STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525619	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norseland Nursing Home	323 Black River Ave Westby, WI 54667

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility failed to ensure that all residents were able to formulate an advance directive, specifically related to code status, for 1 of 19 sampled residents (R5) reviewed for advance directives. The facility does not have R5's advance directives in her medical record. Evidenced by: The facility policy, entitled POLST (Physician Orders for Life Sustaining Treatment)/Advance Directives, dated 2/1/22, states, in part: . Advance Directives: 1. Upon resident move in, the Social Worker will determine if the resident has any advance directives (i.e., Power of Attorney for Health Care, Power of Attorney for Finances). 2. If Advance Directives are not present, the Social Worker will meet with the resident within the first 14 days from arrival to advise them of their right to establish Advance Directives and to offer assistance should they wish to create them. 3. Advance Directives will be reviewed at the initial care conference and the quarterly care conferences. If changes are made to the Advance Directive, appropriate forms will be filled out and signed by the resident. 4. Copies of these documents will be filed in the resident's physical chart as well as updating the hospital records and informing agents of any changes made. R5 was admitted to the facility on [DATE], and has diagnoses that include Alzheimer's Disease, Type Two Diabetes Mellitus and Spinal Stenosis. R5's Quarterly Minimum Data Set Assessment, dated 7/27/22, shows R5 had a Brief Interview of Mental Status (BIMS) score of 3 indicating R5 has severe cognitive impairment. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advance Care Planning (ACP) note by (Physician Name) MD (medical doctor), dated December 3, 2020, states: I have personally examined the patient and have determined that she is unable to receive and evaluate information effectively, and communicate decisions necessary to manage her health care. I recommend that the provisions contained in her Power of Attorney for Health Care be activated. ACP note by (Physician Name) MD, dated December 5, 2020, states: I have personally examined the patient and have determined that she is unable to receive and evaluate information effectively, and communicate decisions necessary to manage her health care. I recommend that the provisions contained in her Power of Attorney for Health Care be activated. R5's Advanced Practice Nurse Prescriber (APNP) office visit note, dated 1/31/22, states, in part: . She has Alzheimer's. Her POA (Power of Attorney) is activated . On 4/29/24 at 3:10 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if R5 has Advance Directives and NHA A indicated yes. Surveyor asked NHA A if she could show documentation of the Advanced Directives to Surveyor. NHA A was unable to locate them in R5's medical record but provided a social service note indicating R5's POA. NHA A also provided two doctor notes recommending POA be activated. Surveyor asked NHA A if R5 has advance directives should they be signed and in R5's medical record and NHA A indicated yes, and they are not. On 4/29/24 at 4:15 PM, NHA A supplied a copy of R5's Advance Directives to Surveyor. NHA A indicated she had just called over to the hospital and received the Advance Directives by fax. NHA A indicated she provided education to the social worker regarding Advanced Directives.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 39713 Based on record review and interview, the facility did not have evidence that residents or their responsible parties received timely Notice of Medicare Non-Coverage for 2 of 3 residents reviewed (R28 and R33). R28 and R33 did not sign the Notice of Medicare Non-Coverage. This is evidenced by: The facility policy titled, SNF Advanced Beneficiary Notice/Notice of Medicare Non-Coverage Policy, last reviewed 4/01/24, states in part . Purpose: To inform resident of their rights when being discharged from a Medicare Part A/Medicare Advantage covered stay, regardless of whether they remain in the facility or not. Medicare beneficiaries have specific rights and protections related to financial liability and the right to appeal a denial of Medicare services under the Medicare program. Procedure: 1. Any resident discharging from a Medicare Part A or Medicare Advantage covered stay will receive a notice of Medicare Non-Coverage at least 48 hours prior to their Last Covered Day. If necessary, notice will be provided to resident representative/POA. 2. A Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) and Notice of Medicare Non-Coverage will be completed when a resident has skilled benefit days remain and is being discharged from Part A services and will continue living in the facility. Example 1 R28 was receiving Medicare A benefits. R28's Medicare coverage ended on 1/30/24. R28 signed the Notice of Medicare Non-Coverage indicating she received the notice of non-coverage from the facility. R28 has a Activated Healthcare Power of Attorney (AHCPOA) and is not her own decision maker. The facility contacted R28's AHCPOA to inform them of the Notice of Medicare Non-Coverage but did not have the AHCPOA sign the form or provide a copy of the form to the AHCPOA. Example 2 R33 was receiving Medicare A benefits. R33's Medicare coverage ended on 1/17/24. R33 did not sign the Notice of Medicare Non-Coverage indicating she received the notice of non-coverage from the facility. On 4/29/24 at 1:58 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A who completes the Notices of Medicare Non-Coverage. NHA A indicates the social worker does or I do at times. Surveyor asked NHA A about R28 and R33's Medicare Notice of Non-Coverage. NHA A states, residents did not sign the notice of non-coverage, but it was discussed with them. NHA A states that R33 went onto hospice services, and they discussed the Notice of Non-Coverage but did not have her sign the form. R28 signed her own Notice of Non-Coverage and when the facility realized she was not her own person discussed the notice with R28's AHCPOA but did not provide her with a copy of the form or have her sign the form.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917 Based on interviews and record reviews, and facility policy review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for R36's immediate needs related to his mental health diagnosis upon admission for one of three residents (Resident (R) 36) of 15 sampled residents. Findings include: Review of the facility's policy titled, Care Plan, updated 04/1/24, revealed each resident would have a specific plan of care, developed on information gathered from the Minimum Data Set (MDS)/Care Area Assessment (CAA)'s, other assessment tools, resident/family expectations, and physician/therapist orders. The policy stated that the plan of care would be developed through an interdisciplinary approach within 48 hours of resident's admission to the facility, and would contain goals, approaches, and interventions to address the risks, problems, and issues associated with the resident. Review of R36's Electronic Medical Record (EMR) under the Face Sheet tab, revealed R36 was admitted from an acute care hospital to the facility on [DATE], with diagnoses which included bipolar depression, post-traumatic stress disorder (PTSD), depression, and anxiousness associated with depression. Review of R36's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/4/24 revealed diagnoses which included bipolar mood disorder, anxiety disorder, and PTSD. The MDS indicated R36 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. Review of R36's EMR under the Physician Orders tab, dated 3/29/24, revealed R36 was administered Lamotrigine (anti-seizure medication) 100 mg (Milligram) tab twice daily for bipolar depression, Prazosin (alpha blocker medication) 1mg capsule once daily for PTSD, Trazodone (anti-depressant medication) 50 mg Tablet once nightly for insomnia associated with depression, Bupropion (anti-depressant medication) XL 300 mg daily for indications of anxiousness associated with depression, and Escitalopram (anti-depressant medication) 20 mg tablet daily for indications of anxiousness associated with depression. Review of the hospital discharge summary, dated 3/29/24 and located in the EMR under the Other tab, revealed the hospital physician indicated that R36 has word-finding difficulties at times and has a slower response time given his head injury in August 2023. The discharge summary indicated no tests were pending at discharge, a reference to Consult to Social Services, and restorative services of physical and occupational therapy. The summary included a list of discharge medications to include lamotrigine, prazosin, trazodone, bupropion, and escitalopram. Review of R36's EMR baseline care plan summary under the Care Plan tab with an ARD of 4/4/24 through 4/29/24, had no care planned problems or interventions associated with his psychosocial diagnosis or medications administered for his psychosocial diagnosis. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/24 at 11:34 AM, DON B (Director of Nursing), stated that her expectation for R36 upon his admission was that he should have had a care plan from nursing and social services to address his psychosocial needs. She stated that the care plan did not indicate nursing or social services had addressed his psychosocial needs related to his mental illness diagnosis and antipsychotic medications. During an interview on 4/30/24 at 3:00 PM, SW E (Social Worker) stated that she had not addressed R36's psychosocial needs in his care plan because it was not on the list of problems documented by the hospital discharging physician.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview, record review, and facility policy review, the facility failed to ensure physician's orders were followed according to professional standards for one resident (R) out of 19 sampled (R16). Specifically, the facility failed to follow physician daily weight orders and orders to check R16's O2 saturation on room air every shift to wean R16 off oxygen. This had the potential to cause R16 not to receive the necessary care for treatment of R16's congestive heart failure (CHF) and the use of unnecessary oxygen. Findings include: Review of the facility's policy titled Weights last reviewed on 4/1/24 states in part, Purpose: To identify and provide nutritional interventions to maintain control of weight loss or gain in residents. Weight will be monitored and assessed to prevent avoidable weight loss and/or weight gain. Procedure: If a resident is determined to be at nutritional risk, they will be weighed weekly, twice weekly, or daily depending upon the assessment of the IDT (interdisciplinary team) during weekly risk meeting. Weights triggering greater than 5lb loss or gain in 1 month/week MD (medical doctor) will be updated along with POA (power of attorney) or guardian. Of note: the facility policy does not address a physician's orders for daily weights for a resident with CHF. Review of the facility's policy titled Oxygen Use and Documentation last reviewed on 4/1/24 states in part, Purpose: To provide guidelines for oxygen use and documentation. Procedure: Oxygen use shall be checked every shift by a nurse. If oxygen is being used, indicate the flow in liters per minute (L/min) in the EMAR/ETAR (electronic medical record/electronic treatment administration record), If oxygen saturation (O2 Sat) checks are done according to the physician's order, note the results in the EMAR/ETAR. R16 was admitted to the facility on [DATE], with the diagnosis that include in part . CHF, atrial fibrillation, cerebral infarction, pleural effusion, type 2 diabetes, and anemia. Review of R16's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 indicates R16 has a Brief Interview for Mental Status (BIMS) score of 13 of 15, which indicates R16 is cognitively intact. Toileting/hygiene, toilet transfers showering, personal hygiene, upper and lower body dressing are all partial/moderate assistance. R16 is independent with bed mobility. Frequently incontinent of urine and always continent of bowel. MDS also indicates that R16 is on oxygen therapy. R16's care plan states, in part, I have the potential to have cardiovascular problems because I have high blood pressure. I show this by having to take BP (blood pressure) medication. I need my nurses to .monitor my vital signs as needed, observe for effectiveness or adverse side effects . assess heart/lung sounds . monitor my respiratory status and use of O2. I need my aides to notify the nurse if I have SOB (shortness of breath) . if I have an increase in edema to my lower legs or abdomen . check my weight as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: R16's care plan does not address her CHF diagnosis. Physician's orders dated 11/29/23, states in part, Check room air oxygen saturation to wean off oxygen every shift NOC (night) AM (morning) PM (evening). May apply oxygen 1-4 Liters via nasal cannula for respiratory distress or O2 (oxygen) sats below 88% every shift NOC AM PM. Physician's telephone order dated 4/2/24, states in part, 1. Increase Bumex to 2 mg BID (twice daily) for CHF. 2. Daily weights. 3. Monitor lung sounds, update Monday. In review of R16's EMAR, the facility was checking R16's oxygen saturation every shift but was not checking R16's oxygen saturation on room air as ordered. In review of R16's progress note dated 1/7/24 at 12:59 PM, resident was not feeling well this morning. Resident complained of dizziness, skin was pale, maybe almost nauseous. Vitals stable, blood sugar slightly higher than her usual in the morning. Sips of water taken in. I feel like my heart is fluttering around. Some work of breathing noted, oxygen saturations stable. Gave morning medications and instructed resident to take slow breaths and focus on her breathing. Sat resident by the cart with me to keep an eye on her. Resident ate breakfast and was doing ok. Resident also ate lunch and color looked better, also stated she felt a little better but felt off, just don't know why. Will continue to monitor resident. Doing well thus far in the shift. Progress notes dated 1/11/24 at 11:02 AM, 13:27 (1:27 PM), and 22:08 (10:08 PM) states, resident had complaints of SOB this morning. Oxygen saturation levels checked at that time was 92% on 2L of oxygen. Gave resident her morning medications, appeared to be doing ok. Resident was wheeling herself back to her room when she stopped RN (Registered Nurse) in the hallway and state, she felt shaky. Resident was taken down to her room, vitals were taken. Blood pressure on higher side though had morning medications. Pulse was still on higher side for resident though had taken her medications. Oxygen saturations were at 86-88% on 2L(liter) of oxygen. Increased to 4L of oxygen, stable at 93% at 4L, provider called and updated. UA (urinalysis) and labs obtained and sent out for review. Bladder scan done; 57 mL's (milliliters) noted in the bladder post void. Lungs diminished, heart irregular per baseline. Increased edema noted bilaterally to lower extremities and rechecked pulse oxygen. Resident was on 4L of oxygen at 96% saturation level, turned oxygen down to 3L and was stable at 92%. Labs reviewed which were unremarkable, faxed over to provider. Called provider and asked what she would like us to do more for resident. Order to give one time dose extra of 1 mg (milligram) Bumex (diuretic) this afternoon and then to call again later for an update. and Follow up on resident's status per physician request. Residents SOB (shortness of breath) has resolved. Oxygen saturation 94 percent of 4 liters. All other vital signs unremarkable. Slight congestion noted to the lower bases of both lungs. Edema 2+ (plus) pitting to the left lower leg and ankle. +1 edema noted to the right ankle. Resident states she is feeling better, but still feels ill. Progress note dated 1/12/24 at 13:29 (1:29 PM) states in part, . RLL (right lower lobe) continues to have course crackles noted, LLL (left lower lobe) clear and diminished. Edema noted to be 3+ bilaterally in the lower extremities yesterday. Today lower extremities are significantly improved (+1 edema). Work of breathing has improved as well. Skin color is more vibrant than yesterday . Progress note dated 1/16/24 at 10:35 AM states in part, . no complaints with exception of I'm a little short of breath . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes dated 1/20/24 at 13:39 (1:39 PM) states, change in condition: resident not feeling well before lunch. Stated her head felt funny, maybe SOB, idk (I don't know). I just don't feel right. Noted that resident had +2 increased edema to LLE (left lower extremities), crackles noted to LLL. Oxygen saturations at 2L was 89-92%. Result: new orders received and noted. 1/20/24 give one-time extra dose of 1 mg Bumex for increased edema. Progress note dated 1/23/24 at 9:30 AM states in part, resident has +2 pitting edema noted to left ankle and +1 pitting edema to left leg. +1 edema to right leg and ankle. Progress note dated 1/24/24 at 13:33 (1:33 PM) states in part, . edema left sided, has 3+ pitting edema, increased edema noted to LLE in ankle and leg . Progress note dated 1/25/24 at 10:41 AM states in part, . lung sounds fine crackles heard in LLL, right lung is clear and diminished. O2 SAT: 97% (on oxygen) 3L. Progress note dated 1/26/24 at 13:54 (1:54 PM) states in part, . Edema has +2 pitting edema, to the left ankle +1 pitting edema to the right ankle. Lung sounds crackles heard, left lower lobes . Progress note dated 01/27/2024 at 20:58 (8:58 PM) states in part, .edema right sided, has 2+ pitting edema, left sided, has 1+ pitting edema . Progress note dated 3/14/24 at 9:58 AM states in part, . edema: bilateral, pedal edema present . Progress notes dated 3/16/24 at 14:52 (2:52 PM) and 14:53 (2:53 PM) state in part, . Edema: Has 2+ pitting edema, to the left foot/leg right sided, trace of edema noted to the right leg within normal limits . alert but sleepy at this time states that she don't [sic] feel good . physician notified and .new orders received and noted. 3/16/24 give another dose of Bumex 1 mg now and additional one 1 mg in the am and update her on resident condition. Progress notes dated 3/17/24 at 13:51 (1:51 PM) and 13:59 (1:59 PM) state in part, . spoke with on call provider regarding change in condition- resident vitals stable, continues to feel poorly, extra dose of Bumex administered this morning, poor output. Result provider stated that we could send resident out to urgent care, the ER (emergency room), or we can't try another dose of Bumex . [Physician Name] given poor output and unknown kidney function did not feel comfortable to given [sic] another dose of Bumex. Given the last two extra doses of Bumex appeared to not work as well as it has in the past. Result: Ok to send out to ER . and Edema left sided, has 3+ pitting edema, right sided, has +1 pitting edema. Progress note dated 3/18/24 at 13:54 (1:54 PM) states, received verbal report from RN at [Hospital Name]. Weight in the hospital was 148.0, Some medication changes were done. She had a chest ex ray [sic] and a U/A while in the hospital. They report trace bilateral lower extremity edema. Resident has crackles in bilateral bases of her lungs. Progress note dated 3/19/24 at 13:17 (1:17 PM) states in part, resident doing well on this shift today . +1 trace of edema noted to BLE (bilateral lower extremities), +2 edema in left ankle which is more of residents baseline, left lower lobe of lung is diminished though clear, right lower lung has fine crackles present- encouraged to cough and deep breath, encouraged to ambulate as allows. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 3/22/24 at 2:34 AM states in part, resident returned to facility from evaluation at [Hospital Name] ER (emergency room). Dx (diagnosis) acute diverticulitis, constipation, pleural effusion, right . Progress note dated 3/29/24 at 13:54 (1:54 PM) states in part, Complaint/symptom: shortness of breath or trouble breathing when sitting at rest, Respirations: Rate: 22, regular, O2 Sat: 87% (on oxygen) 2L . Procedure done: oxygen administered at 4 LPM (liters per minute). Progress note dated 4/2/24 at 13:13 (1:13 PM) states in part, .Complaint: cough, nasal congestion . Respirations: Rate: 22 regular .Lung sounds: crackles heard, left lower lobes . O2 SAT: 93% (on oxygen) 4L . Other: uses accessory muscles . encouraged coughing and deep breathing, physician notified, and orders received. Obtained CBC and chest x-ray .chest x-ray impression [sic]: congestive changes with bibasal infiltrates (both lower lobes contain substances that fill the lung i.e., fluids) and effusions (unusual amount of fluid in the lung) .New orders received-daily weights, monitor lung sounds, start 2mg of Bumex BID for CHF, follow up Monday. Progress notes dated 4/8/24 at 9:58 AM, 10:06 AM, and 10:22 AM state in part, .complaint/symptom: cough: hacking .lung sounds: crackles heard, left lobes . O2 SAT: 94% (on oxygen) 3L . and cyanosis is present, in nailbeds bilaterally . fax sent to: attending physician regarding: faxed weights and medication list. Resident continues with crackles to base of left lung. Edema +1 to BLE. Continues to have cough, fatigue, and weakness. Oxygen saturations range from 90-94% on 3-4L of oxygen. Spoke to DON (Director of Nursing) about care conference given gradual decline . No new orders. Provider to evaluate Wednesday during rounds and Note: resident appears to be fatigued and continues to have weakness. Oxygen saturations are stable with supplemental oxygen via nasal cannula. Resident appears to have nonproductive hacking cough. Resident has been noted to have swallowing concerns during meals, speech therapist to evaluate and treat, as necessary. Noted that resident has increased supplemental oxygen needs, resident diuretics have been increased. Noted that resident heart is in poor condition and may continue to gradually decline. Care conference pending for goals of care. Progress note dated 4/8/24 at 13:37 (1:37 PM) states, Daily weight: lbs. (pounds)-did not obtain weight. Review of facility weight log indicates daily weights during these time frames: 1/25/24-1/29/24, 1/31/24, 3/17/24, 3/19/24-3/22/24, 3/24/24-3/25/24, 3/27/24, 3/29/24-4/8/24, otherwise weights were taken weekly. On 4/29/24, Surveyors reviewed electronic medical record (EMAR) for oxygen saturations to be done every shift on room air. EMAR shows oxygen saturations completed every shift on oxygen. Room air oxygen saturations were not completed as ordered. On 4/30/24 at 8:34 AM, Surveyor interviewed RN J (Registered Nurse). Surveyor asked RN J what the facility procedure was for weights. RN J stated, if they are a new resident, they obtain daily weights on same shift for 3 days then we go to weekly weights on bath day. RN J stated the CNA's get the weights. CNA's are told in the morning during report who needs weights done. Weights are brought to nurse and then the nurses chart the weight in the medical record. Changes in weights are communicated on the to do list in electronic charting system. RN J stated she would update the MD (medical doctor) if weight increase of 3#'s (pounds) overnight or 5#'s in a week. The weight increase would be communicated to the Physician, along with assessment (lung sounds, edema, etc.). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 8:40 AM, Surveyor interviewed CNA K (Certified Nursing Assistant). Surveyor asked CNA K what the facility procedure was for weights. CNA K stated, nurses inform us on shower day who we need to weigh, if new admit we weigh the first 3 days. If weight is off, we will have to get a reweight. Some people are daily weights. Surveyor asked CNA K if R16 is a daily weight. CNA K stated, R16 is not a daily weight. CNA K stated R16 received daily weights when she returned from hospital but that didn't last but just a couple of weeks. Surveyor asked CNA K how order changes are communicated with nursing staff and what is done with weights once obtained. CNA K stated weights are reported to the nurse and they report any weight changes to the physician and document the weights in the medical record. On 04/30/24 at 8:44 AM, Surveyor interviewed CNA L. Surveyor asked CNA L what the process is for obtaining weights. CNA L stated, weights are usually every week on bath day and given to the nurse to document, reweigh if not within 3 pounds. New admission weights are obtained every day for three days and reported to the nurse. Residents that are a daily weight are communicated during morning report. We get any changes in morning report from RN M. R16 used to be a daily weight but is not currently on daily weights. Surveyor asked CNA L if R16 is always on oxygen. CNA L stated that R16 is always on O2. On 4/30/24 at 8:49 AM, Surveyor interviewed RN I. Surveyor asked RN I what standard of practice the facility for CHF residents. RN I stated, we have standing orders with vital parameters, it's standard to do your assessments, vitals, update PCP (primary care provider), complete any new orders as prescribed and update family. Follow-ups are put into the to do list in the electronic charting system. Surveyor asked RN I, the process for obtaining weights. RN I stated, weights would be daily for three days on admission and are done right away in morning before breakfast. If a resident with CHF has acute changes or medication changes, they would be a daily weight. Surveyor asked RN I who decides the frequency of obtaining weights. RN I stated, the provider decides if someone is a daily weight and/or based on nursing discretion. Weekly weights are done on shower days. The CNA brings the nurse the weight and nurse puts it into the electronic charting system to do list. Surveyor asked RN I if R16 is currently a daily weight. RN I stated that R16 is not a daily weight and has had frequent issues with CHF and medication changes. Surveyor asked RN I who decides whether R16 is a daily or weekly weight. RN I stated, we do daily weights for a week when there is a change to her medication otherwise it is being done by the physician or our discretion. Surveyor asked RN I about R16's oxygen use. RN I stated that R16 is always on O2 and that O2 is being checked every shift. Surveyor asked RN I if staff are checking R16's oxygen saturation on room air or how often room air is being assessed. RN I stated, R16's room air O2 is checked monthly .I think, unless orders state otherwise. We have tried weaning R16 off oxygen and have been unsuccessful. (continued on next page)

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Norseland Nursing Home	323 Black River Ave Westby, WI 54667

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 8:57 AM, Surveyor interviewed RN M. Surveyor asked RN M about the facility process for obtaining weights. RN M stated, we get weights weekly on shower days and the nurses chart the weights in the electronic charting system. The Dietician looks at the weights when she comes in weekly and notifies management staff of any significant changes. We notify the provider of any changes, and we have weight notification sheets we send out to the PCP (primary care provider) if changes are noted. The CNAs obtain weights, and they give the weights to the nurse to chart in the electronic charting system. If a discrepancy exists, we will ask the CNA to get reweight. Surveyor asked RN M what the facility standard of practice is for a patient with a change of condition or CHF. RN M stated that the facility does not use a standard of practice. Surveyor asked RN M if R16 is always on oxygen. RN M stated that R16 is always on oxygen. We tried weening her a while ago she was in therapy but that did not work. She is uncomfortable without her O2. Surveyor asked RN M about R16's physician's orders for oxygen. RN M states I think this stem back to therapy's recommendation. She has had exacerbations. R16 for sure likes to wear her oxygen to sleep. Surveyor asked RN M, should staff be assessing R16's room air oxygen as ordered every shift. RN M stated, yes, we should be checking her O2 on room air, every shift, as the order indicates. We should also be trying to wean her off the O2 as the orders indicated. On 4/30/24 at 9:08 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what standard of practice the facility uses. DON B stated, Healthcare Academy, skills, 8-10 educational modules, and [NAME]. Surveyor asked DON B about the process for obtaining weights. DON B stated, the facility just implemented new procedures last week regarding weights as discrepancies had been noted. Surveyor asked DON B how staff are made aware of who to obtain weights on every day. DON B stated, the nurse would in morning report tell the CNA who needs weights and those show up on the nurses to do list. The CNA gets the weight, brings it to the nurse and the nurse charts it. Surveyor asked DON B where staff would find weight parameters. DON B stated the care plan under nutrition will indicate any weight parameters. The electronic charting system does trigger with any significant weight loss or gain. Surveyor asked DON B how frequently weights are obtained. DON B stated the standard is weekly weights. If they are daily weights, a physician orders them. We have had some issues with no stop dates for daily weights. During the interview with DON B, NHA A (Nursing Home Administrator) stated the goal for obtaining weights is weekly but at a minimum monthly, unless a physician order indicates specific parameters. Surveyor reviewed R16's weight order with NHA A and DON B. NHA A states R16's weights should be done daily unless there is an order to discontinue. Surveyor asked NHA A what the expectation of staff would be for following physician orders. NHA A stated that the expectation would be to follow the physician orders. The facility did not ensure physician's orders were followed for R16's daily weights and oxygen assessment and administration.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility did not ensure a resident with limited range of motion receives appropriate treatment and services to increase their range of motion and/or to prevent a further decrease in range of motion for 3 of 16 total sampled Residents (R7, R8, R16) and 1 of 1 supplemental resident's (R31). R8 has therapy recommendations for restorative therapy including the [NAME] Med bike four times weekly for twelve minutes and passive range of motion exercises daily that are not being completed. R16 has orders to participate in a walking program twice a day-AM (morning) and PM (evening), CGA (contact guard assist) with four-wheeled walker, wheelchair to follow-distance as tolerated that is not being completed. R31 is on the restorative walking program and the facility does not have documentation to show R31 is being walked. R7 is on the restorative walking program and the facility does not have documentation to show R7 is being walked. Evidenced by: The facility policy titled, Restorative Policy last reviewed 4/1/2024, states in part, Purpose: to promote resident ability. To improve/maintain/regain self-performance or prevent decline in various ADLs (activities of daily living), so that they may adapt and adjust to living as independently and safely as possible. Resident participation is a requirement for all restorative programming except for PRM (passive range of motion) and splint/brace use to prevent contractures. Procedure: programs will be individualized by identifying goals, approaches, and safety areas for that resident. An accumulation of minutes will include explanations, set-up, verbal cuing, supervision, demonstration, clean-up, etc. Changes in ability and/or function will be reported to the unit nurse so that updates/revisions can be made. As a resident's needs and abilities change, the program will be updated. PT/OT/ST (Physical Therapy/Occupational Therapy/Speech Therapy) will communicate to nursing pertinent recommendations for the resident's restorative program and will be added by the nurse manager or the DON (Director of Nursing). A referral to PT/OT/ST will be forwarded as needed for the residents that are showing a decline in ADL function. Example 1 R8 was admitted to the facility on [DATE], with the latest readmission on 3/8/24. R8 has diagnoses that include in part . iliotibial band syndrome-right leg, contracture-unspecified hand, unspecified abnormalities of gait and mobility, low back pain, myoneural disorder-unspecified, pain in leg unspecified, osteoarthritis- right and left hand, weakness, vitamin D deficiency, syndrome of inappropriate antidiuretic hormone (SIADH). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's Significant Change Minimum Data Set (MDS) dated [DATE] indicates R8 has a Brief Interview of Mental Status (BIMS) of 15 indicating that he is cognitively intact. No mood or behaviors noted. Resident has limited range of motion in upper and lower extremities. Resident is dependent on staff for bathing. R8 requires substantial/maximal assist for upper and lower body dressing, personal hygiene, bed mobility, and transfers. Urinary incontinence is not rated and R8 is always incontinent of bowel. On 8/23/23, facility document titled Therapy Communication to Nursing for R8 states in part, start the following therapy: PT. Goal: Restorative program. Recommendation: May use [NAME] med bike (a therapy device that enables patients with restricted mobility a motor driven, and motor assisted leg and/or arm training from a seated position) daily for maintaining leg strength and mobility. Four times weekly for 12 minutes. Will need assistance to set up. Questions, see therapy. On 3/22/24, facility document titled Therapy Communication to Nursing for R8 states in part . start the following therapy: PT. Goal: Range of motion program. Recommendation: See attached exercises. Complete one time a day to maintain mobility and flexibility in lower extremity. Attached exercises include, calf stretch PROM (passive range of motion), hip PROM-flexion-extension, hip PROM-abduction-adduction, and hip PROM-rotation. R8 is to receive [NAME] bike daily for maintaining leg strength and mobility 4 times weekly for 12 minutes. R8's restorative documentation indicates he has not received this treatment over the last 30 days. R8 is to receive PROM daily. Review of R8's restorative documentation indicates that from 3/22/24 to 4/30/24 R8 received restorative PROM 16 times out of a possible 39 times. Example 2 R16 was admitted to the facility on [DATE] with the diagnosis that include in part . Congestive Heart Failure (CHF), atrial fibrillation, cerebral infarction, pleural effusion, type 2 diabetes, and anemia. Review of R16's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24, located in the EMR under the MDS tab, indicated R4 had a Brief Interview for Mental Status (BIMS) score of 13 of 15, which indicated R16 is cognitively intact. Toileting/hygiene, toilet transfers showering, personal hygiene, upper and lower body dressing are all partial/moderate assistance. R16 is independent with bed mobility. Frequently incontinent of urine and always continent of bowel. The MDS also indicates that R16 is on oxygen therapy. On 11/27/23, facility document titled Therapy Communication to Nursing for R16 states in part, Goal: Return to PLOF (prior level of function) and possibly wean from O2. Recommendation: Please resume walking program one to two times a day with four-wheeled walker, CGA (contact guard assist), with wheelchair to follow. Distance as tolerated. Also, can we try to wean O2. She was stable in the low to mid- 90's at rest and with activity on 1L with PT. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physical therapy discharge summary dated 2/29/24 at 4:37 PM states, in part, Restorative programs: Restorative program establish/trained=restorative ambulation program. Ambulation program establish/trained: Patient to ambulate with nursing daily distance as tolerated with four-wheeled walker and wheelchair to follow. The Certified Nursing Assistant (CNA) Care Card printed 4/30/24, states in part, Restorative: Walking program twice a day-AM and PMs. CGA with four-wheeled walker, wheelchair to follow-distance as tolerated. R8's comprehensive care plan does not address restorative services that were ordered by physical therapy. R8's restorative documentation from 3/1/24 to 4/30/24, shows R8 was walked on the following dates and times: 3/1/24 at 13:09 (1:09 PM) 3/1/24 at 21:03 (9:03 PM) 3/3/24 at 10:24 AM 3/4/24 at 10:44 AM 3/5/24 at 11:24 AM 3/6/24 at 13:15 (1:15 PM) 3/7/24 at 13:13 (1:13 PM) 3/9/25 at 13:50 (1:50 PM) 3/10/24 at 13:24 (1:24 PM) 3/12/24 at 13:14 (1:14 PM) 3/19/24 at 15:15 (3:15 PM) 3/21/24 at 13:16 (1:16 PM) 3/23/24 at 10:17 AM 3/24/24 at 13:50 (1:50 PM) 3/26/24 at 13:25 (1:25 PM) 3/30/24 at 13:40 (1:40 PM) 3/30/24 at 14:09 (2:09 PM) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/15/24 at 13:28 (1:28 PM) 4/28/24 at 13:29 (1:29 PM) Of Note: From 3/1/24 through 4/30/24 R1 was walked a total of 19 times out of a possible 122 times. On 4/28/24 at 10:10 AM, Surveyor interviewed R8. Surveyor asked if R8 had any concerns regarding his care in the facility. R8 states, he is supposed to be receiving additional ROM assistance three time a week from staff; however, this is not being done. Surveyor asked R8 if he knew which staff members are supposed to be completing these exercises with him. R8 stated, physical therapy staff told him that nursing staff are supposed to assist him with his range of motion exercises, but no one had been helping him with his exercises. On 4/29/24 at 2:07 PM, Surveyor interviewed R8. Surveyor asked R8 how missing his restorative therapy sessions has affected him. R8 states, if they kept up on therapy, it would help my knees and legs .it's just never been done. Surveyor asked R8 if he ever refuses his restorative therapy exercises. R8 states, no, I always use it. Anything to help me get better, I'm going to do it. On 4/29/24 at 3:49 PM, Surveyor interviewed PTA R (Physical Therapy Assistant). Surveyor asked PTA R who is responsible for completing the restorative and walking programs. PTA R stated that the CNAs (Certified Nursing Assistants) are expected to complete both programs. Surveyor asked PTA R how restorative and walking program orders are communicated to the nursing staff. PTA R stated that she makes three copies of the orders. One copy goes to the Director of Nursing, one copy goes to the charge nurse, usually RN M (Registered Nurse), and the last copy goes to a floor nurse currently on shift. On 4/30/24 at 1:33 PM, Surveyor interviewed CNA C. Surveyor asked CNA C if the facility has a restorative or walking program. CNA C states we have a walking program and its done if we have time. We often can't get through the entire list. ROM is completed with dressing. Surveyor asked CNA C were the restorative program orders/recommendations come from. CNA C states that the restorative orders come from therapy. Surveyor asked CNA C how she knows who is on a restorative program. CNA C states she can ask others and she also keeps a personal cheat sheet as a reminder. Surveyor asked CNA C what she does when someone refuses restorative. CNA C states that she talks to the nurse or OT about anyone that declines. CNA C states that they have a binder that they document walking in, but since Surveyors have arrived in the building, management took away the binder. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/24 at 13:37 (1:37 PM) Surveyor interviewed RN I (Registered Nurse). Surveyor asked RN I what the procedure is for a resident who shows a decline in function or abilities. RN I states that if it is an acute change, the facility has standing orders for PT/OT/Speech evaluations and that RN I updates the provider to notify them that they are implementing the standing orders. A sheet is completed and given to management notifying them of the implementation of the standing orders. Surveyor asked RN I what staff do with therapy recommendations. RN I states that therapy will write out a communication sheet, 1 sheet goes to the nurse manager who updates the care plan. A copy is made and put into the communication book. Surveyor asked RN I what they do if the resident refuses restorative services. RN I states she talks to the resident about the refusals to attempt to determine a cause and updates the physician. Surveyor asked RN I what the expectation is for staff who can't complete the restorative program to-do list. RN I states that staff should report it to the nurse if they can't get it done and that the nurse should report it to management if they realize it isn't being done. RN I also stated, we really need a restorative aide. Every place I've worked has one and we really need one. On 4/30/24 at 13:45 (1:45 PM) Surveyor interviewed CNA F. Surveyor asked CNA F about the facility restorative program. CNA F states that we walk them and do ROM (range of motion). Surveyor asked CNA F where she finds the restorative program information. CNA F states that the information is on everybody's care plan. Surveyor asked CNA F how she is provided new orders or changes to someone's current restorative program. CNA F states, there may be a note on the desk or with staff report during shift change. Surveyor asked CNA F what she does if she notices someone has a decline in ROM. CNA F states that she notifies a nurse that the resident may need a therapy evaluation. Surveyor asked CNA F about R8's restorative program. CNA F states, R8 has ROM with left arm and leg. Surveyor asked if R8 ever refuses restorative therapy. CNA F states he never refuses ROM therapy. Surveyor asked CNA F what they do if someone refuses restorative therapy. CNA F states, they reapproach in the afternoon and chart any refusals. Surveyor asked CNA F how to perform and complete prescribed exercises. CNA F states, therapy gives us something to follow on what exercises we should do with print out pictures. Surveyor asked CNA F what they do if they are unable to complete restorative therapy with a resident. CNA F states, if it can't get done, I chart not completed because of environment which means i.e., staffing, it happens a lot. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/24 at 1:54 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is for conducting the facility's restorative therapy program. DON B states, all the restorative therapy orders are put in through restorative nurse on the electronic charting system. The process was changed in January as we identified an issue with the electronic charting system not triggering staff to chart the restorative program. Communication comes from PT/OT and a copy is given to the floor nurse and all management personnel and added to the to-do list in the electronic charting system. The walking program binder was also added in January. Surveyor asked who is expected to conduct restorative program orders. DON B states, the CNA's are supposed to conduct restorative program orders, whatever the order is whether it be ROM or the walking program. Surveyor asked DON B what the expectations are for CNA's regarding the restorative program. DON B states, if they can't get it done it is to be passed off to the next shift unless the resident refuses. If the resident refuses it needs to be charted as a refusal. Documentation should be completed whether the resident refuses or the ordered activity is completed. Surveyor asked DON B if the expectation is for CNA's to chart in the walking binder, resident walks, and refusals. DON B states, yes. Surveyor asked DON B if she would expect the CNA to notify a nurse if a resident had a noticeable change in ability. DON B states, yes. Surveyor asked DON B if the expectation would be for a CNA to report frequent refusals of restorative orders. DON B states, yes. Surveyor asked DON B if R8 is at risk for a decline in function. DON B states if he continues to refuse and not participate in prescribed exercises with staff. It can be hit or miss with him. Surveyor asked DON B why R8 is at risk for a decline in ROM. DON B states, R8 has refusals, can make inappropriate comments towards staff, can be unpleasant and rude towards staff, and at times expects staff to do everything for him. DON B indicates also has a right-sided neuromuscular disorder. Surveyor asks DON B what interventions are in place to prevent a decline in R8's ROM. DON B states, R8 has a restorative plan but I do not know what that is off the top of my head. Surveyor asked DON B if R8 also has a ROM restorative plan. DON B states yes. Surveyor asked DON B if R16 is at a risk for a decline in function. DON B states yes, based on age and diagnosis. The facility did not ensure that restorative therapy exercises and activities were completed for each resident to maintain current abilities, prevent decline, or to restore baseline abilities. 41788 Example 3 R31 was admitted to the facility on [DATE], and has diagnoses that include Atherosclerosis of native arteries of left leg with ulceration of other part of lower leg (a disease that causes the arteries that supply the legs and feet to narrow and harden) and venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes). R31's Quarterly Minimum Data Set (MDS) Assessment, dated 3/20/24, shows R31 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R31 is cognitively intact. R31's care plan dated 4/19/24, states, in part: . Need/Preference: I can't complete my cares on my own. I want to return to my previous living situation because I have hemiplegia- CVA (cerebrovascular accident)/left side affected. I show this by having a hard time moving getting tired quickly voicing frustration . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Approach: I walk with 2 helpers providing more than half the effort follow my restorative walking plan ONCE DAILY 2A (assist) 2 WW (wheeled walker), gait belt, w/c (wheelchair) to follow. Currently tolerates 50-75 feet . R31's Therapy Communication to Nursing Form, dated 12/18/23, states, in part: . Resident is Changes to Plan of Care From the following therapy: PT (Physical Therapy) Goal: Walking Program Recommendations: Please walk 1x/day with 2 persons assist using 2 ww, gait belt, and w/c follow. Currently tolerates 50 -75 feet . Certified Nursing Assistant (CNA) documentation for daily ambulating for March 1, 2024, through May 1, 2024, shows R31 was not ambulated on following dates: 4/23, 4/22, 4/21, 4/19, 4/14, 4/13, 4/10, 4/9, 4/7, 4/6, 4/5, 3/31, 3/29, 3/28, 3/24, 3/21, 3/19, 3/18, 3/16, 3/15, 3/14, 3/13, 3/12, 3/10, 3/7, 3/6, 3/4, and 3/1. This shows R31 did not get ambulated 28 days out of 62 days. Of note: This is not following therapy recommendations for every day. R31's Walking Program Documentation sheets from 3/31/24- 4/29/24 shows R31 walked 2 days out of 30 days. Of note: This is not following therapy recommendations for every day. Example 4 R7 was admitted to the facility on [DATE] and has diagnoses that include Polyosteoarthritis (a joint disease that affects at least five joints simultaneously), Muscle weakness (generalized), and difficulty in walking. R7's Quarterly Minimum Data Set (MDS) Assessment, dated 3/20/24, shows that R7 has a BIMS score of 13 indicating R7 is cognitively intact. R7's Care Plan dated 3/1/24, states, in part: . Need/Preference: I need some assistance with my personal cares because I have poor balance, OA (osteoarthritis), get confused, chronic pain, some limitations. I show this by having a hard moving, being forgetful, trying things on my own . Approach: . I walk with the help of 1 person with gait belt and 4 ww . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's CNA Kardex, with a print date of 4/30/24, states, in part: . Restorative: Walk with 1 assist FWW (Front wheeled walker), gait belt, with wheelchair to follow AM and PM daily . R7's therapy recommendations, dated 3/9/23, states, Walking: On the unit assist of 1 with 4 ww, gait belt, wheelchair to follow, and o2 (oxygen) on halfway down the hall and back to room two times a day every day. CNA documentation for daily ambulating for 3/1/24 through 4/28/24, shows a total of 61 days R7 should have been ambulated twice a day totally 122 times R7 should have been ambulated. R7 was ambulated only 30 times out of 122 times as per recommendations of therapy. Of note: This is not following therapy recommendations for every day. R7's Walking Program Documentation sheets from 3/31/24- 4/29/24 shows R7 walked 1 time/day x 1 day out of 30 days. Of note: This is not following therapy recommendations for every day. On 4/30/24 at 1:05 PM, Surveyor interviewed PTA R (Physical Therapy Assistant). PTA R indicated R31 is currently working with PT (physical therapy) and PT has recommended R31 to be on walking program for walking one time a day with a walker with 1 assist as tolerated. Surveyor asked PTA R if she would expect the recommendation to be followed and documented and PTA R indicated yes in the walking book at the nurses' station or in the computer. Surveyor asked who is responsible to walk the residents on the walking program and PTA R indicated the CNAs. PTA R indicated therapy would expect the CNAs to be following the walking program for residents on it and documenting. Surveyor asked PTA R if R7 was on the walking program and PTA R indicated yes. PTA R indicated therapy would expect the CNAs to be following the walking program for R7 and documenting as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norseland Nursing Home	323 Black River Ave Westby, WI 54667

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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 0689 Level of Harm - 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** 50285 Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 1 of 3 residents reviewed (R30) of a total sample of 15. R30 has a history of multiple falls. Facility staff did not implement and/or follow through on fall interventions. R30 had two falls with major injury: one unwitnessed fall that resulted in a 1.5 cm head laceration over left eyebrow with 2 stitches placed and another unwitnessed fall that resulted in a closed fracture of rib on left side. This is evidenced by: Facility Fall Prevention Policy and Procedure, dated 12/31/2009 with last revision date of 7/29/21 states in part: .A care plan will be developed and implemented to prevent falls and other accidents, based on their risk assessment .admitting nurse will do admission and fall risk assessments and adjust safety interventions as needed .care plan to be followed by staff .DON (director of nursing) will do a root cause analysis .and revise the plan of care as necessary to prevent further accidents . Facility Care Plan Policy and Procedure, dated 5/16/13 states in part: .The care plan will be continually reviewed and revised to represent the current status of the resident .the CNA (certified nursing assistant) assignment care can be posted in the resident's closet or it can be viewed from the kiosk .the care plan must be reviewed and revised quarterly, annually, and with any change in condition . Facility Resident Incident Report Policy, dated 7/12/21 and revised 4/1/24 states in part: When a resident injury or incident occurs the unit nurse will assess the situation, complete a resident incident report, and route to the Director of Nursing .Immediate interventions will be implemented by the Unit Nurse .The Director of Nursing or designee will copy the Resident Incident Report to Resident Services and as appropriate for PT (physical therapy)/OT (occupational therapy) for review .The Director of Nursing will make recommendations for improvement in care or other follow up . R30 was admitted to the facility on [DATE] with diagnoses that include corticobasal degeneration (a form of frontotemporal degeneration, a dementia that involves the loss of cognitive functions such as the ability to think, remember, or reason), chronic kidney disease, insomnia due to other mental disorder, anxiety disorder unspecified, Parkinsonism unspecified, other specified disorders of bone density and structure. R30's most recent Minimum Data Set (MDS) dated [DATE] states that R30 has a Brief Interview of Mental Status (BIMS) of 12/15 indicating that R30 has moderate cognitive impairment. Section GG of the MDS, functional abilities and goals, states that R30 requires one assist to transfer, one assist to walk in room, one assist to move about the unit, and one assist for toileting and all other ADLs (activities of daily living). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	R30's care plan dated 10/31/23 states in part, I fall down and hurt myself .because I have Parkinson's disease, take some medications that can make me dizzy, tired, confused, or weak .I need my nurse's to assess for unmet needs, remind me to ask for help .I need my aides to encourage me to use assistance, fall risk care plan, give me non-skid footwear so I don't slip, use the following assistive devices to be able to better help me. Goal .have no falls, avoid injury. R30's care plan dated 4/29/24 states in part, I fall down and hurt myself .because I have Parkinson's disease, take some medications that can make me dizzy, tired, confused, or weak .have fallen in the past .I need my nurse's to fall risk care plan, assess for unmet needs, remind me to ask for help, PT/OT to evaluate if walker is appropriate, may add arm holder if able to fit onto 4 wheeled walker, follow up with therapy recs .I need my aides to encourage me to use assistance, fall risk care plan, give me non-skid footwear so I don't slip, use the following assistive devices to be able to better help me, document my hand exercises in my binder, Call Don't Fall sign placed, 15 minute safety checks. Goal .continue to monitor and implement current fall interventions .may d/c (discontinue)15-minute safety checks to 30 minutes if resident remains fall free for 1 month. It is important to note that R30's care plan was updated during this recertification survey. R30's fall risk assessments are documented as follows: 10/31/23: Total Score: 11 - Resident at risk of falling. 1/29/24: Total score: 12 - Resident at risk of falling. 4/29/24 Total score: 12 - Resident at risk of falling. R30's fall reports list the following falls: 11/20/23 at 4:50 am - unwitnessed fall in resident room, no apparent injury - Resident lost balance while taking off her shoes and lowered herself to the floor. Facility fall interventions: Remind resident to use call light when going to the bathroom, offer to toilet on last rounds of NOC (nocturnal) shift. It is important to note that toileting on last rounds was not on the CNA's closet care card that they use for resident care, nor was it on resident's care plan. 12/30/23 at 3:33 am - unwitnessed fall in resident room - lost balance while attempting to open bathroom door. The facility Incident Report documents observed blood on the floor, walker and resident left side of head .Noted large 5 cm round hematoma around left above eye laceration .applied pressure to laceration . transferred to emergency room for evaluation/treatment. Facility fall interventions: Leave bathroom door ajar at night, night light added for visibility. Of note this is the second fall in less than 30 days where R30 was attempting to use the bathroom independently. The facility did not add toileting on last rounds to the care plan which the facility indicated was their new intervention after the 11/20/23 fall. R30 is care planned as a one assist with transfers and ambulation and should be assisted to the bathroom per R30's care plan to prevent further falls. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	R30 transferred to emergency roiagnom on [DATE] at 4:24 AM. ER encounter diagnosis: accidental fall, initial encounter - laceration of left eyebrow, initial encounter - left elbow pain. ER encounter notes state: . cleaned with Betadine, anesthetized with 1% lidocaine .wound closed with 2 sutures .laceration is 1.5 cm. 1/26/24 at 11:45 PM - unwitnessed fall in resident room - slid off bed due to soaker pad sliding while attempting to sit at edge of bed. The facility Incident Report documents c/o (complained of) pain left side/flank area .redden from shearing against bed frame. Facility fall interventions: Do not use soaker pad, add non-skid floor strips, resident refuses to wear gripper socks, instructed resident on using call light prior to transition/transferring safe transfer technique, use of call light. On 4/28/24 at 10:16 AM, Surveyor observed R30 in resident room in her recliner. The non-skid strips were not on the floor. R30 transferred to emergency roiagnom on [DATE] at 3:13 AM. ER encounter diagnosis: closed fracture of one rib of left side, initial encounter - ground level fall - new onset atrial fibrillation. ER encounter notes state: X-ray imaging of ribs, fracture along the posterior aspect of the left eight rib - CT (CAT Scan-medical imaging) of cervical spine without contrast, no cervical spine fracture seen - CT head without contrast, no intracranial hemorrhage. It is important to note this is the third fall for R30 in three months. Two falls have resulted in major injury. 3/3/24 at 7:15 PM - witnessed fall in resident room, no apparent injuries. The facility Incident Report documents: resident stood up to answer phone-resident turned and lost balance - falling to the floor - resident has hard time steering walker due to left arm weakness. Facility fall interventions: OT/PT to evaluate if walker is appropriate. Binder created to complete/check off R30's exercises. R30's Exercise Check List states in part: .These were implemented on January 24th. Her contractures are getting worse, and she is not the greatest at completing these on her own. Which is making her a bigger fall risk with her walker use. Please put a date and checkmark in the boxes. They are to be completed 3x/day. It is important to note that PT/OT evaluation for R30 was never completed, and the binder exercises indicated they are to be completed three times a day with staff assistance. The exercises were only completed 13 times from 3/18/23 to 4/15/23 with a total of 161 missed opportunities. 3/11/24 at 11:15 AM - unwitnessed fall in room, no apparent injuries. The facility Incident Report documents: resident was walked back to room from activities with assistance, resident got to doorway and walked to recliner by herself - resident attempted to turn around without the use of her walker. Facility fall interventions: educate staff to assist resident with ambulation to destination. Binder created to ensure R30 is completing her exercises from PT/OT. Call Don't Fall sign placed if she would need assistance. It is important to note R30 is a one assist with ambulation. R30 was assisted to her room from activities by a staff member. According to the fall incident report R30 was assisted to her doorway then walked to her recliner by herself instead of staff assisting to the recliner. R30 fell attempting to turn around this fall may have been prevented if R30's care plan was followed as written. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/28/24 10:16 AM, Surveyor observed R30 in resident room in her recliner. There was no Call Don't Fall signage in the room. 4/9/24 at 3:03 AM - witnessed fall in resident's room, no apparent injury. Facility Incident Report states: was walking back to her bed - did not use walker to turn around - staff lowered R30 to the floor. Facility fall interventions: PT consult to assess walker use and to see if an arm board will fit to make it more efficient and safe. It is important to note a PT consultation did not occur. 4/21/24 at 11:30 PM - unwitnessed fall in room, no apparent injury. Facility Incident Report states: slid out of bed while attempting to get out of bed to use the bathroom. Facility fall interventions: 15-minute checks ongoing, moved to other side of room to be closer to the bathroom, refuses gripper socks or different blanket/sheet. It is important this is the third fall related to attempting to use the bathroom. The facility did not identify this as a root cause of falls or implement toileting interventions to prevent further falls. Additionally, 15-minute checks were instituted for staff to chart on 4/22/24 to 4/27/24 but was not included on the care plan until 4/29/24. On 4/29/24 at 2:59 PM, Surveyor interviewed CNA Q (Certified Nursing Assistant). Surveyor asked CNA Q where you would find fall interventions. CNA Q stated in the care plan by the nurse's station. Surveyor asked CNA Q if he knew what the fall interventions were for R30. CNA Q reported that they do 30-minute checks and walk with her to dining room and encourage to use call light for bathroom. CNA Q indicated care plan notes are kept in resident's room inside the cupboard, called Closet Care Card. Surveyor asked CNA Q what was indicated for fall interventions on the Closet Care Card. CNA Q stated 15-minute checks. Surveyor asked CNA Q how often staff complete R30's exercises. CNA Q stated 3 to 4 times per week and that the exercise binder was kept at the nurse's station. On 4/29/24 at 4:17 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked if she would expect staff to assist R30 with her exercises every day. NHA A stated yes. Surveyor asked NHA A if she would expect staff to complete exercises with R30 three times per day as indicated in the binder. NHA A stated yes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/30/24 at 10:39 AM, Surveyor interviewed DON B. Surveyor asked DON B how fall interventions get onto the resident's care plan. DON B stated that she updates the care plan within 24-72 hours. Surveyor asked DON B who is responsible for placing Call Don't Fall signage and non-skid floor strips in resident's rooms. DON B stated that she would put the Call Don't Fall signage up the same day of the fall, and that there were no non-skid fall strips per NHA A. DON B indicated that R30 has a Call Don't Fall sign that has been in the room since 3/11/24. Surveyor asked DON B what the process was for PT/OT to come and assess a resident post fall. DON B stated that the standing order would need to be activated. Surveyor asked DON B how she ensured the exercises that were ordered as a fall intervention were being completed with R30. DON B stated she created a binder for them to complete the exercises with R30. Surveyor asked DON B how often she expected the exercises to be completed. DON B stated once a day. Surveyor asked DON B how CNAs are made aware of changes to the care plan or new fall interventions. DON B stated the Closet Care Plan and verbal communication from shift to shift, as well as the CNA communication binder at the nurse's station. Surveyor asked DON B why if PT was added as intervention for R30's falls on 3/3/24, why was no order received from physician until 4/11/24. DON B replied, I don't know. Surveyor asked DON B if R30 had seen PT after the 4/11/24 order for consultation was received. DON B stated she had not. Surveyor asked DON B how quickly fall interventions should be implemented to keep residents safe. DON B stated immediately but at the most 2 weeks after a fall. Surveyor asked DON B at what point a new intervention should be implemented to keep R30 safe. DON B indicated within 2 weeks. Surveyor asked DON B if refusing to wear gripper socks was an appropriate fall intervention. DON B stated no and that a risk and benefit analysis should have been completed with R30. On 4/30/24 at 11:27 AM, Surveyor and DON B observed R30's room. There was no Call Don't Fall sign in the room. DON B placed Call Don't Fall signs at this time. The Closet Care Card had only 15-minute checks and ensure hand exercises are completed as fall interventions. DON B indicated that the Closet Care Card is the only thing the staff refers to for care of the resident. DON B indicated it is her expectation staff to check communication binder and Closet Care Card every shift. DON B reported they have been having communication concerns with staff and this is a work in progress. 4/30/24 at 11:25 AM, Surveyor interviewed NHA A. Surveyor asked NHA A why the non-skid strips were not installed in R30's room per the fall intervention after 1/26/24 fall. NHA A stated that the facility had gotten new flooring and the non-skid strips do not work well with new flooring, as they are similar color as the floor, and she worried they would create a greater fall risk. Surveyor asked if anything had been implemented as a fall intervention in place of the non-skid floor strips. NHA A indicated that other interventions would be found that were appropriate, but they would use the floor strips if they had to. The facility failed to create a robust fall care plan for a resident at risk for falls, update the care plan after with each fall with new and appropriate interventions, or ensure that the fall interventions were adequately communicated to the frontline care staff. R30 had multiple falls two which resulted in major injury.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on staff interview and record review, the facility did not ensure that pain management was provided consistent with standards of practice for 1 of 2 residents reviewed (R7) reviewed for pain out of a total sample of 15. R7 has orders for scheduled Tylenol and Tramadol pain medication. R7 has pain in left knee and Polyosteoarthritis. Facility has not been assessing pain with scheduled pain medications to track effectiveness of medications. Evidenced by: The facility policy, entitled Pain Assessment and Monitoring, dated 4/1/24, states, in part: . Purpose: To provide care and services to attain or maintain optimal comfort and pain management from acute and/or chronic medical conditions. Procedure: 1. Evaluate the resident for signs/symptoms that may indicate the need for pain management . 3. Documentation will include, but not be limited to: origin/location, duration, intensity of pain, past relief measures, what precipitated the pain, what relieves the pain, etc. 5. Notify the MD (medical doctor) of any persistent or uncontrolled pain so scheduled pain medications or interventions may be implemented/ordered . 9. Residents receiving scheduled pain medications will be evaluated in the routine documentation. 10. The medical record will have parameters for administration of multiple pain medications . R7 was admitted to the facility on [DATE], and has diagnoses that include unspecified dementia, pain in left knee and Polyosteoarthritis. R7's Quarterly Minimum Data Set (MDS) Assessment, dated 2/7/24, shows R7 has a Brief Interview of Mental Status (BIMS) score of 13 indicating R7 is cognitively intact. Section J indicates R7 has pain frequently, pain intensity is severe, and pain interferes with day-to-day activities frequently. R7's Care Plan, dated 2/5/24, states, in part: . Need/Preference: I like to be comfortable because I sometimes hurt as I have arthritis. I show this by telling you that I have pain. Approach: I need my nurses to: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ask me if I hurt, offer me pain medication, offer me a warm or cold pack, give me a massage . notify the provider of unrelieved pain. Evaluate need for routinely scheduled medications . Goal: My Goal is to maintain my pain at an acceptable level. Goal Time: thru 5/5/24 . R7's February, March, and April Medication Administration Record (MAR) states, in part: . Acetaminophen 500 mg (milligrams) Tablet Dose Ordered: (2 tablet/1000mg) by mouth twice a day AM PM First Date: 9/22/21 For: Pain . Tramadol HCl (hydrochloride) 50 mg Tablet Dose Ordered: (1 tablet/50mg) by mouth daily AM first date: 1/20/23 For: Pain . Of note: There are no pain ratings/assessments with administration of the acetaminophen and tramadol. R7's nurses' progress notes from May 1, 2024 - March 1, 2024, states, in part: . 4/9/24 @ 3:52:15 PM Pain/Hurting in Last 30 Days: Yes, Scheduled Pain Meds: Yes . 3/12/24 @ 6:34:51 PM Pain/Hurting in Last 30 Days: Yes, Scheduled Pain Meds: Yes . Of Note: No mention of any non-pharmacologic interventions used or pain ratings. R7's last pain assessment dated [DATE], states, in part: . Been on a scheduled pain medication regimen? Yes Received prn (as needed) pain medications? Yes Offered a prn pain med and declined? No Received non- medication? Yes Intervention for pain? (Left blank) Pain Interview: Have you had pain or hurting at any time in the last 5 days? Yes How much of the time have you been experiencing pain or hurting over the last 5 days? Frequently Location of pain: left ribs (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Description of pain: aching Over the past 5 days, has the pain made it hard for you to sleep at night? Frequently Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain? the past 5 days. Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain? Frequently Please rate your worst pain over the last 5 days on a zero to ten scale (zero= no pain, 10 = worst pain you can imagine): 07 Please rate the intensity of your worst pain over the last 5 days: moderate On 5/1/24 at 9:49 AM, Surveyor interviewed RN I (Registered Nurse) and asked when one would do a pain assessment. RN I indicated with any acute pain and quarterly with Medicare. RN I indicated pain assessments get completed with administration of prn (as needed) meds. Surveyor asked how one would know if scheduled pain medications were effective and RN I indicated one would only know if residents spoke of pain or use nurse judgement. RN I indicated pain assessments only get completed on prn medications and pain levels are not being charted on scheduled meds. Surveyor asked RN I where a resident's comfort level would be found and RN I indicated it should be in the care plan, Surveyor asked RN I if a resident's comfort level could be found somewhere else other than care plan and RN I indicated not knowing. Surveyor asked RN I who is responsible for completing care plans and RN I indicated DON B (Director of Nursing) or nurse manager. On 5/1/24 at 10:03 AM, Surveyor interviewed DON B and asked if pain assessments/ratings are to be completed with administration of scheduled pain medications. DON B indicated with prn pain meds the computer system is set up to populate a pain assessment with administration. DON B looked on R7's MAR and indicated pain ratings/assessments are only pulling up for prn pain medications. Surveyor asked DON B if staff are completing pain ratings with R7's scheduled Tylenol and Tramadol DON B indicated no. DON B indicated she would expect a follow up on residents' pain levels to be documented within one hour of receiving a scheduled pain medication. Surveyor asked DON B how one would know if the pain medications administered were effective for the resident without pain ratings/assessments and DON B indicated one would not know. Surveyor asked for R7's pain assessments and DON B provided R7's pain assessments from 2/3/24 - 2/21/24. DON B indicated 2/21/24 pain assessment was the last pain assessment completed. DON B indicated pain ratings and follow up pain ratings are not being completed for scheduled pain medication and should be. Surveyor asked where a resident's pain goal would be found, and DON B indicated on the care plan. DON B pulled up R7's Care Plan. Surveyor asked if R7's pain goal was on her care plan and DON B indicated no and it should be. DON B indicated the expectation would be for a resident pain goal to be on the care plan. Surveyor asked DON B if R7's, care plan states to maintain R7's pain level at an acceptable level; what is R7's acceptable level? DON B indicated one would not know. Of note, Surveyor attempted to interview R7 and R7 elected not to speak to Surveyor.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on record review and interview, the facility did not ensure that Physician Orders were signed and dated timely for 4 of 19 residents (R7, R5, R2, R16) and 1 supplemental resident reviewed for physician orders. R5's telephone orders are not signed by a physician. R7's telephone orders are not signed by a physician. R2's physician telephone orders were not signed and dated by a physician in a timely manner. R16's physician telephone orders were not signed and dated by a physician in a timely manner. Evidenced by: The facility policy, entitled Physician Services, dated 4/1/24, states, in part: . Policy: It is the responsibility of Norseland Nursing Home to ensure that physician services are available to the residents of this facility. Procedure: I. Physician Services 483.30 . 3. Physician Visits- The Physician must: a. Review the resident's total program of care, including medications and treatments . c. Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines . Example 1 R5 was admitted to the facility on [DATE], and has diagnoses that include Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Type Two Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). R5's telephone orders from 11/28/24 through 4/23/24 are not signed by a physician. Example 2 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7 was admitted to the facility on [DATE], and has diagnoses that include Interstitial pulmonary disease (a group of disorders that cause progressive scarring of the lung tissue), dementia (a general term for the loss of cognitive functioning that interferes with a person's daily life), and chronic kidney disease (longstanding disease of the kidneys leading to kidney failure). R7's telephone orders from 11/22/24 through 4/24/24 are not signed by a physician. On 4/30/24 at 9:05 AM, Surveyor interviewed RN J (Registered Nurse) and asked what the process is for obtaining a telephone order from a physician. RN J indicated one gets the order over the phone from the physician's nurse or physician and then it goes under physician tab in chart. The nurse who receives the order fills in the physician's name and medication. The order gets entered into the computer system. The carbon copy gets torn off and given to a second nurse to check the order against the order entered into the computer system. The second nurse co-signs physician's order under the co-sign tab. RN J indicated the pink carbon copy goes to the nurse desk until the end of the shift where we make sure it gets communicated to oncoming shift. The physician comes to facility typically once a week and the nurse working with the physician has the physician sign the copy. Surveyor asked RN J who would be responsible for obtaining the physician signature on the copies of the telephone orders and RN J indicated the nurse doing rounds with the physician. Surveyor asked RN J where the carbon copies of the telephone orders go after signature is obtained and RN J indicated not knowing. On 4/30/24 at 9:17 AM, Surveyor interviewed RN I and asked what the process is for obtaining a telephone order from a physician. RN I indicated the nurse taking the telephone order from the physician writes the orders on the slip with the date, resident, date of birth, physician's name and nurse receiving the order. The order then gets entered into the computer system into the MAR/TAR (medication administration record/treatment administration record). A second nurse checks the order and co-signs in computer system. The pink carbon copy goes in a folder at the nurse station for the physician to sign. Surveyor asked RN I where the pink carbon copies go after signed and RN I indicated she was not sure. Surveyor asked if a telephone order is required to be signed by a physician and RN I indicated yes within 7 days. RN I indicated the nurse manager rounding with the physician has the physician sign them weekly on Wednesdays. On 4/30/24 at 9:25 AM, Surveyor interviewed DON B (Director of Nursing) and RN M and asked what the process is for obtaining a telephone order from a physician. RN M indicated the nurse taking the order from the physician or the physician's nurse, puts the order on a Physician Order Sheet or on the Provider Communication Form. The order gets entered into the computer system by the nurse taking the order. A second nurse co-signs after checking the order entered into the computer system to the order on paper. DON B indicated the pink carbon copies go into the resident's thin file where we keep them for 5 years. DON B indicated the pink carbon copies are not signed by a physician; they are used for facility communication only. The carbon copies stay on the nurses 24-hour board for oncoming shifts to see. DON B and RN M indicated physicians never view telephone orders because the orders go into the computer system and physician orders get printed out for the physician to sign on rounds. Surveyor asked if a resident does not get seen one month what happens with telephone order and DON B indicated the order will get signed the next month. Surveyor asked DON B if a telephone order should be signed by a physician and DON B indicated not if it is a verbal order. DON B indicated RN M is responsible for printing physician orders off to be signed when a resident is seen by a physician. If a resident is not seen, they are signed on next visit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norseland Nursing Home	323 Black River Ave Westby, WI 54667

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/24 at 11:10 AM, NHA A (Nursing Home Administrator) indicated to Surveyor it is her expectation telephone orders are to be signed by a physician within 10 days. 49434 Example 3 On 4/29/24, Surveyor reviewed R2's physician's telephone orders from 1/2/24 through 4/24/24. Surveyor noted that these orders were signed by facility Registered Nurses (RNs), but no physician signatures were present. Example 4 On 4/29/24, Surveyor reviewed R16's physician's telephone orders from 12/1/23 through 4/22/24. Surveyor noted that these orders were signed by the facility RNs, but no physician signatures were present.

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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** 36917 Based on interviews and record reviews, and facility policy review, the facility failed to provide medically related social services for one of three residents (Resident (R) 36) related to his mental health diagnosis and physician recommendation upon admission of 15 sampled residents. Findings include: Review of the facility's policy titled, Care Plan, updated 04/01/24, revealed each resident would have a specific plan of care developed on information gathered from .physician/therapist orders. Review of R36's electronic medical record (EMR) under the Face Sheet tab, revealed R36 was admitted from an acute care hospital to the facility on [DATE], with diagnoses which included bipolar depression, post-traumatic stress disorder (PTSD), depression, and anxiousness associated with depression. Review of the hospital discharge summary, dated 3/29/24 and located in the EMR under the Other tab, revealed a reference Consult to Social Services . The summary included a list of discharge medications to include trazodone (anti-depressant medication), bupropion (anti-depressant medication), and escitalopram (anti-depressant medication). Review of R36's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/04/24 revealed diagnoses which included bipolar mood disorder, anxiety disorder, and PTSD. The MDS indicated R36 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. Review of R36's Electronic Medical Record (EMR) under the Care Plan tab with an Assessment Reference Date (ARD) of 4/4/24 through 4/29/24, had no care planned problems or interventions associated with his psychosocial diagnosis or medications administered for his psychosocial diagnosis. Review of R36's EMR under the Progress Notes tab, from admission through 4/29/24, social services did not have documentation to address his psychosocial diagnosis or medications administered for his psychosocial diagnosis and needs. During an interview on 4/29/24 at 11:34 AM, DON B (Director of Nursing), stated that her expectation for R36 upon his admission was that he should have had a care plan from nursing and social services to address his psychosocial needs. She stated that the care plan did not indicate nursing or social services had addressed his psychosocial needs related to his mental illness diagnosis and antipsychotic medications. During an interview on 4/30/24 at 3:00 PM, SW E (Social Worker) stated that she had not addressed R36's psychosocial needs in his care plan. She said her focus for R36 was based on the hospital discharge summary problem list located on page one, that did not include a mental illness diagnosis. The SW stated she did not see the physician's reference for social services consult on page three of the hospital discharge summary. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide medically related social service consultation per physician orders or address his psychosocial needs as it relates to his diagnoses and medication therapy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39713 Based on interview and record review, the facility did not ensure that drug regimens are free of unnecessary psychotropic medications, and that a resident taking a psychotropic medication has a care plan that includes targeted behaviors and side effects for 2 of 5 residents (R32 and R36) reviewed for unnecessary medications. R32 was started on Clonazepam (sedative) for involuntary body movements and Citalopram (antidepressant) for Major Depressive Disorder. R32 does not have a diagnosis for Major Depressive Disorder and the care plan contained no mood or behavior monitoring to assess the effectiveness of these medications or any potential side effects. R36 did not have targeted behavior monitoring. Evidenced by: The facility policy titled, Psychotropic Medication Review and GDR (gradual dose reduction) Reduction, last reviewed 4/01/24, does not include any information on care planning targeted behaviors or monitoring for potential side effects of medications being taken. Example 1 R32 was admitted to the facility on [DATE] with diagnosis that includes in part, other specified anxiety disorders and unspecified involuntary movements. R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 states in part, R32 has a BIMS of 11, indicating moderate cognitive impairment. D0150. Resident mood interview: A. little interest or pleasure doing things, No. B. Feeling down, depressed, or hopeless, Yes-Never or 1 Day. E0100. Psychosis Z. None of the above. E0200. Behavioral Symptoms-Presence and Frequency. All indicate behavior not exhibited. R32 has upper and lower extremity impairment on both sides. Toileting, hygiene, and showering are partial/moderate assistance. Upper and lower body dressing and personal hygiene are supervision or touch assistance. Bed mobility is independent. Transfers are partial to moderate assistance. R32 is always continent of bowel and bladder. On 4/30/24, Surveyor reviewed R32's mood and behavior charting for the period of 1/1/24 through 5/1/24 with no documented behaviors noted. Surveyor reviewed Certified Nursing Assistant (CNA) closet card which includes a section for behavior which is blank. R32's comprehensive care plan states in part . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan dated 03/18/2024: I: can't complete my cares on my own. I WANT: to return to my previous living situation. BECAUSE I: Have acute illness, cardiac disease, involuntary movements after my strokes (take clonazepam). Of note, this is the only mention of Clonazepam and there is no mention of Citalopram within the care plan. R32's signed physician orders dated 4/18/24 state in part, Citalopram Hydrobromide 20 mg (milligram) tablet dose ordered: (1 tablet/20 mg) by mouth daily AM (morning). First date 09/27/2023 for Major Depressive Disorder (Major Depression). R32's signed physician orders dated 4/18/24 state in part, Clonazepam 0.5 mg tablet dose ordered: (1 tablet/0.5 mg) by mouth twice a day AM Supper. First date 10/23/23 for Involuntary Body Movements. Social services progress note dated 3/23/24 at 8:27 AM states, quarterly review: R2 is well adjusted to the facility and states that he is happy with his care, room, and roommate. R32 requires reminders of daily activities. His long-term memory is largely intact. There are no mood or behavior concerns. His family is supportive and visit often. R32 requires a level of assist that likely could not be met in a lower level of care setting. He gets along well with staff and other residents and participates in activities of his choosing. He denies any concerns or issues at this time. On 5/1/24 at 8:46 AM, Surveyor interviewed RN S (Registered Nurse). Surveyor asked RN S where staff would be able to find targeted behaviors and potential side effects of medication. RN S states, I would look in the care plan. RN S also states, I wish it indicated what behaviors we are to be looking for. On 5/1/24 at 8:48 AM, Surveyor interviewed RN I. Surveyor asked RN I where staff would be able to find targeted behaviors and potential side effects of medication. RN I states, I usually put them in the to-do list and specify what behavior you are looking for. I am not sure who puts the behaviors in the electronic charting system for the CNAs. Surveyor asked RN I how often they chart behaviors for residents taking psychotropic medications. RN I stated, every shift for someone on an antipsychotic. Surveyor asked RN I if mood, behavior, and side effects should be care planned. RN I stated, for sure. On 5/1/24 at 8:56 AM, Surveyor interviewed CNA L. Surveyor asked CNA L where she documents resident behaviors. CNA L states, there is behavior charting on the kiosk in the electronic charting system. Surveyor asked CNA L how she knows which behaviors to monitor. CNA L states that there are no targeted behaviors on the care plan. The care plan only includes wandering, fall risk, or no male cares. On 5/1/24 at 9:01 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if psychotropic medications should be care planned. DON B states, psychotropic medications should be care planned and added to the to do list in the electronic charting system. Surveyor asked DON B if targeted behaviors should be on the care plan. DON B states, targeted behaviors should be listed on the care plan. Surveyor asked DON B who creates the care plans. DON B states, the admission care plans are done by me and the nurse manager. Surveyor asked DON B how often care plans are reviewed and updated. DON B states, the care plans are reviewed and updated quarterly and as needed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure that each resident was free of unnecessary psychotropic medications and that the comprehensive care plan included targeted behaviors and potential side effects of the medications. 36917 Example 2 Review of R36's electronic medical record (EMR) under the Face Sheet tab revealed R36 was admitted from an acute care hospital to the facility on [DATE], with diagnoses which included bipolar depression, post-traumatic stress disorder (PTSD), depression, and anxiousness associated with depression. Review of R36's EMR under the Physician Orders tab, dated 3/29/24, revealed R36 was administered Lamotrigine (anti-seizure medication) 100 mg tab twice daily for bipolar depression, Prazosin (alpha blocker medication) 1 mg capsule once daily for PTSD, Trazodone (anti-depressant medication) 50 mg Tablet once nightly for insomnia associated with depression, Bupropion (anti-depressant medication) XL 300 mg daily for indications of anxiousness associated with depression, and Escitalopram (anti-depressant medication) 20 mg tablet daily for indications of anxiousness associated with depression. There were no specific orders for monitoring R36's medication side effects or behaviors. Review of R36's EMR under the Care Plan tab indicated his care plan with an Assessment Reference Date (ARD) of 4/4/24 through 4/29/24 had no problems or interventions associated with his psychosocial diagnosis or medications administered for his psychosocial diagnosis. Review of R36's EMR Medication Administration Record (MAR) from his admitted [DATE] through 4/29/24, indicated administration of R36's medications as ordered by the physician but did not indicate monitoring of side effects or behaviors associated with R36's diagnosis or medication administration. During an interview on 4/29/24 at 11:34 AM the Director of Nursing B (DON), stated that the care plan did not indicate nursing or social services had addressed his psychosocial needs related to his mental illness diagnosis and antipsychotic medications. She could not provide documentation from the EMR for R36 to indicate his psychotropic medications had been reviewed or monitored for side effects or behaviors associated with R36's mental health diagnosis or medications.

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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** 42038 Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, this has the potential to affect the total census of facility, 42 residents. The facility allowed staff to return to work too soon after reporting respiratory symptoms and were not requiring staff to be tested for COVID-19 per Centers for Disease Control and Prevention (CDC) guidance. The facility allowed staff to return to work too soon after gastrointestinal (GI) symptoms. This is evidenced by: The facility's policy titled Infection Control Measures for Acute Respiratory Illness Outbreak revised on 10/19/23 states in part .3. Surveillance 1. Monitor staff call- ins and have anyone with COVID like symptoms perform an Antigen test. If the test is negative and the staff member continues to present symptoms, they must wear a mask while working. 2. When an ARI (Acute Respiratory Illness) or COVID-19 outbreak is identified, the facility's Infection Preventionist will maintain and update a line list to organize case information . 5. Documentation of testing 1. For symptomatic residents and staff, DON (Director of Nursing) or IP (Infection Preventionist) will document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results .6. Return to work for staff 1. If a staff member has tested positive for COVID-19, they will be required to follow quarantine guidelines as below .Per baseline [Facility Name] functions at a Contingency Staffing level .i. Conventional staffing: 1. At least 10 days since symptoms first appeared or 7 days with two negative tests (if asymptomatic) and 2. At least 72 hours have passed since last fever without the use of fever-reducing medications and 3. Symptoms have improved. ii. Contingency staffing: 1. 5 days with/ without negative test (if symptomatic or mild to moderate illness) and 2. Symptoms have improved . The facility's policy titled Employee Illness no date, states in part .Employees requesting to return to work after a communicable illness will consult with Infection Preventionist/ designee or their supervisor before returning to work .NOTE: these are examples only- See State and updates to Federal Guidance on restrictions for work: .Disease/ Problem: Diarrheal Diseases *Acute Stage (diarrhea with other symptoms) Work Restriction: Restrict from resident contact, contact with the resident's environment, or food handling Duration of Restriction: Until symptoms resolve, 48 hours since last episode (handwritten in). Disease/ Problem: *Norovirus (CDC) Work Restriction: Exclude from Duty Duration of Restriction: If you have symptoms consistent with norovirus infection (per the CDC symptoms include acute onset of vomiting, non-bloody diarrhea, abdominal cramps, nausea, and sometimes a low- grade fever), stay home for a minimum of 48 hours after symptom resolution. Disease/ Problem: Viral Respiratory Infections, Acute febrile Work Restrictions: Consider excluding from care of high-risk residents or contact with their environment during community outbreak of RSV or Influenza. Duration of Restriction: Until acute symptoms resolve, 24 hours fever free (handwritten in) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It is important to note that the facility's policy does not address Viral Respiratory Infections without a fever and does not indicate when an employee has symptoms that they should test for COVID-19. CDC guidance titled Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 dated 9/23/22 states in part .Test-based strategy: HCP who are symptomatic could return to work after the following criteria are met: Resolution of fever without the use of fever-reducing medications, and Improvement in symptoms (e.g., cough, shortness of breath), and Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT . https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html Surveyor reviewed the facility's Staff Illness Tracking for February 2024, March 2024, and April 2024. Per the documentation, the following staff returned to work too soon and did not perform COVID-19 testing per the guidance, nor did they test for Influenza during the facility's outbreak in February 2024. The documentation is as follows: Date: 2/7/24 Employee Name: CNA L (Certified Nursing Assistant) Unit last worked: 200. Date last worked: 2/6/24. Date of sx (symptoms): 2/6/24 Reason for call- in: Respiratory, Headache, Sinus/ Nasal Congestion Well date: 2/7/24. Return to work: 2/8/24. CNA L's Call-In/ [NAME] Report states that CNA L had migraine, sore throat, headache, and sinus. Date: 2/13/24 Employee Name: RN I (Registered Nurse) Unit last worked: 200. Date last worked: 2/13/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Date of sx: 2/13/24 Reason for call- in: Diarrhea Well date: 2/14/24. Return to work: 2/16/24. RN I's Call-In/ [NAME] Report states that RN I left the faciity on [DATE] at 7:50 AM with diarrhea. RN I returned to work prior to 7:50 AM on 2/16/24. It is important to note that the facility entered an Influenza Outbreak on 2/17/24 that affected 4 residents. Date: 2/20/24 Employee Name: CNA F Unit last worked: 100. Date last worked: 2/15/24. Date of sx: 2/18/24 Reason for call- in: Nausea, Vomiting, Headache, Diarrhea, and Sinus Well date: 2/19/24. Return to work: 2/21/24. CNA F's Call-In/ [NAME] Report states that CNA F had Diarrhea and stomach cramps on 2/19/24. Date: 2/21/24 Employee Name: RN N Unit last worked: both (100 and 200) Date last worked: 2/21/24. Date of sx (symptoms): 2/21/24 Reason for call- in: Respiratory and Sinus Well date: 2/23/24. Return to work: 2/29/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor did not receive RN N's Call-In/ [NAME] Report. Date: 2/20/24 and 2/21/24 Employee Name: RT O (Recreation Therapist) Unit last worked: rec therapy. Date last worked: 2/19/24. Date of sx (symptoms): 2/20/24 Reason for call- in: Respiratory and Sinus Well date: 2/21/24. Return to work: 2/22/24. RT O's Call-In/ [NAME] Report states that RT O reported symptoms of pressure in sinuses, exhaustion, sore throat, and congestion. RT O's COVID test was negative, no fever, and RT O was not tested for influenza as this was during the facilities influenza outbreak. Date: 2/27/24 Employee Name: RN I Unit last worked: 100. Date last worked: 2/26/24. Date of sx (symptoms): 2/26/24 Reason for call- in: Respiratory, Cough, Sinus Well date: 2/29/24. Return to work: 3/1/24. Surveyor did not receive RN I's Call-In/ [NAME] Report. Date: 3/5/24 Employee Name: CNA Q Unit last worked: 100. Date last worked: 3/4/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Date of sx (symptoms): 3/5/24 Reason for call- in: Nausea, Vomiting, Diarrhea Well date: food related. Return to work: 3/6/24. CNA Q's Call-In/ [NAME] Report states that CNA Q had Diarrhea and Nausea/ Vomiting. Date: 3/12/24 Employee Name: DA P (Dietary Aide) Unit last worked: Kitchen. Date last worked: no date listed. Date of sx (symptoms): 3/12/24 Reason for call- in: Nausea Well date: 3/13/24. Return to work: 3/13/24. DA P's Call-In/ [NAME] Report states that DA P had Nausea/ Vomiting, not feeling well, feels like crap. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/30/24 at 3:36 PM, Surveyor interviewed RN M, who is also the Infection Preventionist. Surveyor asked RN M how she determines when staff can return to work after calling off with an illness, RN M stated staff have to be 48 hours without nausea and vomiting and have to be 24 hours fever free without a fever reducing agent. Surveyor asked RN M to review the Staff Illness Tracking form. Surveyor asked RN M what CNA L's respiratory symptoms were based off the line list, RN M reported that she believed CNA L had a cough. Surveyor asked if that should have been indicated on the line list, RN M stated yes. Surveyor asked RN M if CNA L called in sick on 2/7/24, how could her well date be 2/7/24 and then her return-to-work date be 2/8/24, RN M stated that she would have to do a better job at recording times. Surveyor asked RN M if RN I should have returned to work on 2/16/24, RN M stated that it depends on RN I's symptoms. Surveyor asked RN M if RN I had been symptom free for a full 48 hours before returning to work, RN M stated RN I should have returned to work on 2/17/24. Surveyor discussed CNA F's call- in with RN M. Surveyor asked RN M if CNA F were symptom free on 2/19/24, if she called in sick on 2/19/24, RN M stated that she would have to check. Surveyor asked RN M about RT O. Surveyor asked RN M if, considering that the facility was in an Influenza outbreak, did RT O get tested for influenza, RN M stated no. Surveyor asked RN M if RT O had 2 negative COVID tests before returning to work, RN M stated that the form does not indicate. Surveyor asked RN M if she would expect that RT O would have been tested for Influenza and have 2 negative COVID tests before returning to work, RN M stated yes. Surveyor asked RN M when CNA Q's well date was, RN M reported that CNA Q indicated that his illness was food related. Surveyor asked RN M, based on CNA Q's symptoms, when should he have returned to work, RN M stated 3/8/24. Surveyor asked RN M if DA P returned to work too soon, RN M stated that the Dietary Manager allowed DA P to return to work, but she should have been off longer. Surveyor asked RN M if the staff member with respiratory symptoms were tested for COVID, RN M stated no. Surveyor asked if she would expect them to have been COVID tested , RN M stated she would not expect COVID testing to be done if they weren't in a COVID outbreak. Surveyor asked RN M if during their Influenza outbreak, would she expect staff with symptoms to get tested for Influenza, RN M stated that a few staff members did get tested . RN M did not provide documentation of staff members that were tested for Influenza. The facility failed to ensure that staff members remained off work for the specified time based on current standards of practice for acute respiratory illnesses and GI symptoms, nor did they require staff to complete testing, when showing signs and symptoms of potential communicable diseases.