STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525602	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenhaven	612 E Oak St Glenwood City, WI 54013

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48793 Based on interview and record review, the facility did not develop and implement a comprehensive person-centered care plan addressing medical and nursing needs for residents on blood thinners and bleeding risk. This occurred for 1 of 2 residents (R) reviewed (R3). Findings include: R3 was admitted on [DATE]. R3's diagnoses include unspecified dementia, chronic atrial fibrillation, and essential hypertension. R3's Minimum Data Set (MDS) assessment, completed on 10/22/24, confirmed R3 is currently using an anticoagulant daily for the last 7 days. R3's care plan was reviewed and did not have an anticoagulant/ bleeding risk care plan in place. R3's physician orders indicated: -Warfarin oral tablet 5mg, give 1 tab one time a day every Tuesday, Wednesday, Thursday, Saturday, and Sunday for atrial fibrillation. -Warfarin oral tablet 7.5mg, give 1 tablet by mouth one time a day Monday, and Friday for atrial fibrillation. On 12/09/24 at 12:23 PM, Surveyor interviewed R3's Power of Attorney (POA) I and asked about R3's medication regimen. POA I indicated that POA I is concerned that R3 is not receiving proper care for certain medications R3 is on such as anticoagulant therapy. POA I indicated that R3 is on Warfarin. On 12/10/24 at 7:29 AM, Surveyor interviewed Registered Nurse (RN) E and asked RN E if RN E assessed R3 for possible risk of bleeding and where would Surveyor find the assessments in the Electronic Health Record (EHR). RN E indicated that RN E assesses R3's skin for any bleeding issues, but there is no set assessment documentation in the EHR. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 3:07 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C and asked how the facility assesses R3 for bleeding risk since R3 is on anticoagulant therapy. ADON C indicated that R3 received INR draw when physician orders. Surveyor asked how staff are to know that R3 could be a potential bleeding risk without R3 having an anticoagulant/bleeding risk care plan. ADON C indicated R3 does not have a care plan for bleeding risk being on anticoagulation in place. ADON C indicated that staff have no way to know to monitor for bleeding risk and that expectation is for staff to be monitoring R3 for bleeding risk.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation, interview and record review, the facility did not provide care consistent with professional standards to prevent development of a pressure injury (PI) for one of three residents (R) reviewed for pressure injuries (R2) R2 was admitted to the facility on [DATE], with no skin impairments and developed a stage 2 pressure injury to the coccyx area (tailbone), which remains unhealed, has lack of timely care plan interventions, and lack of repositioning. Findings include: According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, 2019, Reposition all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated. Determine repositioning frequency with consideration to the individual's level of activity and ability to independently reposition. Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved. According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, 2019, A pressure injury is defined as localized damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence but may also be related to a device or other object. R2 was admitted to the facility on [DATE] with the following diagnoses, in part, chronic obstructive pulmonary disease with (acute) lower respiratory infection, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unilateral primary osteoarthritis, left hip. On 12/09/24 at 11:01 AM, Surveyor interviewed R2, who acknowledged he had pain on his bottom by nodding yes to the question, Do you have any pain at or around your bottom area? R2's admission Minimum Data Set (MDS) assessment dated [DATE] stated R2 was completely dependent on caregivers for all Activities of Daily Living (ADLs) and all mobility. The MDS assessment also identified R2 was at risk for the development of pressure injuries but had no current unhealed pressure injuries. Under the skin and ulcer treatment section of the MDS assessment, No was marked for turning/repositioning program, and nutrition or hydration program to manage skin problems. There were no refusals or rejection of cares documented on the MDS. R2's admission MDS assessment dated [DATE] stated R2 was completely dependent on caregivers for all Activities of Daily Living (ADLs) and all mobility. The MDS assessment identified R2 was at risk for the development of pressure injuries but had no current unhealed pressure injuries. Under the skin and ulcer treatment section of the MDS assessment, No was marked for turning/repositioning program, and nutrition or hydration program to manage skin problems. There were no refusals or rejection of cares documented on the MDS. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's admission MDS assessment, dated 10/14/24, stated R2 was completely dependent on caregivers for all Activities of Daily Living (ADLs) and all mobility. The MDS assessment identified R2 was at risk for the development of pressure injuries but had no current unhealed pressure injuries. Under the skin and ulcer treatment section of the MDS assessment, No was marked for turning/repositioning program, and nutrition or hydration program to manage skin problems. There were no refusals or rejection of cares documented on the MDS. R2's Braden score was 12.0 on 11/07/24, which indicated R2 was high risk for developing pressure injuries. R2's Braden score was 12.0 on 11/07/24, which indicated R2 was high risk for developing pressure injuries. R2's baseline care plan, dated 07/26/24, had nothing indicating current or history of skin integrity issues. On 12/10/24, Surveyor reviewed R2's care plan and there was no care plan for skin integrity concerns or pressure injuries. The Skin Only document dated 07/26/24, indicated R2 had no skin impairments. The Skin Only document, dated 10/30/24, indicated that R2 had a pressure ulcer/injury to the left (L) inner/lower buttock (most distal). It was staged as a stage II: partial thickness with skin loss and measured 0. 6cm long and 1.3cm wide. The first documentation (progress note) indicating that R2 had a skin issue was dated 10/30/24 and stated, Skin Evaluation: Skin is ashen in color. Skin warm/dry to touch. Decreased skin turgor. Resident has current skin issues. Skin Issue: Pressure Ulcer / Injury. Skin issue location: L inner/lower buttock (most distal) Pressure Ulcer / Injury Stage: Stage II - Partial thickness skin loss. Length: 0.6cm Width: 1.3cm Skin Issue: Pressure Ulcer / Injury. Skin issue location: L inner/lower buttock (most proximal) Pressure Ulcer / Injury Stage: Stage II - Partial thickness skin loss. Length: 0.6cm Width: 0.7cm Skin Issue: Other skin issue. Other skin issue: bruise from edge of brief Skin issue location: L outer/lower buttock Length: 5.2cm Width: 0.3cm Skin Issue: Other skin issue. Other skin issue: bruise from edge of brief Skin issue location: right (R) side Length: 7.5cm Width: 0.3cm Skin Issue: Other skin issue. Other skin issue: bruise from edge of brief Skin issue location: L side Length: 5cm Width: 0.4cm Note / Notification / Education: Skin note: Has been sitting in his recliner for the past few weeks during the day and night, as he cannot breathe well laying in bed, even with the head up; does have a cushion in his w/c and recliner chair when he is up. Comfort cares, not moving a lot or getting up out of his recliner chair a lot. Did get him to lay down in bed for an hour this am on his side, but is up again. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skin Only document, dated 11/07/24, indicated R2 had a superficial open area (excoriation/pressure), on the lower/inner buttock. The skin condition measured 5cm long and 3.5 cm wide; there was no depth indicated. Skin issue number two indicated that R2 has a superficial open area (excoriation/pressure), location was open slit in coccyx which measured 2.5cm long by .01cm wide no depth indicated. A physician's orders, dated 12/05/25, stated, Coccyx: apply barrier cream & leave open to air (OTA), two times a day AND as needed qday (every day) as needed (PRN). Care plan related to pressure injuries was not added at this time, and no changes to the care plan were completed until 12/11/24. On 12/10/24 at 8:23 AM, Surveyor observed R2 being offered to get up out of bed. R2 chose not to get up yet. R2 was lying on back with head of bed elevated approximately 25 degrees. On 12/10/24 at 9:10 AM, Surveyor observed peri cares being performed by Certified Nursing Assistant (CNA) H and CNA F for R2. CNA H and CNA F rolled R2 to the left side towards the wall. Surveyor observed a 2.5-inch horizontal open area on R2's left buttock. Surveyor observed CNA H take soapy wet washcloth and cleanse it by rubbing vigorously upwards on the open area. The 2.5-inch open area began bleeding a little and R2 indicated that sore was painful. CNA H dried the area and applied moisture barrier cream to the open area and R2's buttocks. CNA H and CNA F rolled R2 to his back and finished covering R2 up with blankets. Surveyor asked CNA H if the open area on R2's left buttock was new. CNA H indicated the open area comes and goes but it has been open for about two weeks now. CNA H indicated the wound nurse was made aware when it opened and told staff that wound nurse would be at the facility today to address the open area on R2's buttocks. CNA H indicated when it was open in past nurses would apply a mepilex but we haven't done that for a while. On 12/10/24 at 10:12 AM, Surveyor observed R2 still lying on back in same position, lying on back with head of bed elevated. Surveyor had been observing outside of resident's room since 8:05 AM this morning. On 12/10/24 at 11:27 AM, Surveyor observed R2 lying in bed on back and CNA F transferred R2 to toilet. Surveyor observed Registered Nurse (RN) E clean R2's bottom up and apply clempstine to R2's buttocks. Surveyor observed CNA F and RN E transfer R2 to recliner. Surveyor observed R2 sitting directly on buttocks with no off-loading noted. On 12/10/24 at 11:34 AM, Surveyor interviewed RN E and asked if RN E is aware that R2's left buttock is opened. RN E indicated that RN E worked last weekend, and R2's left buttock opened up. RN E reported this to hospice nurse. RN E indicated that hospice nurse discontinued mepilex dressing as it was holding moisture from R2's sweating and it always became wrinkled. RN E indicated hospice nurse ordered to keep area dry as possible and apply barrier cream to the opened area on left buttock. On 12/11/24 at 4:10 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C regarding expectations for a resident who is assessed to be at risk for pressure injuries. ADON C would expect that residents with pressure injuries be offloaded on average every two hours for an extended period. There was a time that R2 really preferred their armchair, but recently they have been in bed more. ADON C would also expect that a care plan related to pressure injury care be created right away when a pressure injury is indicated. ADON C said they have not updated the care plan as of 12/11/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure resident safety through assessment and ensure the environment remains as free of accident hazards as is possible for 3 of 4 residents (R) reviewed (R12, R16, and R15). -R12 was evaluated by the facility to be a fall risk with assist of 1 during ambulation. R12 was observed self-ambulating to R12's room from dining room. -R16 was evaluated by the facility to be a fall risk with assist of 1 during ambulation. R16 was observed self-ambulating to R16's room from dining room. -R15 was evaluated by the facility for choking hazard during mealtimes. R15 was observed eating meals alone without supervision. Findings include: R12 was admitted on [DATE]. R12's diagnoses include Parkinson's, history of falling, schizoaffective disorder, polyneuropathy, unsteadiness on feet, reduced mobility, and lack of coordination. R12's MDS assessment, completed on 11/05/24, confirmed R12 scored 9 out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognition impairment. R12 requires supervision touch assistance with sitting to standing. R12 requires partial to moderate assistance from staff walking 50-150 feet distance. R12's care plan was initiated on 03/07/22, and included the following interventions: Activities of Daily Living: -Ambulation: The resident is able to ambulate with his 4 wheeled walker and standby assist throughout the facility revised on 10/10/24. -Locomotion: The resident is able to perform ambulation with 4 wheeled walker to and from meals with contact guard assist revised on 10/10/24. -Transfers: Assist of 1 with contact guard assist for all transfers. Prompt resident to take their time and move slowly secondary to balance issues revised on 10/10/24. On 12/09/24 at 10:59 AM, Surveyor observed R12 get up from recliner in lounge and ambulate to R12's room alone, no staff present. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 8:22 AM, Surveyor observed R12 ambulating out of room down the hallway, while Certified Nursing Assistant (CNA) D was dropping off trash in the soiled utility room. R12 walked about 200 feet before CNA D approached R12 and walked beside R12. Surveyor did not observe CNA D use contact guard assist during ambulation. R12 walked to dining room table and sat down. CNA D walked over to Household D. On 12/10/24 at 1:20 PM, Surveyor observed R12 ambulating from dining room to R12's room. No staff were present to assist R12. On 12/11/24 at 11:10 AM, Surveyor interviewed Assistant Director of Nursing (ADON) C and asked what expectations are for R12's transfer status. ADON C indicated that R12 is assist of one with gait belt and contact guard assist. ADON C explained contact guard assist is light touch assistance when ambulating. Surveyor stated to ADON C that Surveyor observed R12 ambulating by R12's self-several times to and from meals to R12's room down the hallway. ADON C indicated that R12 ambulating alone is not acceptable and staff will be educated on importance of ambulating with R12 to and from meals and while ambulating on unit. Example 2 R16 was admitted on [DATE]. R16's diagnoses include unspecified dementia, abnormality of gait and mobility, lack of coordination, hypothyroidism, and type 2 diabetes mellitus. R16's Minimum Data Set (MDS) assessment, completed on 09/17/24, confirmed R16 scored 9 out of 15 on the BIMS, indicating moderate cognition impairment. R16 requires supervision touch assistance with sitting to standing. R16 requires partial to moderate assistance from staff during transfers. R16's care plan was initiated on 03/26/24, and included the following interventions: Activities of Daily Living: -Ambulation: The resident is able to ambulate with walker and standby assist revised on 07/23/24. -Resident needs cues to remember to place both hands on handles of walker and not one on frame of walker for safety. On 12/10/24 at 8:27 AM, Surveyor observed R16 self-propelling in wheelchair to R16's room. R16 shut bedroom door. On 12/10/24 at 8:31 AM, Surveyor heard a fast loud alarm go off in R16's room. On 12/10/24 at 8:35 AM, Surveyor interviewed CNA D who was sitting at dining room table and asked what alarm is going off in R16's room. CNA D indicated the alarm Surveyor is hearing is R16's recliner sensor, probably R16 transferring self from wheelchair to recliner. On 12/10/24 at 8:37 AM, Surveyor observed CNA D use walkie while sitting at dining room to call for assistance to answer R16's chair alarm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 8:40 AM, Surveyor observed CNA H enter R16's room and noticed that R16 transferred self to recliner. CNA H turned recliner sensor alarm off and walked out of R16's room. On 12/10/24 at 8:43 AM, Surveyor interviewed CNA H and asked if R16 should be ambulating by R16's self. CNA H indicated that R16 should be one assist with gait belt doing transfers but is caught self-transferring a lot. On 12/11/24 at 11:10 AM, Surveyor interviewed ADON C and asked what interventions were put into place for R16 after falling on 10/11/24. ADON C indicated that bathroom light is to be on over shower at all times, ensure clear path to the bathroom and doorway at night to ensure safety. ADON C admitted the intervention was documented in the fall progress note when the event occurred but was not initiated on the care plan. Surveyor asked ADON C how staff would know to follow this intervention when caring for R16. ADON C indicated the intervention should have been initiated on care plan but did not revise care plan until today on 12/11/24. Surveyor asked ADON C if ADON C knew what R16's status for transfer is. ADON C indicated that R16 is an assist of 1 with gait belt with front wheel walker. Surveyor told ADON C that Surveyor observed R16 self-transfer several times throughout the 3-day survey. ADON C indicated that staff should be present to help R16 transfer to meals, from recliner, and to bathroom. Example 3 R15 was admitted on [DATE]. R15's diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, conversion disorder with seizures, diabetes mellitus, and dementia with behavioral disturbance. R15's MDS assessment, completed on 09/24/24, confirmed R15 scored 00 during a Brief Interview for Mental Status (BIMS), indicating not able to assess due to severe cognition impairment. R15 requires supervision and setup assistance with eating. R15's care plan was initiated on 06/16/23, and included the following interventions: Nutrition: -Eating: Monitor, document, and report as needed any signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, and appears concerned during meals. -Needs meal set up and supervision during meals. On 12/10/24 at 7:55 AM, Surveyor observed 6 residents (R3, R16, R11, R19, R15, and R1) in the dining room on Household E at the meal table. Three residents were eating breakfast. Surveyor did not observe any staff in the dining room to monitor residents while eating. On 12/10/24 at 8:02 AM, Surveyor observed kitchen staff walk from Household D to Household E and serve R15 breakfast meal. Kitchen staff walked back out of dining room and over to Household D. R15 began eating R15's breakfast. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor did not observe any staff in close proximity of Household E's dining room to assist/supervise R15 during breakfast meal. On 12/10/24 at 8:12 AM, Surveyor observed CNA H walk into kitchenette on Household E, wave at R15, grabbed a dish out of cupboard and walked back over to Household D. On 12/10/24 at 8:16 AM, Surveyor observed CNA D serve R19 the breakfast meal and walk out of dining room to Household D. On 12/10/24 at 8:24 AM, Surveyor observed CNA D serve R13 breakfast and sit down to assist at the assist table. On 12/10/24 at 9:35 AM, Surveyor observed CNA H deliver a brownie to R15 in R15's room. CNA H exited R15's room and walked down the hallway. On 12/10/24 at 10:05 AM, Surveyor did not observe any staff member go into R15's room to check on R15 while eating the brownie CNA H gave R15. On 12/11/24 at 11:10 AM, Surveyor interviewed ADON C and asked what expectation is for R15 during mealtimes. ADON C indicated that ADON C expects staff to supervise R15 during meals as R15 is a choking hazard with post stroke symptoms. Surveyor indicated to ADON C that Surveyor observed R15 left alone to eat breakfast on 12/10/24. ADON C indicated that R15 should always be supervised while eating due to pocketing food.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on interview and record review, the facility did not ensure residents (R) with indwelling Foley catheters received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections (UTI) from the catheter. R2's Foley catheter was changed on a routine monthly basis without clinical indications and not following professional standards of practice. This occurred for 1 of 2 residents reviewed for urinary catheters. (R2). Findings include: The Centers for Disease Control and Prevention (CDC) suggests changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Record review identified R2 was admitted to the facility on [DATE], with the following diagnoses, in part: benign prostatic hyperplasia with lower urinary tract symptoms, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other obstructive and reflux uropathy. Record review identified R2 had an indwelling catheter, R2's orders stated, Change catheter 16 FR every day shift every 4 weeks on Tue for benign prostate hyperplasia, obstruction AND as needed for plugging not relieved by flushing or for UA collection. This order was activated on 12/03/24. On 12/11/24 at 8:30 AM, Surveyor requested reasoning for indwelling catheter change on a 4-week basis. On 12/11/24 at 11:14 AM, Surveyor interviewed Assistant Director of Nursing (ADON) C regarding catheter orders for R2. ADON C said they could not find a physician reason for the change in catheter orders on a monthly basis. They did know about the change in the standard of practice and believed that most of their residents were currently following the standard. ADON C said it would be the facility's expectation to follow the current standard of practice. No other documentation regarding a reason for R2's orders were given to surveyor by end of survey.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not provide medically related social services to address Post Traumatic Stress Disorder (PTSD) for 1 of 19 residents (R) reviewed to ensure appropriate social services are provided for each resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being (R17). -The facility failed to provide medically related social service for developing a plan of care addressing R17's PTSD. -The facility failed to provide non-pharmacological interventions for R17 to cope with PTSD and anxiety. This is evidenced by: Findings include: R17 was admitted to the facility on [DATE] with diagnosis which include post-traumatic stress disorder (PTSD), generalized anxiety disorder, major depressive disorder, sleep disturbance, psychophysiological insomnia, and agoraphobia disorder. R17's Minimum Data Set (MDS) assessment, dated 11/26/24, indicated that R17 has a Brief Interview for Medical Status (BIMS) score of 15 out of 15, which indicates R17 has intact cognition. R17's Patient Health Questionnaire (PHQ)-9 indicated, R17 scored a 02 with little interest or pleasure in doing things, feeling down, depressed, or hopeless for 2-6 days out of the week. R17's care plan was reviewed and did not have a PTSD care in place. Surveyor reviewed R17's psychiatric progress note, dated 11/11/24, Patient Health Questionnaire (PHQ)-9 indicated R17 scored a 10 for moderate severity in depression with functional impairment as very difficult. Surveyor reviewed R17's physician orders indicating, Give Lorazepam oral tablet 1mg three times a day for anxiety and give 1mg oral every 8 hours as needed for anxiety-ordered on 12/06/24. On 12/09/24 at 11:31 AM, Surveyor interviewed R17 and asked about any emotional or social concerns. R17 indicated that R17 had PTSD and a history of PTSD. R17 indicated that staff are great and knock before entering room and announce self, but I like my door always left open. R17 indicated that facility just started R17 on Lorazepam for anxiety beginning of December. R17 indicated that R17 is always depressed and just wants to leave. Surveyor asked R17 if R17 has options to speak to someone about R17's emotional well-being. R17 indicated that facility does not have an actual social worker and most times nurses just tell R17 to take another anxiety medication to relive symptoms. On 12/10/24 at 8:45 AM, Surveyor observed R17 lying in bed crying in the dark. Surveyor interviewed R17 who indicated that R17 just did not want to be here. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 11:41 AM, Surveyor observed R17 lying in bed in the dark. Surveyor did not observe R17 get out of bed for breakfast or lunch. On 12/10/24 at 3:05 PM, Surveyor observed R17 lying in bed in the dark, awake but staring at ceiling. On 12/11/24 at 2:07 PM, Surveyor interviewed Social Worker/Health Unit Clerk (HUC) J and asked who helps R17 with emotional support. Social Worker/HUC J indicated that residents can talk to Social Worker/HUC J whenever they want. Social Worker/HUC J indicated that R17 has come into Social Worker/HUC J's office many times and we have talked. Surveyor asked Social Worker/HUC J if Social Worker/HUC J can provide documentation of the sessions and any other non-pharmacological interventions put into place. Social Worker/HUC J indicated Social Worker/HUC J does not always chart the sessions. Surveyor could not find any documentation in R17's Electronic Medical Record (EHR) pertaining to Social Worker/HUC J and R17's sessions. On 12/11/24 at 2:18 PM, Surveyor interviewed Assisted Director of Nursing (ADON) C and asked how the facility is managing R17's emotional well-being and support for PTSD/anxiety as Surveyor could not find a PTSD care plan, non-pharmacological interventions put into place for R17. ADON C indicated that R17 does not have a care plan addressing PTSD but will make one right away. Surveyor asked ADON C if R17 had any behavior monitoring for anxiety and PTSD. ADON C indicated there was not behavior monitoring in place at this time but would implement a PTSD care plan and behavior monitoring. On 12/11/24 at 2:31 PM, Surveyor observed R17 lying in bed in the dark. Surveyor did not observe R17 get out of bed today. Surveyor reviewed tasks and Treatment Administration Record (TAR) and found no documentation of behavior monitoring for anxiety or PTSD.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation, interview and policy review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. When staff heated up Resident (R) 124's food in the microwave, staff did not check to ensure the food was at safe eating temperatures. In the kitchen refrigerator there was food that was not dated appropriately to ensure food safety. This has the potential the affect all 19 of 19 residents (R) residing in the facility. Findings include: Example 1 Facility Policy titled, Food temperatures, states, 6. To take hot food temperature, insert the thermometer at 45 degree angle to the middle of the food items taking care not to touch the container or bone if it has one. Wait for the thermometer to rise to the maximum temperature, read and record the temperature and then remove the thermometer from the food item and immediately clen with a fresh alcohol swab. Repeat this process until all hot food temperatures have been taken . 15. Leftovers must be, labeled, covered, cooled and stored (within ,d+[DATE] hour after cooking or service) in a refrigerator. Prior to re-serving, leftover foods must be reheated to a minimum internal temperature for 165 degrees Fahrenheit for a minimum of 15 seconds. On [DATE] at 12:22 PM, Surveyor observed Dietary Aide (DA) L heating up R124's lunch of hamburger and mashed potatoes in the microwave. After being in the microwave for 90 seconds DA L did not temp the food to ensure safe food temperatures before serving to R124. Surveyor asked DA L why they did not temp it and they were not sure. DA L said they do the same thing every day and they did wonder that, but what they did know is that R124 likes the food steaming hot or will ask it to be heated up again. DA L has always put it in for a minute and a half. DA L agreed that temping the food would make sense for resident safety. On [DATE] at 12:31 PM, Surveyor interviewed Dietary Manager (DM) K regarding not temping food out of the microwave. DM K said, Oh yes, that makes sense we should be temping the food to make sure it is not too hot. They did not have a known time management system to ensure heating, but facility will implement soon as possible. 47657 Example 2 On [DATE] at 9:15 AM, Surveyor conducted an initial tour of the facility's kitchen and noted the following: *A plastic zip bag with uncooked hotdogs dated [DATE] and unlabeled with expiration or discard date in facility cooler (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*2 plastic sealed containers of canned cranberries labeled with prep date of [DATE] and unlabeled with expiration date or discard date in facility cooler *A 3-tier cart with a sealed plastic container that later was identified as breadcrumbs by DM K unlabeled and undated. *A deep fryer uncleaned and pieces of French fries and crumbs. On [DATE] at 9:35 AM, Surveyor interviewed DM K regarding findings. DM K stated that the bag of hotdogs and container of cranberries should have been labeled with expiration or discard date and that both items should have been discarded after 3 days. DM K stated the container of breadcrumbs should have been labeled and dated with discard or expired date. DM K immediately removed container and disposed of contents. DM K stated they used the deep fryer the evening prior for cooking French fries and indicated the fryer should have been cleaned immediately after use.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 47807 Based on interview and record review, the facility did not ensure that a communication process was implemented, including how the communication will be documented between the long term care (LTC) facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. The facility did not have a communication binder for hospice services to relay information to the facility regarding hospice services. This has the potential to effect 1 of 1 resident (R) investigated for hospice services (R2). Findings include: Surveyor completed record review of R2's progress notes and could not find the communication with hospice besides notes documented by facility staff members. On 12/11/24 at 2:15 PM, Surveyor requested communication for R2 regarding hospice communication and the orders for wound care. The Assistant Director of Nursing (ADON) C admitted they could not locate a communication binder with hospice for R2. Surveyor asked if they had a different system and ADON C said the hospice binder was their main way to communicate with hospice. Hospice does not have access to the facility's Electronic Medical Record. Hospice typically leaves a binder for a resident on hospice, and they have binders for all other residents on hospice in the facility. ADON C said the facility will need to talk to hospice to determine why they did not have the communication binder that they typically have.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47807 Based on interview and record review, the facility did not ensure the mandatory staffing data that had been submitted from 01/01/24-09/30/24 was complete, accurate, and auditable. The submitted data from 01/01/24-09/30/24 was not complete, accurate, or auditable. This has the ability to affect all 19 of 19 residents in the facility. This is evidenced by: The Payroll Based Journal (PBJ) Staffing Data Reports that were generated quarterly document that the facility triggered No RN Hours for the dates of 01/08/24 (MO), 02/02/24 (FR), 03/15/24 (FR), 03/29/24 (FR). The PBJ Staffing Data Reports that were generated quarterly document that the facility triggered Failed to have Licensed Nursing Coverage 24 Hours/Day for the dates of 05/13/24 (MO), 05/16/24 (TH), 05/17/24 (FR), 06/02/24 (SU), 06/03/24 (MO), 06/09/24 (SU), 06/30/24 (SU), 07/06/24 (SA), 08/03/24 (SA), 09/06/24 (FR), 09/29/24 (SU). Surveyor completed record review of daily postings for infraction dates, including nursing schedules, Director of Nursing pay stubs, and Multiple Data Set (MDS) Coordinator pay stubs. Surveyor did not find any dates where the facility did not have 24 hour nursing coverage of no registered nurse coverage for at least 8 hours. On 12/11/24 at 1:15 PM, Surveyor interviewed Administrator Assistant (AA) M regarding PBJ data reporting. AA M determined that on the dates of infraction the MDS Coordinator or Director of Nursing covered as the registered nurse for the facility, and they were not coded as the registered nurse even though they were covering that position. Both the Director of Nursing and MDS Coordinator are registered nurses. They would expect that PBJ data be submitted accurately, and they might have to do more manual submissions to ensure that.

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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** 48793 Based on interview and record review, the facility did not establish an Infection Control Program under which it investigates, controls, and prevents infections in the facility, and a system for recording incidents identified under the facility's Infection Control Program, including corrective action in a timely manner, for both residents and staff. This has the potential to affect all 19 residents in the facility. -The facility did not a have a clear water management process or plan in effect to prevent transmission of Legionella infection. This has the potential to affect 19 of 19 residents reviewed. -The facility did not have a complete tracking program in place for the early detection of infections and potentially exposed residents (R). -Observations were made of the facility not implementing Transmission Based Precautions (TBP) for 1 of 1 sampled resident on TBP. -Facility did not have a clear process for handling infectious linens. This is evidenced by: Example 1 The facility policy titled, Water Management Plan-Water Flow Diagram, dated 11/29/24, states in part: Plan Strategies - . #1.2. Areas to be documented will include temperature monitoring, disinfection procedures, flushing protocols . Regular Audits and Review- #3.1. Conduct routine audits and reviews of the implemented measures and the accuracy of documentation related to Legionella prevention and control . The Center for Disease Control and Prevention (CDC) guidelines titled, Controlling Legionella in potable water systems, last reviewed March 15, 2024, states in part: Flush low-flow piping runs and dead legs at least weekly and flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as-needed to maintain water quality parameters within control limits. On 12/11/24 at 9:17 AM, Surveyor reviewed the facility's Water Management Plan (WMP) and did not observe the flow diagram or WMP updated with locations of hot spots/stagnation areas deemed high risk areas of Legionella growth. Surveyor did not find a description in the WMP explaining how often and how long household B/C sinks/toilets are to be ran and flushed. Surveyor did not observe weekly flushes for unoccupied rooms on household D (D7 and D8), and household E (E1). On 12/12/24 at 10:01 AM, Surveyor interviewed Assistant Director of Nursing (ADON) C and asked ADON C about the facility's WMP. ADON C indicated that Nursing Home Administrator (NHA) A and Maintenance usually work on monitoring the WMP, but ADON C knows that Infection Control (IC) plays a role as well. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/12/24 at 5:05 PM, Surveyor interviewed NHA A who indicated that NHA A and Maintenance are responsible for the WMP in the facility. Surveyor indicated to NHA A that the WMP was missing stagnation areas on the flow diagram, description in the WMP for process for flushing household B/C as well as no weekly flushes completed for unoccupied rooms on household D/E. NHA A indicated that NHA A thought this was being done but it would be fixed right away. Example 2 Surveyor reviewed Infection Control (IC) surveillance logs and found missing information identifying onset of symptoms, when precautions were implemented, any testing, last well date, when symptoms ended, when precautions ended, and if provider was notified. Surveyor reviewed IC 2024 data line lists for residents and staff. Surveyor noted that all line lists from January 2024-December 2024 were inconsistent and missing data. Surveyor reviewed and noted line lists were missing the symptoms onset date, description of symptoms, pathogen/organism, testing, symptoms resolution, outcome (hospital, death, etc.), precautions type, precautions start and stop dates, antibiotics type, antibiotics start and finish dates, and provider notified. Line lists had incomplete data. On 12/11/24 at 10:13 AM, Surveyor interviewed ADON C who is the Infection Preventionist (IP). Surveyor asked ADON C about the process for tracking surveillance of resident infections and sicknesses. ADON C indicated that line lists were incomplete throughout the whole year for 2024 to present as ADON C did not realize all data needed to be tracked on the line lists. ADON C indicated that ADON C has not been tracking the incomplete data on the line lists located in the IC binder. Example 3 R13 was admitted to the facility on [DATE] and had diagnoses that include necrotizing fasciitis, paroxysmal atrial fibrillation, and acute respiratory failure with hypoxia. Surveyor reviewed R13's progress notes and vital signs indicating, .-On 12/02/24 cough present, dry nonproductive cough noted. -On 12/03/24 temperature 100.0, with 92% oxygen on room air, frequent hacking cough, fine crackles with minimal air movement in right base of lungs. -On 12/04/24 provider noted chest x-ray resulted pneumonia with new order of Augmentin 875/125mg twice a day for seven days. -On 12/05/24 some cough noted. -On 12/06/24 temperature 99.3, cough present, receiving antibiotics. -On 12/08/24 temperature 100.0, right posterior middle lobe diminished on auscultation, rhonchi on auscultation, left posterior lower lobe crackles on auscultation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-12/10/24 fax sent to provider updating that today is [R13's] last day of antibiotic for pneumonia but continues to have a cough, lung sounds still very diminished in the right base fine crackles in the left base, temperature 99.9 this AM, and [R13] feels like [R13's] is starting to cough some stuff up. Had a temperature of 100.0 over the weekend as well. New order placed for chest x-ray with diagnosis of cough by provider . On 12/09/24 at 9:44 AM, Surveyor observed Enhanced Barrier Precautions (EBP) sign on R13's door and an EBP cart outside of R13's room. CNA F used hand sanitizer and donned gown and gloves. CNA F entered R13's room and provided cares. CNA F doffed gown and gloves, then hand sanitized and exited R13's room. Surveyor did not observe CNA F wearing a mask. On 12/09/24 at 1:13 PM, Surveyor observed Enhanced Barrier Precautions (EBP) sign on R13's door and an EBP cart outside of R13's room. On 12/10/24 at 9:41 AM, Surveyor observed RN E enter R13's room with gown and gloves on. RN E administered nebulizer to R13. RN E doffed gown and gloves and exited R13's room. Surveyor did not observe RN E wearing a mask. On 12/10/24 at 1:13 PM, Surveyor reviewed R13's EHR (Electronic Health Record) which stated R13 has a fever of 100.0 that started this morning 12/10/24 around 10:00 AM. Surveyor did not observe a droplet precaution sign on R13's door. Surveyor only observed an EBP sign on door. On 12/10/24 at 1:47 PM, Surveyor interviewed RN E and asked if R13 was on droplet precautions due to R13's fever. RN E indicated that RN E did not know that R13 should be on droplet precautions. RN E indicated that RN E reached out to the provider this morning when RN E completed vitals and assessed R13 to have a temperature. RN E indicated that R13 had a fever on Saturday as well. RN E indicated that RN E was keeping an eye on it since RN E worked the next few days but R13 still had fever today on 12/10/24. Surveyor asked RN E what the usual process for precautions is when someone has a fever to prevent infection from spreading. RN E indicated that is usually decided by ADON/IC C. RN E indicated that RN E did not implement precautions as should have for fever and cough present. On 12/10/24 at 2:20 PM, Surveyor interviewed ADON C and asked why R13 was not on droplet precautions due to pneumonia and recent spike in fever. ADON C indicated that ADON C did not realize that R13 was infectious. ADON C indicated that no one let ADON C know that R13 had spiked a fever over the weekend. Surveyor asked ADON C what ADON C's expectation for staff is to report fever or symptoms of R13 to ADON C. ADON C indicated that RN E should have let ADON C know about R13 spiking a fever on Saturday, but that RN E did not. ADON C indicated that R13 should have been placed on droplet precautions right away when fever spiked over the weekend. ADON C indicated that ADON C will be investigating the incident right away. On 12/11/24 at 8:21 AM, Surveyor observed droplet precautions sign on R13's door. Surveyor interviewed CNA D and asked what process CNA D utilizes when providing cares for R13 now that R13 has droplet precautions sign on. CNA D indicated that CNA D would wear face mask, gloves, and gown when entering R13's room now. Surveyor asked CNA D if CNA D has been utilizing a mask when entering R13's room the past two days. CNA D indicated that CNA D has not been wearing a mask until the morning of 12/11/24 when the droplet sign was implemented. CNA D was not aware that R13 should have been on droplet precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 4 On 12/11/24 at 7:51 AM, Surveyor toured laundry services. Surveyor observed Laundry Aide (LA) G walk Surveyor through process of sorting dirty linens. LA G donned a laundry gown to protect clothes and gloves then began sorting through clear plastic bags of soiled linens. LA G opened a clear plastic bag and noticed a bloody washcloth and set the bloody washcloth aside. LA G continued sorting laundry and placed soiled linens into the washer. Surveyor interviewed LA G and asked what LA G's process for contaminated infectious linens is. LA G indicated that all linens are handled the same unless it's a really severe infectious linen. LA G indicated that then LA G would don eye protection and possibly a mask. Surveyor asked if the bloody washcloth is supposed to be in a red biohazard bag or clearly identified to be potential infectious linen. LA G indicated that LA G has never seen red biohazard bags or any bags other than the clear bags. LA G indicated that Surveyor would need to ask ADON/IC C about the process. LA G then placed bloody washcloth in a bleached basin to soak with another soiled Bowel Movement (BM) towel to sit for a while. LA G indicated that LA G lets the basin sit all day until the next morning then throws in the washing machine with all other soiled linens. LA G finished the washing cycle, doffed gloves, and then doffed gown and hung soiled gown over top of the other clean gowns. LA G indicated that all gowns get washed at the end of the day, but that LA G reuses the soiled gown for the next cycle of soiled linens. On 12/11/24 at 8:48 AM, Surveyor requested handling contaminated infectious linens policy from ADON/IC C. On 12/11/24 at 1:10 PM, Surveyor interviewed ADON/IC C and asked about correct process for handling potentially infectious linens and bloody washcloths. ADON/IC C indicated that ADON C was not aware the bloody washcloth needed to be labeled potentially infectious, but that LA G should be wearing full PPE when handling infectious linen. ADON/IC C indicated full PPE is eye wear, gloves, and gown. ADON/IC C indicated that the infectious linen handling policy needed to be revamped.