STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525598	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Senior Community Inc	3505 County Road Y Sheboygan, WI 53083

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49010 Based on observation and resident and staff interview, the facility did not maintain the dignity of 3 residents (R) (R18, R23, and R50) in the dining room during meal time with the potential to affect more than 4 of 55 residents residing in the facility. R18's vital signs were obtained at the dining table during the lunch meal on 9/24/24. Medications were administered to residents at the dining table, including R23. Residents who sat at the same table were not served at the same time, including R50. Findings include: On 9/23/24 at 11:49 AM, Surveyor observed lunch service in the Oak dining room. There were thirteen residents in the dining room. Surveyor witnessed the following: ~ On 9/23/24 at 11:49 AM, staff obtained R18's blood pressure at the table with other residents present. Dining service had already started. ~ On 9/23/24 at 11:57 AM, staff administered medication to multiple residents while eating, including R23. ~ On 9/23/24 at 12:10 PM, four residents were served and 9 residents were without food. ~ On 9/23/24 at 12:35 PM, the last resident's food was served. All residents at the table had already finished eating. Dessert had not yet been served. On 9/24/24 at 7:45 AM, Surveyor observed breakfast service in the Maple dining room. There were seventeen residents in the dining room. Surveyor witnessed the following: ~ On 9/24/24 at 7:54 AM, five residents had food (three had yogurt, one had a sliced banana, and one had Cheerios). The other residents had drinks. ~ On 9/24/24 at 7:55 AM, staff administered medication to a resident. Medication pass continued throughout breakfast for multiple residents in the dining room. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ On 9/24/24 at 7:55 AM, Surveyor observed Dietary Aide (DA)-N cook and serve breakfast alone in the Maple dining room. DA-N prepared meals one by one while residents waited and watched each resident get served. ~ On 9/24/24 at 8:00 AM, one resident was served the first full breakfast. There were seventeen residents in the dining room waiting to eat. ~ On 9/24/24 at 8:44 AM, the last full breakfast was served. There were seven residents in the dining room. Ten residents had already eaten and left the dining room. On 9/24/24 at 1:11 PM, Surveyor observed the Oak dining room during lunch service and witnessed the following: On 9/24/24 at 1:11 PM, Surveyor observed Licensed Practical Nurse (LPN)-D obtain R18's vital signs at the dining table. First LPN-D took R18's blood pressure and then checked R18's oxygen level. While LPN-D took R18's vital signs, R18 had food on R18's plate and was unable to eat. On 9/24/24 at 8:25 AM, Surveyor interviewed DA-N who confirmed DA-N cooked and served residents one by one and often went table by table which took awhile. DA-N stated the cooking process was typically relaxed and confirmed taking an hour to serve the meal was typical. On 9/24/24 at 8:37 AM, Surveyor interviewed Anonymous Staff (AS)-Q who stated AS-Q heard complaints from residents that food took too long because it was served one table at a time. AS-Q stated it could take fifteen minutes between residents at the same table and it was typical for the meal service to take an hour in the dining room. On 9/24/24 at 1:14 PM, Surveyor interviewed LPN-D who confirmed LPN-D checked R18's blood pressure and oxygen level prior to administering R18's medication. LPN-D stated R18 was not in distress or ill. LPN-D conceded LPN-D shouldn't obtain residents' vital signs at the dining table. On 9/24/24 at 2:21 PM, Surveyor interviewed R18 who indicated R18 was unable to eat while staff checked R18's vital signs at meals. On 9/24/24 at 2:49 PM, Surveyor interviewed R50 who indicated R50 often waited for food. R50 indicated it felt awkward when one resident received their food and the others did not get theirs. R50 indicated R50 would like it if everyone received their meals at the same time. R50 stated R50 waited a half hour that morning for a toaster waffle and a banana. On 9/24/24 at 2:58 PM, Surveyor interviewed R23 who stated meals took awhile and R23 felt R23 waited too long. R23 stated receiving medication in the dining room made the facility feel more like a hospital than a home. On 9/25/24 at 9:35 AM, Surveyor interviewed Director of Nursing (DON)-B who stated vital signs should be obtained in a resident's room and not at the dining table, unless the resident is in distress. On 9/25/24 at 12:35 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-O who indicated when residents get antsy while waiting for food and other residents have food, CNA-O tells the cook to hurry up. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24 at 12:58 PM, Surveyor interviewed CNA-P who indicated sometimes residents gets anxious if their table partners don't receive their food at the same time and don't want to eat if others don't have food. CNA-P stated it can take awhile in between serving each resident their food and staff have to occupy residents while they wait. CNA-P indicated CNA-P sometimes asks kitchen staff to get a specific resident their meal because the resident has waited awhile and the other residents at the table have their food. On 9/25/24 at 1:11 PM, Surveyor interviewed LPN-G who indicated sometimes residents don't understand why one resident gets their food and others have to wait. LPN-G stated a resident mentioned to LPN-G that other residents received their food ten minutes prior and wondered why they didn't have their food. LPN-G stated LPN-G explained to the resident that the kitchen was working on making their meal.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff and resident representative interview, and record review, the facility did not ensure 1 resident (R) (R31) of 18 sampled residents and their activated Power of Attorney (POA) were offered care conferences and involved in continued care planning. R31's only care conference was completed on 9/17/21. Social Worker (SW)-C verified care conferences should be held yearly, when there is a change in a resident's condition, or if requested by a resident's family. Findings include: On 9/23/24, Surveyor reviewed R31's medical record. R31 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), epilepsy, and cognitive communication deficit. R31's Minimum Data Set (MDS) assessment, dated 7/31/24, indicated R31 had severely impaired cognition. R31 had an activated POA. R31's medical record did not indicate care conferences were offered or declined by R31's POA. On 9/23/24 at 11:58 AM, Surveyor interviewed R31's POA who indicated they were not involved with R31's plan of care and had not attended any care conferences since R31 was first admitted . R31's POA indicated they would like to have care conferences and did not know why the facility didn't have them. R31's POA stated they lived farther away, could not visit R31 daily, and needed time to set up appointments to work around their schedule. R31's POA indicated they would like to be a part of decision making for R31's care prior to the implementation of cares and goals by the facility. On 9/24/24 at 11:08 AM, Surveyor interviewed SW-C who confirmed R31 had only one care conference since R31 was admitted on [DATE]. SW-C indicated R31's POA was involved with communication on a regular basis and SW-C was waiting for R31's POA to return a message. SW-C indicated R31's POA didn't come to the facility often and was not interested in an official conference. SW-C indicated care conferences were held yearly, with a change in condition, or if requested by a resident's family. Surveyor requested the facility's care conference policy from SW-C. SW-C indicated SW-C did not think R31 should have gone 3 years without a care conference. SW-C confirmed there was no documentation to indicate care conferences were offered or decined. SW-C indicated the facility did not have a process for tracking care conferences but set up care conferences annually. SW-C indicated residents' care plans were updated when MDS assessments were completed. Surveyor did not receive a care conference policy from the facility as of this writing.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 32768 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R109) of 3 sampled residents signed and received a copy of the Skilled Nursing Facility Advanced Beneficiary Notice (ABN) form which is used to inform residents of their final day of Medicare Part A insurance coverage, potential liability for payment (daily cost of care and services at the facility), and standard claim appeal rights and instructions. The facility did not provide an ABN form (a document that explains financial liability, including the facility's daily rate for services) to R109 when R109's Medicare benefits ended on 5/16/24 and R109 remained in the facility. Findings include: The Centers for Medicare & Medicaid Services (CMS)-10055 Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (ABN) form indicates: The ABN provides information to the beneficiary so the beneficiary can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility .The ABN is only issued if the beneficiary intends to continue services and the Skilled Nursing Facility believes the services may not be covered under Medicare. From 9/23/24 to 9/25/24 Surveyor reviewed R109's medical record. R109 was provided a Notice of Medicare Non-Coverage (NOMNC) form that indicated services would end on 5/16/24. R109 remained in the facility and started Medicare Part A on 5/20/24. The facility provided a generated form that indicated the last day of Medicare coverage was 5/16/24 and private pay for room and board would be effective 5/17/24. The form did not include the appropriate information including standard claim appeals rights with instructions. On 9/25/24 at 9:02 AM, Surveyor interviewed Social Worker (SW)-C who indicated SW-C did not provided an ABN form for residents who remained in the facility. SW-C indicated the facility rarely had Medicare residents (and most were Medicare Advantage residents) so SW-C had not been providing the Medicare ABN form.

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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** 45942 Based on staff and resident representative interview and record review, the facility did not ensure 3 residents (R) (R1, R19 and R32) of 5 sampled residents received a written transfer notice that included the date of the transfer, the reason for the transfer, the location of the transfer, and appeal rights. R1 was transferred to the hospital on 8/7/24. Neither R1 or R1's Power of Attorney (POA) were provided with a written transfer notice. R19 was transferred to the hospital on 8/17/24. Neither R19 or R19's POA were provided with a written transfer notice. R32 was transferred to the hospital on 2/20/24. Neither R32 or R32's POA were provided with a written transfer notice. Findings include: The facility's Transfers and Discharges policy, dated 2/11/22, indicates: Involuntary Removal: 1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility .Residents will be transferred or discharged from Sheboygan Senior Community (SSC) only for medical reasons or for his or her welfare or that of other residents, and will be given reasonable advance notice to ensure orderly transfer or discharge, and such actions will be documented in the medical record. Residents will receive an explanation of the need for such transfers or discharges, except when there is a medical emergency .SSC has a system for reviewing complaints and/or allegations of violations of resident rights including involuntary discharge or transfer. A resident or resident representative does have the right to appeal any planned involuntary discharge or transfer. An individual must submit a signed written summary of the issue to the Administrator. If the complainant does not feel the matter has been resolved satisfactorily the individual may contact the Division of Health. 1. From 9/23/24 to 9/25/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, chronic kidney disease (CKD), and vascular dementia. R1's Minimum Data Set (MDS) assessment, dated 6/11/24, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R1 had severely impaired cognition. R1 had an activated POA. R1's medical record indicated R1 was transferred to the hospital on 8/7/24 for abdominal pain. R1's medical record did not indicate R1 or R1's POA were provided with a written transfer notice. On 9/23/24 at 10:48 AM, Surveyor interviewed R1's POA who did not recall receiving a transfer notice when R1 was transferred to the hospital on 8/7/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 9/23/24 to 9/25/24, Surveyor reviewed R19's medical record. R19 was admitted to the facility January 2024 with diagnoses including Alzheimer's disease, dementia, unsteadiness on feet, and weakness. R19's MDS assessment, dated 8/26/24, had a BIMS score of 4 out 15 which indicated R19 had severely impaired cognition. R19 had an activated POA. R19's medical record indicated R19 was transferred to the hospital on 8/17/24 due to a fall. R19's medical record did not indicate R19 or R19's POA were provided with a written transfer notice. 3. From 9/23/24 to 9/25/24, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including heart failure, CKD, and dementia. R32's MDS assessment, dated 2/29/24, had a BIMS score of 5 out 15 which indicated R32 had severely impaired cognition. R32's medical record indicated R32 was transferred to the hospital on 2/20/24 due to change in condition. R32's medical record did not indicate R32 or R32's POA were provided with a written transfer notice. On 9/24/24 at 10:49 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated Social Worker (SW)-C took care of written transfer notices when residents were transferred out of the facility. On 9/24/24 at 11:07 AM, Surveyor interviewed SW-C who indicated nursing staff were responsible for written transfer notices. SW-C indicated nursing staff clicked the form on the computer and provided the form to the resident at the time of the transfer. SW-C indicated SW-C gave Director of Nursing (DON)-B the information. On 9/25/24 at 9:10 AM, Surveyor interviewed DON-B who confirmed R1, R19, and R32 and/or their representatives were not provided with a written transfer notice. DON-B indicated written transfer notices should be provided to residents and/or their representatives when residents are transferred. On 9/25/24 at 9:35 AM, Surveyor interviewed DON-B who stated the transfer policy was in the facility's admission packet. DON-B confirmed DON-B did not know a written transfer notice should to be given to a resident or their representative each time a resident is transferred out of the facility. DON-B indicated DON-B thought the forms were sent with residents in the transfer packet. DON-B confirmed nursing staff were not aware and needed to be educated.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff and resident representative interview and record review, the facility did not ensure 3 residents (R) (R1, R19, and R32) of 4 sampled residents reviewed for hospitalization received written information on the duration of the bed-hold policy, the reserve bed payment policy, and the right to return to the facility. R1 was transferred to the hospital on 8/7/24. Neither R1 or R1's activated Power of Attorney (POA) were provided with a written bed-hold notice. R19 was transferred to the hospital on 8/17/24. Neither R19 or R19's POA were provided with a written bed-hold notice. R32 was transferred to the hospital on 2/20/24. Neither R32 nor R32's POA were provided with a written bed-hold notice. Findings include: The facility's Bed Hold, Readmission or Return to the Facility policy, dated 2/11/22, indicates: The facility shall inform and provide in writing to the resident and/or the resident's representative the facility's bed hold and return to the facility policy at the time of transfer .specifying the duration of the bed hold policy. Procedure: 1) The nurse will obtain the Bed Hold Policy and Return to Facility notice and provide the notice to the resident and their representative at the time of transfer .2) The nurse will ensure that a copy of the notice accompanies the resident when the resident leaves the facility. 3) The nurse will inform the resident representative, on the telephone, if necessary, about the bed hold and return to facility policy and ask how best to provide a copy of the notice to the representative, a) The nurse will inform the representative that the notice accompanied the resident at the time the resident left the facility, b) The nurse will document the provision of the Bed Hold Policy and Return to Facility notice to the resident and information given to the representative in the resident's record. 4) The Social Worker will contact the resident representative on the next working day to ensure that the representative understands the bed hold and return to facility information. 1. From 9/23/24 to 9/25/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, chronic kidney disease (CKD), and vascular dementia. R1's Minimum Data Set (MDS) assessment, dated 6/11/24, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R1 had severely impaired cognition. R1 had an activated POA. R1's medical record indicated R1 was transferred to the hospital on 8/7/24 for abdominal pain. R1's medical record did not indicate R1 or R1's POA were provided with a written bed-hold notice. On 9/23/24 at 10:48 AM, Surveyor interviewed R1's POA who did not recall receiving a bed-hold notice when R1 was transferred to the hospital on 8/7/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 9/23/24 to 9/25/24, Surveyor reviewed R19's medical record. R19 was admitted to the facility in January 2024 with diagnoses including Alzheimer's disease, dementia, unsteadiness on feet, and weakness. R19's MDS assessment, dated 8/26/24, had a BIMS score of 4 out 15 which indicated R19 had severely impaired cognition. R19 had an activated POA. R19's medical record indicated R19 was transferred to the hospital on 8/17/24 due to a fall. R19's medical record did not indicate R19 or R19's POA were provided with a written bed-hold notice. 3. From 9/23/24 to 9/25/24, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including heart failure, CKD, and dementia. R32's MDS assessment, dated 2/29/24, had a BIMS score of 5 out 15 which indicated R32 had severely impaired cognition. R32's medical record indicated R32 was transferred to the hospital on 2/20/24 due to change in condition. R32's medical record did not indicate R32 or R32's POA were provided with a written bed-hold notice. On 9/24/24 at 10:49 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated Social Worker (SW)-C took care of written bed-hold notices when residents were transferred out of the facility. On 9/24/24 at 11:07 AM, Surveyor interviewed SW-C who indicated nursing staff were responsible for bed-hold notices. SW-C indicated nursing staff clicked the form on the computer and gave the form to the resident prior to the transfer. SW-C indicated SW-C gave Director of Nursing (DON)-B the information. On 9/25/24 at 9:10 AM, Surveyor interviewed DON-B who confirmed R1, R19, and R32 did not receive written bed-hold notices. DON-B indicated bed hold notices should be provided to residents and/or their representatives when residents are transferred. On 9/25/24 at 9:35 AM, Surveyor interviewed DON-B who stated the bed-hold policy is in the facility's admission packet. DON-B confirmed DON-B did not know a written bed-hold notice should be given to a resident or their representative each time a resident is transferred out of the facility. DON-B indicated DON-B thought the forms were sent with the resident in the transfer packet. DON-B confirmed nurses were not aware and needed to be educated.

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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** 45942 Based on staff interview and record review, the facility did not ensure the care plan was reviewed and revised as needed for 1 resident (R) (R32) of 18 sampled residents. R32 had new diagnoses of cerebrovascular accident (CVA) (stroke) and Parkinson's disease. The facility did not revise R32's care plan to address R32's new diagnoses. Findings include: From 9/23/24 to 9/25/24, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] with diagnoses including heart failure, chronic kidney disease (CKD), and dementia. R32's Minimum Data Set (MDS) assessment, dated 2/29/24, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R32 had severely impaired cognition. R32 had an activated Power of Attorney (POA). R32's medical record indicated R32 was admitted to the hospital on 2/20/24 for a CVA and was readmitted to the facility on [DATE]. A progress note, dated 3/28/24, indicated R32 had a new diagnosis of Parkinson's disease. R32's care plan did not address R32's CVA or Parkinson's diagnosis. On 9/25/24 at 9:10 AM, Surveyor interviewed Director of Nursing (DON)-B who reviewed R32's care plan during the interview. DON-B confirmed R32's care plan did not address R32's new diagnoses of CVA and Parkinson's disease. DON-B indicated if a resident had a new diagnosis, the resident's care plan should be updated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R19) of 19 sampled residents received the necessary care and services to prevent or monitor weight loss. R19 had an order for weekly weights which were not consistently obtained and documented. In addition, R19 experienced a severe weight loss and the appropriate follow-up was not completed. Findings include: The facility's Weighing and Measuring the Resident policy, with a revised date of 3/2011, indicates: The purpose of this procedure is to determine the resident's weight and height, provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and provide a baseline height in order to determine the ideal weight of the resident .4. Weight is usually measured upon admission and monthly during the resident's stay .1. Report significant weight loss/gain to the nurse supervisor. 2. The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria (where percentage of body weight loss = (usual weight-actual weight)/(usual weight) x 100): a. 1 month - 5% weight loss is significant; greater than 5% is severe; b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe; c. 6 months - 10% weight loss is significant; greater than 10% is severe .4. Report other information in accordance with facility policy and professional standards of practice. Between 9/23/24 and 9/25/24, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, congestive heart failure (CHF), chronic kidney disease (CKD), and peripheral vascular disease (PVD). R19's Minimum Data Set (MDS) assessment, dated 8/26/24, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R19 had severely impaired cognition. R19 had an activated Power of Attorney for Healthcare (POAHC). R19's plan of care indicated R19's weight should be obtained on bath day which was on the Wednesday PM shift. R19's medical record indicated R19's physician ordered weekly weights and indicated R19 could have a nutritional supplement per dietary discretion on 1/23/24. On 9/25/24, Surveyor reviewed R19's weights and noted the following: ~ 9/11/24 - 153.4 pounds (lbs) ~ 8/28/24 - 166.8 lbs ~ 8/14/24 - 166 lbs ~ 8/11/24 - 166.2 lbs (continued on next page)

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	525598	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Senior Community Inc	3505 County Road Y Sheboygan, WI 53083

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ 8/07/24 - 160.8 lbs ~ 8/04/24 - 163 lbs ~ 7/31/24 - 171 lbs ~ 7/24/24 - 175.4 lbs ~ 7/17/24 - 163.8 lbs ~ 7/10/24 - 154.8 lbs ~ 7/03/24 - 168 lbs ~ 6/26/24 - 173.4 lbs ~ 6/23/24 - invalid weight noted ~ 6/19/24 - 173.2 lbs ~ 6/12/24 - 171 lbs ~ 6/05/24 - 170.8 lbs ~ 6/02/24 - 169 lbs ~ 5/22/24 - 168.2 lbs ~ 5/15/24 - 182.8 lbs ~ 5/08/24 - 168.2 lbs ~ 5/02/24 - 176.6 lbs ~ 4/24/24 - 175.4 lbs ~ 4/11/24 - 176 lbs ~ 4/07/24 - 167 lbs ~ 4/03/24 - 175.8 lbs ~ 3/27/24 - 177.8 lbs ~ 3/20/24 - 174.4 lbs ~ 3/13/24 - 174.6 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ 3/06/24 - 178.4 lbs ~ 2/28/24 - 176.6 lbs ~ 2/07/24 - 179 lbs ~ 1/31/24 - 177.2 lbs ~ 1/27/24 - 176.4 lbs ~ 1/25/24 - 175.8 lbs ~ 1/24/24 - 176.0 lbs ~ 1/23/24 - 175.6 lbs ~ 1/22/24 - 173.0 lbs ~ 1/21/24 - 175.4 lbs ~ 1/20/24 - 176.4 lbs ~ 1/19/24 - 178.4 lbs ~ 1/18/24 - 176.8 lbs ~ 1/17/24 - 177.8 lbs ~ 1/16/24 - 177 lbs ~ 1/15/24 - 176.4 lbs ~ 1/13/24 - 171.4 lbs ~ 1/12/24 - 178.6 lbs ~ 1/11/24 - 174.2 lbs ~ 1/10/24 - 170.9 lbs ~ 1/09/24 - 170.8 lbs The documented weights indicated R19 had a severe weight loss of 12.14% in 6 months. On 3/13/24, R19 weighed 174.6 lbs. On 9/11/24, R19 weighed 153.4 pounds (which was a -12.14 % weight loss). Surveyor noted there were missing weights on 2/14/24, 2/21/24, 4/17/24, 5/29/24, 8/21/24, 9/4/24, and 9/18/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R19's progress notes There were no progress notes that indicated R19's POAHC and the facility's dietitian were notified of R19's 9/11/24 weight loss. On 9/25/24 at 1:15 PM, Surveyor interviewed Director of Nursing (DON)-B who verified weights should be completed as ordered. DON-B stated DON-B and two other staff were responsible for reviewing weights. DON-B indicated the facility's system used red flags to indicate significant weight differences. DON-B stated the weight difference should be noted and the resident should be re-weighed to ensure the weight entered was correct. DON-B stated if the weight variance was correct, the resident's POAHC, physician, and the facility's dietitian should be notified. DON-B indicated there should be a progress note in R19's medical record to confirm notifications were completed. DON-B reviewed R19's weights and stated R19 had a 13-pound weight loss according to R19's 9/11/24 weight. DON-B stated R19's weight on 9/11/24 was red flagged and DON-B and the team must have missed it. DON-B indicated had DON-B caught the 9/11/24 red flagged 13-pound weight loss, DON-B would have had staff re-weigh R19. DON-B stated a 13-pound weight loss in two weeks should have been investigated and addressed even if the resident was on an end-of-life program or diuretic. DON-B also indicated staff should have weighed R19 on 9/18/24 as ordered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R208) of 5 sampled residents was monitored for adverse reactions or side effects of a high-risk medication. R208 was prescribed clopidogrel (an anticoagulant medication). R208's care plan did not contain monitoring interventions for adverse reactions or side effects of the high-risk medication. Findings include: According to medlineplus.gov, clopidogrel may cause side effects including, but not limited to: Excessive tiredness, dizziness, nausea, vomiting, stomach pain, diarrhea, nosebleed, hives, rash, itching, difficulty breathing or swallowing, swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower legs, black and tarry stools, red blood in stools, bloody vomit, vomit that looks like coffee grounds, unusual, bleeding or bruising, pink or brown urine, slow or difficult speech, weakness or numbness of an arm or a leg, changes in vision, shortness of breath, purple patches or bleeding under the skin, confusion, yellowing of the skin or eyes, or seizures. Between 9/23/24 and 9/25/24, Surveyor reviewed R208's medical record. R208 was admitted to the facility on [DATE] and had diagnoses including dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, left ventricular failure, ischemic cardiomyopathy, and peripheral vascular disease (PVD). R208's Minimum Data Set (MDS) assessment, dated 9/10/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R208 had intact cognition. R208's physician orders included clopidogrel 75 mg (milligrams) via gastric tube once daily (dated 9/4/24). R208's plan of care did not indicate R208 received anticoagulant medication. R208's Medication Administration Record (MAR) did not include monitoring orders for adverse reactions or side effects of clopidogrel. On 9/25/24 at 9:36 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who stated LPN-G was unaware of any place where medication side effects were documented, monitored, or listed in the R208's medical record. LPN-G stated if LPN-G needed to know a medication's side effects, LPN-G Googled or looked up the medication in a reference book. LPN-G indicated the facility's medication monitoring was focused on behavior tracking and not side effects. On 9/25/24 at 9:00 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed side effect monitoring was not consistently in place for residents who receive high-risk medications. DON-B confirmed interventions should be in the resident's medical record for staff to monitor and be aware of side effects.

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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** 50479 Based on record review and staff interview, the facility did not ensure 4 residents (R) (R17, R45, R46, and R6) of 5 sampled residents who received psychotropic medication were monitored for adverse reactions or side effects of the medication. R17 was prescribed lorazepam (an antianxiety medication), sertraline (an antidepressant medication), and quetiapine (Seroquel) (an antipsychotic medication). R17's plan of care did not indicate R17 was monitored for adverse reactions or side effects of the medications. R45 was prescribed Seroquel. R45's plan of care did not indicate R45 was monitored for adverse reactions or side effects of the medication. R46 was prescribed lorazepam, sertraline, and quetiapine (Seroquel). R46's plan of care did not indicate R46 was monitored for adverse reactions or side effects of the medications. R6 was prescribed lorazepam, sertraline, and mirtazapine (an antidepressant medication also used for appetite). R6's plan of care did not indicate R6 was monitored for adverse reactions or side effects of the medications. Findings include: The facility's Medication Utilization and Prescribing-Clinical Protocol policy, dated 2001, indicates: The staff and physician will identify and address unexpected, unintended, undesirable, or excessive responses to a medication based on the severity of underlying conditions, the seriousness of any adverse drug reactions, risk of worsening of medical conditions, and other factors .The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to ensure the medication and dosage are still relevant and not causing undesired complications. The facility's Antipsychotic Medication Use policy, dated July 2022, indicates: .17. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: a. General/anticholinergic: Constipation, blurred vision, dry mouth, urinary retention, sedation; b. Cardiovascular: orthostatic hypotension, arrhythmias; c. Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; d. Neurologic: akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke or TIA. The Abnormal Involuntary Movement Scale (AIMS) is a 12 item clinician-rated scale widely used to assess for the presence and severity of dyskinesias in residents taking antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Medlineplus.gov: lorazepam may cause side effects including, but not limited to: Drowsiness, dizziness, weakness, unsteadiness, diarrhea, nausea, changes in appetite, restlessness or excitement, constipation, blurred vision, ringing in your ears, anxiety, memory problems, difficulty concentrating, sleep problems, seizures, shaking, muscle twitching, changes in mental health, aggression, depression, burning or prickling feeling in your hands, arms, legs or feet, seeing or hearing things that others do not see or hear, thoughts of harming or killing yourself or others, overexcitement, or losing touch with reality. According to Medlineplus.gov: mirtazapine may cause side effects including, but not limited to: Drowsiness, dizziness, anxiousness, confusion, increased weight and appetite, dry mouth, constipation, nausea, vomiting, flu-like symptoms (fever, chills, sore throat, mouth sores, other signs of infection), chest pain, fast heartbeat, seizures, new or worsening depression, thinking about harming or killing yourself or planning or trying to do so, extreme worry, agitation, panic attacks, difficulty falling asleep or staying asleep, aggressive behavior, acting without thinking, severe restlessness, and frenzied abnormal excitement. According to Medlineplus.gov: sertraline may cause side effects including, but not limited to: Nausea, diarrhea, constipation, vomiting, dry mouth, heartburn, loss of appetite, weight changes, dizziness, excessive tiredness, nervousness, uncontrollable shaking of a part of the body, excessive sweating, seizures, abnormal bleeding or bruising, hallucinations, fever, confusion, fast heartbeat, shivering, severe muscle stiffness or twitching, loss of coordination, rash, hives, swelling, difficulty breathing, new or worsening depression, thinking about harming or killing yourself or planning or trying to do so, extreme worry, agitation, panic attacks, difficulty falling asleep or staying asleep, aggressive behavior, irritability, acting without thinking, severe restlessness, and frenzied abnormal excitement. According to Medlineplus.gov, Seroquel may cause side effects, including but not limited to: Dizziness, feeling unsteady, or having trouble keeping your balance, pain in the joints, back, neck, or ears, dry mouth, vomiting, constipation, stomach pain or swelling, increased appetite, excessive weight gain, irritability, difficulty thinking or concentrating, difficulty speaking or using language, unusual dreams, numbness, burning, or tingling in the arms or legs, fainting, seizures, changes in vision, uncontrollable movements of your arms, legs, tongue, face, or lips, painful erection of the penis that lasts for hours, excess sweating, fast or irregular heartbeat, unusual bleeding or bruising, difficult or painful urination, or other signs of infection, hives, rash, blisters, tightening of the neck muscles or the throat, tongue sticking out, difficulty breathing, or swallowing. 1. From 9/23/24 to 9/25/24, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. R17's Minimum Data Set (MDS) assessment, dated 6/11/24, indicated R17 had severe cognitive impairment. R17 had an activated Power of Attorney for Healthcare (POAHC). R17's medical record contained the following physician orders: ~ Quetiapine 25 milligrams (mg) twice daily (dated 3/4/24) ~ Sertraline 75 mg once daily (dated 11/1/23) ~ Lorazepam 0.5 mg at bedtime (dated 6/14/24) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Lorazepam 0.5 mg one to two tablets as needed (PRN): one tablet for mild to moderate anxiety or terminal restlessness; two tablets for severe anxiety or terminal restlessness (dated 6/24/24) R17's care plan, dated 2/26/24, indicated R17 received psychotropic medication for Alzheimer's disease, anxiety, and depression and required ongoing monitoring for effectiveness and adverse effects of the medications. R17's medical record did not contain monitoring interventions for adverse reactions or side effects of quetiapine, sertraline, or lorazepam. In addition, R17 did not have a baseline or ongoing assessments for the medications. On 9/24/24 at 1:39 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff and providers monitor residents for side effects of psychotropic medication, but it is not routinely documented in residents' medical records. On 9/25/24 at 9:36 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who indicated psychotropic medication monitoring was completed by observing the resident's behavior and monitoring for sleepiness. LPN-G indicated psychotropic medication monitoring was focused on behavior rather than potential adverse drug reactions. LPN-G indicated residents' medical records had an automatic notification that prompted nursing staff to document behaviors every shift if the resident received antipsychotic medication. LPN-G showed Surveyor the prompt which read, Behavior charting every shift, please document refusals and aggressive behaviors. (Of note, R17 did not have the prompt in R17's medical record.) LPN-G indicated it was not routine practice to document monitoring for adverse drug reactions of antipsychotic medication and stated if an adverse drug reaction was identified, it would be documented in the resident's progress notes. LPN-G was unaware of any place in the medical record where potential adverse reactions to medication were listed for nursing staff to reference. LPN-G indicated if LPN-G needed to know potential medication side effects, LPN-G searched the Internet or used a reference book. 45942 2. On 9/24/24, Surveyor reviewed R46's medical record. R46 was admitted to the facility on [DATE] with diagnoses including Alzheimer disease, depression, agitation, and restlessness. R46's MDS assessment, dated 9/13/24, had a BIMS score of 5 out of 15 which indicated R46 had severe cognitive impairment. R46 had an activated Power Of Attorney (POA). R46's medical record contained the following physician orders: ~ Lorazepam oral tablet 0.5 mg give 0.25 mg twice daily ~ Sertraline oral tablet 50 mg once daily ~ Quetiapine oral tablet 50 mg twice daily R46's plan of care did not contain monitoring interventions for adverse reactions or side effects of lorazepam, sertraline, or quetiapine. R46's medical record also did not contain a baseline or ongoing assessments. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/24 at 11:32 AM, Surveyor interviewed DON-B confirmed DON-B was unable to locate assessments for R46. 48794 3. Between 9/23/24 and 9/25/24, Surveyor reviewed R45's medical record. R45 was admitted to the facility on [DATE] and had diagnoses including dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, panic disorder, adjustment disorder with mixed and anxiety and depressed mood, anxiety disorder, and cognitive communication deficit. R45's MDS assessment, dated 9/10/24, had a BIMS score of 15 out of 15 which indicated R45 had intact cognition. R45 had a physician order for Seroquel 25 mg once daily for visual hallucinations (dated 7/23/24). R45's medical record did not contain monitoring interventions for adverse reactions or side effects of Seroquel. On 9/25/24 at 9:00 AM, Surveyor interviewed DON-B who confirmed the facility did not have side effect monitoring in place for R45. DON-B stated R45's medical record should contain interventions for staff to monitor and be aware of adverse reactions and side effects of the antipsychotic medication. 49010 4. Between 9/23/24 and 925/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including anxiety, major depression, heart failure, atrial fibrillation, abnormal weight loss, and anorexia. R6's MDS assessment, dated 6/17/24, had a BIMS score of 15 out of 15 which indicated R6 had intact cognition. R6's medical record contained the following physician orders: ~ Lorazepam 0.5 mg by mouth at bedtime ~ Mirtazapine 30 mg by mouth at bedtime ~ Sertraline 50 mg by mouth once daily. R6's plan of care indicated staff were to monitor for side effects of medication, but did not indicate what side effects were possible and what specifically to monitor for. R6's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include information for staff to monitor R6 for adverse reactions or side effects of the medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure the individual designated as the food and nutritional services director met the minimum qualifications for the role. This had the potential to affect all 55 residents residing in the facility. Dietary Manager (DM)-H did not complete an approved dietary manager or food service manager certification course or other related education. Findings include: On [DATE] at 9:04 AM, Surveyor interviewed DM-H who indicated DM-H worked in the facility for several years and had been the Dietary Manager for 3 to 4 years. DM-H indicated DM-H was ServSafe certified; however, DM-H's certification expired in August and DM-H had not renewed it. DM-H indicated DM-H was not currently enrolled in a dietary or food service manager certification course. On [DATE] at 3:40 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed DM-H was not certified or enrolled in a certified training program. NHA-A stated it was not in the facility's budget to get DM-H certified.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48794 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect 54 of 55 residents residing in the facility. Cooling temperature logs were not completed for leftover and pre-made food. Staff did not consistently monitor or document cooked food temperatures or hot/cold holding temperatures. Staff did not consistently test or document parts per million (PPM) of the quaternary sanitizing solution per manufacturer's instructions. Staff did not monitor and document dishwasher and surface temperatures. Staff did not follow procedures for reheating food in a microwave. Staff did not wear hair restraints when entering the kitchen where resident food was prepared. Staff did not perform appropriate hand hygiene and safe food handling practices when serving food. Findings include: On 9/23/24 at 9:04 AM, Surveyor completed an initial tour of the kitchen with Dietary Manager (DM)-H who stated the facility followed the Federal Food Code. Cooling Temperatures: The 2022 Federal Food and Drug Administration (FDA) Food Code documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celsius (C) (135 Fahrenheit (F)) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less. The 2022 FDA Food Code section 3-501.15 documents at Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Food Preparation and Service policy indicates: Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices .1. Potentially hazardous foods are cooled rapidly. This is defined as cooling from 135 degrees F to 70 degrees F within two hours and then to a temperature of 41 degrees F or below within the next 4 hours. The total cooling time between 135 degrees F to 41 degrees F is not to exceed 6 hours .2. Large or dense foods are cooled using special interventions in order to meet the time and temperature requirements for cooling. During an initial tour of the kitchen that began at 9:04 AM on 9/23/24, Surveyor observed multiple containers in the cooler, including sauerkraut, tuna salad, stuffing, and chili. DM-H confirmed the contents were leftover meals or pre-made meals for resident consumption. DM-H stated the facility did not maintain a cooling log to ensure appropriate cooling methods were followed for leftover or pre-made food. Food Holding Temperatures: The 2022 FDA Food Code documents at section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding .Time/Temperature Control for Safety Food shall be maintained: (1) At 57 Celsius (C) (135 Fahrenheit (F)) or above, except that roast cooked to a temperature and for a time specified in 3-401.11 (B) or reheated as specified in 3-403.11 (E) may be held at a temperature of 54 C (130 F) or above; (2) At 5 C (41 F) or less. In a January 2001 report, the National Advisory Committee on Microbiological Criteria for Foods (NACMCF) recommended the minimum hot holding temperature specified in the Food Code: Be greater than the upper limit of the range of temperatures at which Clostridium perfringens (C. perfringens) and Bacillus cereus (B. cereus) may grow; and provide a margin of safety that accounts for variations in food matrices, variations in temperature throughout a food product, and the capability of hot holding equipment to consistently maintain product at a desired target temperature. C. perfringens have been reported to grow at temperatures up to 52 C (126 F). Growth at this upper limit requires anaerobic conditions and follows a lag phase of at least several hours. The literature shows that lag phase duration and generation times are shorter at incubation temperatures below 49 C (120 F) than at 52 C (125 F). Studies also suggest that temperatures that preclude the growth of C. perfringens also preclude the growth of B. cereus. The Centers for Disease Control and Prevention (CDC) estimates that approximately 250,000 foodborne illness cases can be attributed to C. perfringens and B. cereus each year in the United States. These spore-forming pathogens have been implicated in foodborne illness outbreaks associated with foods held at improper temperatures. This suggests that preventing the growth of these organisms in food by maintaining adequate hot holding temperatures is an important public health intervention. Taking into consideration the recommendations of NACMCF and the 2002 Conference for Food Protection meeting, the FDA believes maintaining food at a temperature of 57 C (135 F) or greater during hot holding is sufficient to prevent the growth of pathogens and is therefore an effective measure in the prevention of foodborne illness. (continued on next page)

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	525598	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheboygan Senior Community Inc	3505 County Road Y Sheboygan, WI 53083

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2022 FDA Food Code documents at section 3-401.11 Raw Animal Foods: (A) Except as specified under (B) and in (C) and (D) of this section, raw animal foods such as eggs, fish, meat, poultry, and food containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one of the following methods based on the food that is being cooked .Internal Cooking Temperature Specifications for Raw Animal Foods .Raw eggs cooked for immediate service, fish, intact meat, except whole meat roasts and whole muscle intact beef steak at 145 F for 15 seconds .Commercially raised game animals, rabbits at 155 F for 17 seconds .Non-intact meats and raw eggs not for immediate service, wild game animals, poultry, stuffed fish, meat, pork, pasta, ratites, stuffing containing fish, meat, ratites, and poultry at 165 F for greater than 1 second. The 2022 FDA Food Code documents at section 3-403.11: .(C) and (D) Food that is taken from a commercially processed, hermetically sealed container or intact package cooked to a temperature of 135 F. From 9/23/24 through 9/25/24, Surveyor reviewed cooking logs for breakfast, lunch, and dinner from 9/1/24 through 9/22/24. Surveyor noted staff did not consistently document cooking temperatures for 43 of 66 meals served. On 9/23/24 at 11:54 AM, Surveyor observed dining service on the Hickory household. Surveyor noted staff did not check the temperature of the food prior to serving. Surveyor also noted a hot holding cart that contained food near the steam table was not plugged in. On 9/23/24 at 12:29 PM, Surveyor interviewed Dietary Aide (DA)-I and DA-J. DA-J stated the facility used to check hot and cold holding temperatures but staff were told they no longer needed to. DA-J and DA-I were unable to state why the facility stopped checking holding temperatures. On 9/23/24 at 11:45 AM, Surveyor observed dining service on the Maple household. Surveyor noted staff did not check the temperature of the food prior to serving. At 12:37 PM (which was the end of dining service), Surveyor asked DA-L to check the food temperatures of two trays and noted the following: ~ Mashed potatoes -126.1 degrees F ~ Three bean salad - 49.6 degrees F ~ Banana pudding - 48 degrees F ~ Cabbage roll - 125.1 degrees F ~ Cheesy potatoes- 130 degrees F ~ Carrots - 115.7 degrees F At 12:44 PM, Surveyor interviewed DA-L who stated DA-L did not know if the temperatures were within standards for food safety. DA-L stated DA-L had never temped food before and had not received training on checking temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an initial tour of the kitchen that began at 9:04 AM on 9/23/24, Surveyor reviewed food cooking and holding temperature logs with DM-H and noted missing entries. DM-H acknowledged the missing temperatures and indicated temperatures should be documented by the cook when the food is removed from the oven. DM-H stated staff do not complete holding temperatures because all food goes directly from the oven to the hot holder and is sent to the households to be served. Sanitizing Solution: The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. The facility's undated Sanitization policy indicates: The food service area is maintained in a clean and sanitary manner .6. Manual washing and sanitizing is a three-step process for washing, rinsing and sanitizing .c. Sanitize with hot water (at least 171 degrees F for 30 seconds) or chemical sanitizing solution. Chemical sanitizing solutions are used according to manufacturer's instructions. During an initial tour of the kitchen that began at 9:04 AM on 9/23/24, Surveyor reviewed the sanitization logs for the three-compartment sink with DM-H. The logs contained 10 entries for July 2024, 4 entries for August 2024, and 4 entries for September 2024. DM-H acknowledged the inconsistencies and stated the log should be completed each time the sink is filled which should be prior to each meal or when the water is dirty. Dishwasher/Surface Temperature Monitoring: The 2022 FDA Food Code documents at Section 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature: (A) The temperature of the wash solution in spray type warewashers that use hot water to sanitize may not be less than: (1) For a stationary rack, single temperature machine, 74 C (165 F); (2) For a stationary rack, dual temperature machine, 66 C (160 F); (3) For a single tank, conveyor, dual temperature machine, 71 C (160 F) or (4) For a multi-tank, conveyor, multi-temperature machine, 66 C (150 F). The 2022 FDA Food Code documents at 4-302.13 Temperature Measuring Devices, Manual Warewashing: Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature of the water used. A temperature measuring device is essential to monitor manual warewashing and ensure sanitization. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required 71 C (160 F). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 71 C (160 F). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 71 C (160 F). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Sanitization policy indicates: The food service area is maintained in a clean and sanitary manner .5. Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are: High-Temperature Dishwasher (Heat Sanitization): (1) Wash temperature (150F -165F); and (2) Rinse temperature (180F) (160F at the rack level/dish surface reflects 180F at the manifold which is the area just before the final rinse nozzle where the temperature of the dish machine is measured); or 165F for a stationary rack, single temperature machine. During an initial tour of the kitchen that began at 9:04 AM on 9/23/24, Surveyor reviewed surface temperature logs and noted 10 entries for August 2024 and 5 entries for September 2024. DM-H stated test strips should be run through the dishwasher once per day. From 9/23/24 to 9/25/24, Surveyor requested to review dishwasher temperature logs for the main kitchen and the household dishwashers. The logs were not provided. Microwave Heating: The 2022 FDA Food Code documents at 3-403.11 Reheating for Hot Holding: (A) Except as specified under (B) and (C) and in (E) of this section, Time/Temperature Control for Safety food that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees for 15 seconds. (B) Except as specified under (C) of this section, Time/Temperature Control for Safety food reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees Fahrenheit and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. The facility's undated Food Preparation and Service policy indicates: Previously cooked food is reheated to an internal temperature of 165F for at least 15 seconds before holding for hot service. On 9/23/24 at 11:54 AM, Surveyor observing dining service in the Hickory household. Surveyor observed DA-I reheat soup for a resident. DA-I reheated the soup for 30 seconds, stirred the soup, and reheated the soup for another 30 seconds. DA-I then served the soup to the resident without checking the temperature. On 9/23/24 at 12:29 PM, Surveyor interviewed DA-I who acknowledged DA-I did not check the temperature of the soup before serving. DA-I stated staff used to temp check all reheated items, but no longer do that. Hair Restraints: The 2022 FDA Food Code documents at 2-402.11: Food Employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively to keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy indicates: Food and nutritional services employees follow appropriate hygiene and sanitary procedures to prevent the spread of food borne illness .All employees who handle, prepare or serve food are trained in the practice of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents .Hairnets or caps and/or beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. On 9/24/24 at 8:14 AM, Surveyor observed Certified Nursing Assistant (CNA)-M in the kitchen without a hair restraint where food for resident consumption was being prepared. On 9/24/24 at 8:16 AM, Surveyor observed Nursing Home Administrator (NHA)-A in the main kitchen without a hair restraint. Surveyor observed NHA-A walk through the dish area into the cooking area past the hairnet station and stand approximately 3 feet into the cooking area where food for resident consumption was being prepared. On 9/24/24 at 8:30 AM, Surveyor interviewed CNA-M who stated CNA-M usually tried to get the attention of staff in the kitchen and did not enter the kitchen. CNA-M confirmed CNA-M should have donned a hair restraint when entering the kitchen. On 9/24/24 at 9:03 AM, Surveyor interviewed NHA-A who stated NHA-A was not required to wear a hairnet because NHA-A stood in the doorway and was not all the way into the kitchen. Hand Hygiene: The 2022 FDA Food Code documents at 2-301.14: Food Employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. The 2022 FDA Food Code documents at 3-301.11 Preventing Contamination from Hands: (A) Food Employees shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, Food Employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. The facility's undated Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy indicates: Food and nutritional services employees follow appropriate hygiene and sanitary procedures to prevent the spread of food borne illness .All employees who handle, prepare or serve food are trained in the practice of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents .Gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands washed and gloves are replaced: .a. after direct contact with residents; b. after assisting medical treatments; c. between handling raw meats and ready-to-eat-foods; and d. between handling soiled and clean dishes .The use of disposable gloves does not substitute for proper handwashing .Food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/23/24 at 11:54 AM, Surveyor observed dining service on the Hickory household. Surveyor observed DA-J don gloves without completing hand hygiene. DA-J touched a hot dog bun and a baked bread roll and plated three plated with gloved hands. DA-J then removed gloves and donned new gloves without completing hand hygiene. DA-J touched baked bread rolls, cut breaded chicken with a knife, and picked up a hamburger bun with gloved hands. DA-J then removed gloves and donned new gloves without completing hand hygiene. DA-J opened the hot holding door with a gloved hand and touched a hamburger bun with the same gloved hand. DA-J also plated food and touched breaded chicken, a baked bread roll, and another breaded chicken breast with the same gloved hands. DA-J then removed gloves and donned new gloves without completing hand hygiene. DA-J touched a breaded chicken breast, DA-J's glasses, serving cards, and a grilled cheese sandwich with gloved hands. DA-J then removed gloves and did not complete hand hygiene. On 9/23/24 at 12:29 PM, Surveyor interviewed DA-J who stated proper hand hygiene is to perform hand hygiene between glove changes. DA-J confirmed DA-J did not wash DA-J's hands during dining service.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50988 Based on staff interview and record review, the facility did not acquire a current contract/agreement in writing for outside dialysis services for 1 resident (R) (R360) of 1 resident reviewed for dialysis services. R360's physician orders indicated R360 received dialysis three times per week. The facility did not have a current contract or agreement with the dialysis provider. The facility also did not have a policy related to dialysis treatment. Findings include: On 9/24/24, Surveyor reviewed R360's medical record. R360 was admitted to the facility on [DATE] with diagnoses including hypertensive chronic heart and kidney disease with stage 5 renal disease. R360 received hemodialysis three times weekly. On 9/24/24 at 11:15 AM, Surveyor requested the dialysis contract/agreement from Health Services Specialist (HSS)-F for R360's renal dialysis. HSS-F indicated the facility did not have a contract with the dialysis center. When Surveyor requested a policy and procedure for dialysis, HSS-F indicated the facility did not have a policy and procedure for dialysis. On 9/24/24 at 1:20 PM, Surveyor requested the dialysis contract/agreement from Nursing Home Administrator (NHA-A) for R360's renal dialysis. NHA-A indicated the facility did not have a contract with the dialysis center and did not know a contract was required. When Surveyor requested the facility's policy and procedure for dialysis, NHA-A indicated the facility did not have a policy and procedure. NHA-A indicated NHA-A did not know a policy and procedure was required and stated the facility did not usually have dialysis patients.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 50479 Based on staff interview and record review, the facility did not ensure minimum required members of the Quality Assessment and Assurance (QAA) committee met at least quarterly. The facility did not have documentation that indicated the minimum required members of the QAA committee met at least quarterly. As of 9/25/24, the facility's most recent QAA committee meeting with all required members in attendance was on 6/12/23. Findings include: On 9/24/24, Surveyor requested the facility's policy and procedure for Quality Assurance and Performance Improvement (QAPI). Director of Nursing (DON)-B provided Surveyor with an undated QAPI Plan which was worded in the style of a template and did not describe the facility's specific QAPI policy and procedure. The QAPI Plan did not designate staff (including the DON, Medical Director or designee, the Infection Preventionist, and at least 3 other staff members one of whom was the Nursing Home Administrator (NHA), owner, board member, or other individual in a leadership role) required to participate in the QAPI committee and did not establish the frequency of QAPI committee meetings. The QAPI Plan also did not outline how the facility developed, monitored, or evaluated quality indicators. On 9/24/24 at 8:49 AM, Surveyor reviewed the facility's QAA committee meeting sign in sheets and noted the following: ~ The 2023 2nd quarter meeting, dated 6/12/23, had all required members in attendance. ~ The QAA committee did not meet for the 3rd quarter (July, August, and September) of 2023. ~ The 2023 4th quarter meeting, dated 11/2/23, did not include the Medical Director or designee. ~ The 2024 1st quarter meeting, dated 3/29/24, did not include sufficient staff members. ~ The QAA committee did not meet for the 2nd quarter (April, May, and June) of 2024. ~ The 2024 3rd quarter meeting, dated 8/8/24, did not include the Infection Preventionist. On 9/25/24 at 10:14 AM, Surveyor interviewed NHA-A who confirmed the QAA committee meeting sign in sheets accurately reflected the committee's meeting dates and attendance.

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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. 32768 Based on staff interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe and sanitary environment and prevent the transmission of communicable disease and infection. This practice had the potential to affect all 55 residents residing in the facility. The facility did not appropriately monitor residents and staff for infections and outbreaks. Findings include: The facility's Surveillance for Infections policy, dated 9/2017, indicates: The Infection Preventionist (IP) will conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiological significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions .1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiological significant organisms and HAIs to guide appropriate interventions and prevent future infections .4. For targeted surveillance using facility-created tools, follow these guidelines. a. Daily (as indicated): record detailed information about the resident and infection on an individual infection report form; b. Monthly: Collect information from individual resident reports and enter line listing of infections by resident for the entire month; c. Monthly: Summarize monthly data for each nursing unit by site and by pathogen; d. Monthly/Quarterly: Identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends. Calculating Infection Rates: 1. Obtain the month's total resident days from the business office. The following days is used as the denominator to calculate the monthly infection rate: Total resident days (daily census of each day in the designated time period added together). 2. To determine the incidence of infection per 1000 residents days, divide the number of new HAIs for the month by total resident days for the month x 1000. From 9/23/24 to 9/25/24, Surveyor reviewed the facility's infection line lists for residents and staff. The facility provided Surveyor with a partial line list for residents with random dates and months for infections from February 2024 to September 2024. The line list did not include symptoms, labs, and dose or duration of antibiotics used. The line list also did not track and trend infections or contain monthly infection rates or percentages. In addition, the facility provided a staff illness line list for August 2024. The line list contained two staff and no return to work dates. On 9/25/24 at 9:12 AM, Surveyor interviewed Director of Nursing (DON)-B who verified the line lists and antibiotic tracking were incomplete. DON-B indicated DON-B started at the facility on 7/8/24 and was assigned the IP role along with another Registered Nurse (RN). DON-B indicated DON-B looked at previous line lists which also contained gaps but did not provide the line lists to Surveyor. DON-B indicated DON-B just started infection control training and had only completed two modules so far.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 32768 Based on staff interview and record review, the facility did not ensure a staff person designated as the Infection Preventionist (IP) completed specialized training in infection prevention and control. This practice had the potential to affect all 55 residents residing in the facility. Director of Nursing (DON)-B and Registered Nurse (RN)-E were the facility's designated IPs and did not complete specialized training in infection prevention and control. Findings include: The facility's Infection Preventionist policy, dated 9/2017, indicates: The IP is responsible for coordinating the implementation and updating of the infection control program. Qualifications: 1. The IP is qualified by education, training, experience and/or certification and has sufficient knowledge to perform the role 2. The IP remains current with infection prevention and control issues and is aware of national organizations guidelines as well as those from national/state/local and public health authorities. 3. Evidence of training is provided through a certificate(s) of completion or equivalent documentation. On 9/25/24 at 9:12 AM, Surveyor interviewed DON-B who indicated DON-B started at the facility on 7/8/24 and was assigned the IP role. DON-B indicated DON-B started IP training recently and had only finished 2 modules. DON-B indicated another nurse would also be completing the training. DON-B indicated the other nurse would assume the IP role and DON-B would oversee the program. On 9/25/24 at 9:20 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the facility did not have a qualified IP. NHA-A indicated the former DON and IP submitted a 30-day notice and ended employment with the facility on 6/30/24. NHA-A indicated NHA-A hired DON-B and planned to have a consultant monitor DON-B. NHA-A indicated DON-B should have been on board sooner with the infection prevention and control program and stated the facility had a plan moving forward to have DON-B and another nurse maintain the program.