nursing Assistant (CNA)-H with gloved hands touch a resident on the shoulder to wake her then pick up toast to put jelly on with both gloved hands. CNA-H was then observed to get another tray and touch another resident on the arm with gloved hands while serving them. On [DATE], at 08:23 AM, Surveyor observed CNA-H change gloves without washing hands or using alcohol based hand rub. On [DATE], at 08:24 AM, Surveyor observed CNA-H touch another resident on the shoulder then put clothing protector on the resident. CNA-H then took lids off drinks, cut food up, picked up toast to put jam on toast. CNA-H then took gloves off and used alcohol based hand rub. Surveyor noted that CNA-H did not wash her hands or changed gloves before touching ready to eat food and after touching non-sanitized food surfaces. On [DATE], at 01:54 PM, Surveyor interviewed Director of Nursing (DON)-B and asked about the expectation for hand hygiene related to meal tray passing in the dining room. DON-B stated the expectation is for gelling (alcohol based hand rub) before move onto next person and that staff should wear gloves if assisting with food. DON-B stated that staff should wash hands after ,d+[DATE] gels. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE], at 3:23 PM, during the daily exit meeting, Surveyor let the Nursing Home Administrator-A and the DON-B know of the concern related to hand hygiene during tray passing in the dining room. No additional information was provided. 49011

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 20025 Based on interview and record review the facility did not ensure 1 of 5 Certified Nursing Assistants (CNAs) reviewed received the required 12 hours of continuing competence training. This deficient practice has the ability to affect 90 residents whom could receive care from the CNA. CNA-M was hired on 10/31/22 and received only 4.5 hours of continuing competence training. Findings include: 1.) On 9/10/24, Surveyor obtained a sample of 5 CNAs to review for their 12 hours of continuing competence training. Surveyor reviewed CNA-M's training record. CNA-M was hired on 10/31/22 and her training hours indicate she only received 4.5 hours of continuing competence training. On 9/10/24 at 11:45 a.m., Surveyor interviewed DON (Director of Nursing)-B regarding CNA-M's continuing competence training. Surveyor asked DON-B if this the in-service hours provided for CNA-M were accurate. DON-B stated yes there isn't any other in-service hours for CNA-M. On 9/10/24 at 11:49 a.m., Surveyor interviewed NHA (Nursing Home Administrator)-A. Surveyor asked NHA-A who is responsible for ensuring CNAs attain their required continuing competence training hours. NHA-A stated their training department is responsible and emails her with CNAs who need to do their in-services. NHA-A stated CNA-M must have fell through the cracks and did not have the required 12 hours of continuing competence training complete. No additional information was provided as to why the facility did not ensure that CNA-M received the required 12 hours of continuing competence training.