STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525626	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Community Home	1320 Wisconsin St Hudson, WI 54016

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility did not provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This occurred for 1 of 1 sampled resident being reviewed for heart failure with increased edema, Resident (R) R17. R17 had no edema in lower extremities on admission. R17 was observed to have 3+ pitting edema in left lower extremity on 02/12/25. The facility did not assess or add interventions to decrease increasing edema for R17. Facility did not complete weekly assessments for heart failure inlcuding missed weights weekly. This is evidenced by: According to the National Institutes of Health (NIH) Congestive Heart Failure (CHF): Nursing Diagnosis, 2023, indicates nurse assessment of CHF is to assess current symptoms such as dyspnea, fatigue, orthopnea, peripheral edema, vital signs, cardiovascular examination such as (abnormal heart sounds, jugular venous distention), respiratory examination such as (auscultate lung sounds for crackles or wheezing and assess respiratory effort), daily weights, edema assessments, dietary habits, weight changes, medication adherence and any side effects related to diuretics or blood pressure medications, and assess emotional well-being related to potential anxiety or depression related to the chronic nature of CHF. R17 was admitted to the facility on [DATE]. R17's diagnoses included Heart Failure (HF) unspecified, anemia, old myocardial infarction, paroxysmal atrial fibrillation, and localized edema. R17's Minimum Data Set (MDS), dated [DATE], confirmed R17 scored 10 out of 15 during Brief Interview for Mental Status (BIMS), indicating moderate impaired cognition. R17 was admitted with a diuretic for HF. Surveyor reviewed R17's cardiac impairment related to HF, hypertension, and Hyperlipidemia care plan initiated on 01/14/25, which states in part . -Administer antilipemic per MD (Medical Doctor) order. Monitor for effectiveness and adverse effects. Notify MD as necessary. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Administer diuretics per MD order. Monitor for effectiveness and adverse effect and notify MD as necessary. -Monitor/document/report to MD PRN (as needed) signs and symptoms of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB (shortness of breath) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (Tachycardia) lethargy and disorientation. -Monitor/document/report to MD PRN any signs and symptoms of hypokalemia in residents receiving diuretic therapy: Fatigue, muscle, weakness, diminished appetite, nausea and vomiting and dysrhythmias. Monitor potassium levels. Surveyor reviewed R17's physician orders, which state in part . -On 09/06/24 Furosemide Oral Tablet; Give 40 mg by mouth one time a day related to HF, unspecified. Surveyor reviewed R17's completed assessments, which state in part . .-On 09/05/24 admission assessment indicates no edema noted on admission. Of note: Surveyor could not find any assessments of R17's edema in lower extremities. Surveyor reviewed R17's physician notes, which state in part: -On 09/09/24 no edema noted to lower extremities, continue Furosemide 40mg tablet daily. -On 10/02/24 no edema noted to lower extremities, continue Furosemide 40mg tablet daily. -On 11/06/24 weight is up 8 pounds in the last month, trace pitting edema noted to [R17's] left lower extremity. [R17] states [R17] sits with his feet dependent for most of the day. No compression stockings in place. Plan: Order Tubi grips for bilateral lower extremity edema. No changes to medications at this time. Surveyor reviewed R17's nurse progress notes, which state in part . -On 09/05/24 [R17] had no edema skin issues noted. -On 11/06/24 [R17] seen provider today, follow up in 2 months, start Tubi grip sleeves, lower extremities, off at night. -On 12/16/24 provider discontinued Tubi grips, resident request. Surveyor reviewed R17's tasks in Electronic Health Record, which state in part . -On 01/14/25, Monitor for s/s of CHF (congestive heart failure) exacerbation: shortness of breath, coughing or wheezing, swollen ankles or legs, weight gain, fatigue, and heart palpitations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/14/25, Monitor for s/s of fluid imbalance related to CHF/diuretic use: BP changes, SOB, confusion, fatigue, N/V (nausea/vomiting), irregular heartbeat, weakness, change in urination. -On 01/14/25, Monitor for s/s of hypertension, dull headache, vertigo, increased B.P (blood pressure), fluid retention, blurring of vision, epistaxis. Of note: Surveyor did not find any documentation that the tasks were checked off for monitoring fluid retention and edema. Of note: R17 did not have a cardiac care plan put in place until 01/14/25. Surveyor reviewed R17's history of weights from 09/06/24-02/12/25, which state in part . -On 09/06/24-173.0 lbs. -On 09/10/24- 172.4 lbs. -On 10/07/24-176.4 lbs. -On 10/18/24- 175 lbs. -On 10/27/24- 178.8 lbs. -On 11/25/24- 177.8 lbs. -On 12/01/24- 174.0 lbs. -On 12/04/24- 176.8 lbs. -On 12/17/24- 178.0 lbs . Of note: Surveyor reviewed R17's weight and found facility not following weekly weights per facility protocol. Observations and Interviews: On 2/10/25 at 9:51 AM, Surveyor interviewed R17 and asked how R17's care is at the facility. R17 indicated no concerns noted other than R17 stated, My leg is so swollen, do you know why? Surveyor observed swelling and edema in left leg from ankle up to the left knee. R17 indicated that R17's left leg has been swollen for a long time now and unsure if facility is doing anything about it. Surveyor asked R17 if he sits with his legs up at all. R17 indicated that R17 sits on edge of bed most of the day but will lay down periodically in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/25 at 10:17 AM, Surveyor interviewed Registered Nurse (RN) E and asked about process for assessing HF. RN E indicated that usually if a resident is newly admitted with HF, RN E would assess lungs, edema, heart, and vitals. Surveyor asked RN E if RN E has assessed any increase in edema in R17 since admission. RN E indicated that RN E was unsure if it has increased but R17 does have quite a bit of swelling in the left lower extremity. Surveyor indicated to RN E that R17 had no edema on admission and then in November weekly weights were missed. R17 had a provider appointment 11/26/24 and provider noted 8lbs increase and trace-1 pitting edema. Surveyor asked RN E what R17's edema is today on 02/12/25. RN E indicated that RN E is unsure but knows it is swollen. Surveyor asked RN E if RN E could take Surveyor into R17's room and assess R17's left lower extremity for edema. RN E assessed R17 and found that R17 has 3+ pitting edema in left lower extremity and will be notifying the physician right away. RN E indicated that usually if there is an increase in edema it is documented in the EHR and provider and DON B are notified right away. RN E indicated that RN E is surprised there has been no documentation of R17's increase in edema in the left lower extremity. On 02/12/25 at 10:35 AM, Surveyor interviewed Director of Nursing (DON) B and asked DON B what is expectation for monitoring and assessing HF in R17. DON B indicated that if any resident has HF it is expectation that vitals, weights, and assessing for Shortness of Breath (SOB), and edema, are monitored. Surveyor asked DON B if DON B had a policy for assessing HF. DON B indicated the facility does not have a specific HF policy. Surveyor asked how often weights are to be completed for R17. DON B indicated the facility has standing orders to complete weights weekly for all residents unless specific parameters are ordered from provider. DON B indicated that if R17 does not have a specific order in EHR then standing orders need to be weekly weights. DON B's expectation is that any increase in edema needs to be assessed and reported to provider right away. DON B indicated that all residents who have HF need to be continuously monitored and assessed for increased in fluid retention or edema. Surveyor indicated to DON B that Surveyor reviewed R17's care plan which indicates that nursing staff should be monitoring for signs and symptoms of HF exacerbation: shortness of breath, coughing or wheezing, swollen ankles or legs, weight gain, fatigue, and heart palpitations. Surveyor asked DON B where is the documentation in R17's EHR. DON B indicated that DON B could not find documentation of the monitoring and it must not be being completed. DON B indicated that it is DON B's expectation that nursing staff are assessing for the signs and symptoms of HF decline and R17's diuretic medication. Facility did not have evidence of asuculatation of lungs, daily weights, and edema assessments completed per standard of practice for HF. Surveyor indicated to DON B that at one point in November the facility went a month without weighing R17 and R17 had a provider visit where the provider assessed an 8lb increase and trace-1 pitting edema in lower left extremity. Provider ordered Tubi grip to be applied in day and off at night. DON B indicated the staff should have been weighing R17 at least weekly and not sure how that got missed for the 8lb increase. DON B indicated that R17 was refusing the Tubi grips for about a week after provider ordered the Tubi grips to be applied so the provider discontinued the Tubi grips but had no other orders put into place. Surveyor asked DON B about the vagueness in R17's HF care plan that did not include any specific interventions to prevent the swelling other than administering diuretic medication. DON B indicated the care plan should be updated to encourage R17 to elevate lower extremities often, weight R17 weekly, and other specific interventions.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview, and record review, the facility did not ensure that 1 of 4 residents (R16) reviewed for pressure injuries (PI) received care consistent with professional standards of practice to prevent potential skin breakdown and promote healing of existing PIs. R16 was at risk for PI on admission having no PIs, weekly PI assessments were not completed consistently, physician was not notified with changes in the PI, alternate support surfaces were not provided when skin issues were noted. The PI care plan was not developed until 2 months after the identification of the stage 3 PI. Offloading of the PI was not observed by Surveyor. This is cited at actual harm. Findings include: The facility policy, titled Prevention of skin breakdown, revised [DATE], states: .D. Repositioning: a. Reposition bed-bound persons at least every two hours and chair bound persons every hour to hour and half consistent with overall goals of care . The facility policy titled Weekly skin rounds/Quality Assurance Review, revised [DATE], states: .Weekly wound rounds are completed weekly to determine the progress of healing, presences of possible complications, presence of pain and the status of the area and the area surrounding the pressure injury . R16 was admitted to the facility on [DATE]. R16's diagnoses included cauda equina syndrome (when a bundle of nerves at the bottom of spinal cord is compressed or damaged), sepsis, unspecified, malignant neoplasm of prostate, muscle weakness, unsteadiness on feet, diabetes mellitus type 2, and pulmonary hypertension. R16's Minimum Data Set (MDS), dated [DATE], confirmed R16 scored 10 during Brief Interview for Mental Status (BIMS), indicating moderate impaired cognition. R16 was admitted with at risk for skin breakdown, and no current PIs. Surveyor reviewed R16's skin integrity alteration care plan initiated on [DATE], which states in part: - Daily skin observation with cares. Report new or worsening concerns to nurse immediately initiated [DATE]. - House lotion to dry skin with cares as needed initiated [DATE]. - Treatment as ordered. Observe for changes and report concerns to MD/NP as warranted initiated [DATE]. - Inform resident/family/caregivers of any new area of skin breakdown initiated on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises or Discoloration noted during bath or daily care initiated on [DATE]. - Pressure reducing/relieving mattress initiated [DATE]. - ROHO to seated positions initiated on [DATE]. - Turn and reposition q (every) ,d+[DATE].5 initiated on [DATE]. - Encourage side to side positioning when in bed initiated on [DATE]. - Enhanced Barrier Precautions in place due to chronic wound initiated on [DATE]. - Float heels initiated on [DATE]. Surveyor reviewed R16's pressure ulcer stage 3 to coccyx area care plan initiated on [DATE], which states in part: -Administer treatments as ordered and monitor for effectiveness. -Assess/record/monitor wound healing (weekly). Measure length, width and depth where possible. --Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. -Monitor dressing (daily) to ensure it is intact and adhering. -Monitor nutritional status. Serve diet as ordered, monitor intake and record. -ROHO to seated positions. Surveyor reviewed R16's physician orders, which state in part: -On [DATE], Reposition every 2 hours to off load buttocks every shift. -On [DATE], Protein gel cup one time a day. -On [DATE], Monitor open area to coccyx daily, until resolved every evening shift. -On [DATE], Cleanse wound, and peri wound tissue with wound cleaner. Apply 2x2 (2 by 2) collagen on the wound base (use all of it on the wound only). Place bordered super absorbent 5x5 dressing diagonally. change daily. Date and time dressing. Surveyor reviewed R16's nurse progress notes, which state in part: R1's skin/wound note dated [DATE] states in part . Location: R gluteal fold, Stage if pressure injury: MASD (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Measurements (in cm's (in centimeters)) length/width/depth: 5x4x0.1, Description of alteration: partial thickness skin/tissue loss with wound bed granular with maceration throughout wound bed. wound edges ill defined. mod (moderate) amt (amount) of serosanguious drainage noted. peri wound per resident's usual. no odor or s/sx (signs or symptoms) of infection. no complain of pain or discomfort. Additional Comments (if needed): ROHO added to seated positions, change pad Q 2h (every 2 hours). Will request catheter placement until wound healed. R16's skin/wound note dated [DATE] states in part . Location: Right post thigh, L (left) butt, coccyx, Stage if pressure injury: MASD, Measurements (in cm's) length/width/depth: R (right) post (posterior) thigh: 2x1.8x0.1, L butt: 1.5x0.7x0.1, Coccyx: 2.8x1x0.1, Description of alteration: wound bed covered in red granular tissue. Wound edges macerated. Peri wound per resident's usual. No odor or s/sx of infection. No c/o (complaints of) pain or discomfort. Of note: Surveyor found no documentation that R16's provider was notified of skin changes. Of note: Surveyor found no weekly wound measurements or description of wound bed for [DATE]. R16's skin/wound note dated [DATE] states in part . Location: coccyx. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 2.8x1x0.1. Description of alteration: Partial thickness skin/tissue loss with wound bed covered in pink granular tissue. Wound edges oval and intact. Peri wound per resident's usual. Small amt of serosanguinous drainage noted. No odor or s/sx of infection. No c/o pain or discomfort. Location: Left buttock. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 1.5x0.7x0.1. Description of alteration: Partial thickness skin/wound tissue loss with wound bed covered in light red granular tissue. Wound edges irregular and intact. Small amt of serosanguinous drainage noted. No odor or s/sx of infection. No c/o pain or discomfort. Peri wound per resident's usual. Location: Right gluteal fold. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 3x4x0.1. Description of alteration: partial thickness skin/tissue loss with wound bed covered in light red granular tissue. sm (small) amt of serosanguinous drainage noted. Peri wound per resident usual. No odor or s/sx of infection. No c/o pain or discomfort. Autolytic debridement performed. R16's skin/wound note dated [DATE] states in part . Location: Coccyx. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 1.5x2x0.1. Description of alteration: Partial thickness skin/tissue loss with wound bed covered in ,d+[DATE]% granular tissue. wound edges oval and intact. No drainage noted. Peri wound per resident's usual. No odor or s/sx of infection. No c/o pain or discomfort. Autolytic debridement performed. Location: Left buttock. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 4x3.5x0.1. Description of alteration: Partial thickness skin/tissue loss with wound bed covered in ,d+[DATE]% granular tissue and ,d+[DATE]% slough. Wound edges irregular and intact. Peri wound per resident's usual. Scant amt of serosanguinous drainage noted. No odor or s/sx of infection. No c/o pain or discomfort. Autolytic debridement performed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Location: R gluteal fold. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 1.5x2x0. 1. Description of alteration: Partial thickness skin/tissue loss with wound bed covered in ,d+[DATE]% granular tissue. No drainage noted. Peri wound per resident's usual. No odor or s/sx of infection. Autolytic debridement performed. Of note: Surveyor reviewed left buttock wound deteriorating and facility did not implement any new pressure relieving interventions. Facility missed [DATE] weekly skin assessment, no measurements noted. Facility missed [DATE] weekly skin assessment related to gluteal and buttock wounds; no measurement noted. R16's skin/wound note dated [DATE] states in part . Location: Coccyx. Stage if pressure injury: stage 3. Measurements (in cm's) length/width/depth: 4.2 x 2 x 0.2. Description of alteration: Wound bed has , d+[DATE]% pink granulated tissue with ,d+[DATE]% slough present. No tunneling or undermining. Moderate serosanguineous drainage noted. Periwound moist but intact. Concern for deep tissue at 6 o'clock w/in wound bed. Of note: Facility assessed R16's wound to be a PI stage 3 on [DATE]. Provider was not notified of PI deterioration, and no new interventions were put into place. R16's skin/wound note dated [DATE] states in part . Location: Coccyx. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 2.8x2x0.1. Description of alteration: Wound bed covered in pink, granular tissue. Peri wound per resident's usual. No drainage noted. No odor or s/sx of infection. No c/o pain or discomfort. Autolytic debridement performed. Of note: Facility incorrectly labeled R16's PI back to MASD versus assessment of PI stage 3 from [DATE]. Surveyor reviewed Skin/wound notes from [DATE], [DATE], and [DATE] and coccyx wound decreases in size to on [DATE]- measures 0.5x0.5x0.1cm. R16's skin/wound note dated [DATE] states in part . Location: Coccyx. Measurements: 3x3x0.1cm. Of note: R16's PI has increased in size; facility did not implement any new interventions. R16's skin/wound note dated [DATE] states in part . Location: Coccyx. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 4.5 x 5. Description of alteration: Partial tissue loss. Minimal serous drainage. Surrounding tissue per normal skin tone. No pain. Autolytic debridement. No signs or symptoms of infection. Of note: Facility is calling this MASD instead of a PI. Facility did not implement a PI care plan for R16 until [DATE]. R16's skin/wound note dated [DATE] states in part . Location: Coccyx. Stage if pressure injury: MASD. Measurements (in cm's) length/width/depth: 3.5 x 1.5 x <.01. Description of alteration: Epithelial cell noted in wound bed. Minimal serous drainage. Surrounding tissue per normal skin tone. Autolytic debridement. Denies pain or discomfort. Observations and interviews: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:59 AM, Surveyor interviewed R16 and asked how R16's care is at the facility. R16 indicated no concerns noted at this time. Surveyor observed wheelchair insert in recliner and asked R16 about the cushion in recliner. R16 indicated that R16 has a pressure injury from sitting too long on buttocks but the facility dresses it every evening on night shift. R16 indicated that R16 had a sore at home for a while, but it healed. Then when R16 was admitted about 1.5 months ago sitting around too long caused R16's buttocks to break open. On [DATE] at 12:19 PM, Surveyor observed R16 in recliner sitting at a 45-degree angle watching TV. Surveyor observed pressure relief pad insert in recliner. On [DATE] at 2:05 PM, Surveyor observed staff in room and laying R16 down. Surveyor walked in and did not see pillows underneath R16 to off load the bottom while lying in bed. Surveyor observed R16 lying flat on back in bed at a 90-degree angle. Surveyor asked R16 if R16 should have pillows underneath to off load the PI on coccyx. R16 stated, Yes I should, but I will have to call for assistance as I cannot do it myself. R16 rang call light. Of note: Surveyor observed no repositioning for 2 hours. On [DATE] at 2:17 PM, Surveyor observed Certified Nurse Assistant (CNA) I enter R16's room and assist R16 with placing pillow underneath R16. Surveyor interviewed CNA I and asked what are R16's repositioning needs. CNA I indicated that R16 should be repositioned every 1.5 hours and to off load bottom. CNA I indicated that R16 is pretty good with it so CNA I just does what R16 asks CNA I to do when R16 is ready. On [DATE] at 6:55 AM, Surveyor observed CNA K enter R16's room. Surveyor observed R16 lying supine on back in bed. Surveyor did not see any pressure relief on coccyx. On [DATE] at 7:11 AM, Surveyor observed R16 sitting in recliner leaned slightly right at a 90-degree angle. Surveyor observed roho cushion insert in recliner. On [DATE] at 8:25 AM, Surveyor observed Registered Nurse (RN) E deliver breakfast tray to R16. Surveyor observed R16 sitting in recliner leaned to right side slightly at a 90-degree angle. Surveyor observed roho cushion insert in recliner. On [DATE] at 8:54 AM, Surveyor observed R16 sitting in recliner leaned to right side slightly at a 90-degree angle. Surveyor observed roho cushion insert in recliner. On [DATE] at 9:13 AM, Surveyor observed RN E go into R16's room and grab breakfast tray. Surveyor observed R16 still in recliner but reclined slightly less than 90-degree angle backwards in recliner. On [DATE] at 9:40 AM, Surveyor observed R16 place call light on. Surveyor observed R16 ask CNA H if R16 could get into bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:45 AM, Surveyor observed CNA H assist R16 out of recliner with gait belt, and dycem mats on floor. Surveyor observed two pillows on bed located on each side of bed. R16 sat on top of the pillows and swung legs over to lay down. R16 directed CNA H to place pillow under heels. Surveyor observed left heel still touching mattress, right heel elevated. Surveyor observed R16 lying on back. Surveyor observed R16 place head of bed up to a 90-degree angle and CNA H stated, That is high, is that how you do your bed? R16 responded and stated, Yes. Surveyor observed CNA H exit R16's room. Of note: Surveyor did not observe CNA H encourage or offer to lay R16 on side to off load coccyx area. On [DATE] at 11:50 PM, Surveyor observed R16 lying in bed on back. Surveyor observed R16 at a 90-degree angle, lying directly on coccyx area watching tv. On [DATE] at 1:35 PM, Surveyor observed R16 lying in bed on back with head of bed about 90-degree angle with left side pillow down near feet and heel pillow not under feet. On [DATE] at 1:37 PM, Surveyor interviewed R16 and asked who moved pillows. R16 indicated that R16 removed the left side pillow due to R16 being uncomfortable. Surveyor asked R16 and Family Member L if R16 can reposition self. R16 indicated not in this bed. R16 indicated that at home R16 could move around in bed but not in R16's bed at the facility. R16 indicated that R16 must ring call light if R16 wants to be repositioned. R16 stated, I don't want to bother them, so I wait for them. Surveyor asked Family Member L if staff come in every 1 or 2 hours to reposition. Family Member L indicated that sometimes I will come in, in the morning around 9 AM to visit R16 and nothing has been done until lunch time. Family Member L is concerned with PI getting worse. Surveyor asked R16 and Family Member L if facility offered an air mattress for R16 or did R16 refuse the air mattress. R16 indicated that no one has offered an air mattress. R16 asked Surveyor if air mattress would help with R16's wound. Family Member L indicated that Family Member L did not know air mattress was an option. Of note: Surveyor did not observe air mattress in place as care planned. On [DATE] at 2:20 PM, Surveyor interviewed CNA H and asked CNA H what CNA H's process is for R16's repositioning care plan. CNA H indicated that R16 can reposition self in bed and sometimes is on R16's side. Surveyor indicated to CNA H that Surveyor has not seen R16 off back and coccyx [DATE] or today. CNA H indicated that R16 was up in recliner this morning for breakfast. Surveyor indicated to CNA H that R16 has been sitting in recliner for over 3 hours this morning on [DATE]. CNA H indicated that CNA H thought that was fine since R16 has pressure relieving cushion in recliner. Surveyor asked CNA H if CNA H repositioned R16 while lying in bed after breakfast, before lunch, or after lunch since R16 has been in bed since 9:45 AM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Christian Community Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1320 Wisconsin St Hudson, WI 54016	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	CNA H indicated that when I placed R16 in bed I propped R16 with two pillows on each side. Surveyor indicated that when Surveyor was observing the offloading the pillows placed under R16's hips on each side was adequate for pressure relief of coccyx off the bed. Surveyor asked CNA H if CNA H could place hand underneath R16's coccyx and feel the space between mattress and R16's coccyx. CNA H indicated that CNA H did not test if there was space. Surveyor indicates that care plan is to encourage R16 to be off back and reposition unto sides often. Surveyor indicated to CNA H that Surveyor did not observe CNA H offer to reposition R16 on side. CNA H indicated that CNA H did not offer or encourage to reposition R16 on side because R16 will usually ask if R16 wants to be on sides. On [DATE] at 2:41 PM, Surveyor interviewed Director of Nursing (DON) B and asked what is DON B's expectation of R16's repositioning care plan in place. DON B indicated that R16 should be encouraged to get off R16's coccyx and reposition side to side every ,d+[DATE].5 hours. Surveyor indicated that Surveyor has not observed R16 repositioned every ,d+[DATE].5 hours and at one-point R16 sat in recliner on coccyx for over 3 hours and in bed over 3 hours without being repositioned. DON B indicated that staff should be repositioning every ,d+[DATE].5 hours as care planned. Surveyor asked DON B if R16's wound on coccyx was a pressure injury and why R16 did not have a PI care plan in place until [DATE]. DON B indicated there were two wound nurses who thought Moisture Associated Skin Damage (MASD) and the other thought stage 3 PI. DON B reached out to a wound care specialist who confirmed that R16's wound on coccyx is a stage 3 PI. DON B confirmed to Surveyor that R16 should have had a PI care plan implemented back in September when the PI was discovered but was not put into place until [DATE]. Surveyor asked DON B where is R16's air mattress. DON B indicated that DON B was unaware that R16 did not have an air mattress in place. Surveyor confirmed with DON B that R16's mattress was observed to be a basic Direct Supply Panacea foam mattress. On [DATE] at 8:01 AM, Surveyor interviewed DON B and asked expectation of how long R16 should be up for meals. DON B indicated it is R16's right to sit up for however long R16 would like but that DON B's expectation would be that staff still reposition R16 every ,d+[DATE].5 hours while sitting as well. Surveyor asked DON B if R16 had any nutritional interventions to assist healing with R16's PI deterioration. DON B indicated that on [DATE], Pro gel was implemented to help with PI healing, but there were no other interventions for nutrition before [DATE]. Surveyor asked DON B when was the first official date R16's PI was found. DON B indicated that [DATE] was the first alteration in skin integrity and identified as a PI on [DATE]. Surveyor asked DON B if R16's development of a stage 3 PI in the facility was avoidable or unavoidable. DON B stated, Well with the observations of lack of repositioning of [R16] off of [R16's] buttocks and no air mattress in place, I feel it could have been avoided if those measures were in place. On [DATE] at 10:40 AM, Surveyor interviewed previous wound care RN J and asked about education in wound care. RN J indicated that RN J took skin and wound management 9 years ago but did not pass the exam to become certified. Surveyor asked how RN J assessed that R16's wound was related to MASD versus PI. RN J indicated that now that RN J looks back on R16's case, R16's wound should had been labeled PI as R16 had a lot of issues like immobility and incontinence but there was a lot going on on R16's back side from back surgery. On [DATE] at 10:45 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked for RN F's (current wound nurse) training. NHA A indicated that RN F let RN F's wound certification lapse, but facility is trying to figure out how she can retest. NHA A provided Surveyor with Wound Care Certified certification which expired on [DATE].

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48793 Based on observation, interview and record review, the facility did not ensure a resident with limited mobility receives appropriate restorative services, and assistance to maintain or improve mobility with the maximum practicable independence for 1 out of 2 sampled residents (R7). R7 was not ambulated per recommendation of Physical Therapy (PT) or receive restorative exercises per recommendation of PT. This is evidenced by: R7 was admitted to the facility on [DATE]. R7's diagnoses included cerebral infarction unspecified, type 2 diabetes mellitus, history of falling, essential hypertension, and unspecified diastolic congestive heart failure. R7's Minimum Data Set (MDS), dated [DATE], confirmed R7 scored 12 out of 15 during Brief Interview for Mental Status (BIMS), indicating moderate impaired cognition. R7 understands and is understood by others, and he can make his needs known. R7 needs partial to moderate assistance with toileting, sit to stand, and ambulation. Surveyor reviewed R7's PT recommendations titled, Restorative Program, dated on 12/06/24, which states in part: -Walking program; gait belt, contact guard assist, 100-150 feet with front wheel walker. - Nu Step or Sci Fit level 3 for 10-15 minutes as tolerated. Surveyor reviewed R7's care plan, which states in part . -R7 has restorative nursing program in place initiated on 01/14/25. -Ambulation assist of one with two-wheel walker with wheelchair to follow. Surveyor reviewed Certified Nurse Assistant (CNA) care plan tasks that indicated: -Nursing rehab: Active Range of Motion (ROM): document number of minutes spent providing ROM (active). Of note: Surveyor did not find documentation from 02/07/25-02/11/25. -Nursing rehab: Walking (Specify): document distance walked in (ft). Of note: Surveyor did not find documentation from 02/07/25-02/11/25. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nursing rehab: Walking (Specify): document number of minutes spent training and skill practice in walking. Of note: Surveyor did not find documentation from 02/07/25-02/11/25. On 02/10/25 at 10:14 AM, Surveyor interviewed R7 and asked if R7 had any physical concerns with mobility and Activities of Daily Living (ADL)s. R7 indicated that facility is not really working with R7 on PT or exercises enough. R7 indicated that facility offers simple little arm exercises but nothing with R7's legs that will make R7 stronger so R7 doesn't lose independence. On 02/11/25 at 8:03 AM, Surveyor observed R7 self-propelling back to room after breakfast. R7 wheeled into R7's room and decided to stand up and self-transfer. R7 was standing up from wheelchair and started walking to bathroom. On 02/11/25 at 8:04 AM, Surveyor observed CNA K enter R7's room. CNA K immediately asked R7 to hang on while CNA K grabbed wheelchair to assist R7. R7 stated, No I need to go to bathroom, and I want to walk there. CNA K grabbed wheelchair anyway and had R7 sit down in wheelchair. CNA K then propelled R7 to bathroom. CNA had R7 stand up and stand pivot to toilet. On 02/11/25 at 8:15 AM, Surveyor interviewed CNA K and asked why CNA K did not allow R7 to ambulate to bathroom since the care plan indicated R7 could ambulate with one assist. CNA K indicated that CNA K is with agency staff and did not know what R7's care plan stated. On 02/11/25 at 10:07 AM, Surveyor interviewed PT M and asked if R7 was on PT. PT M indicated that R7 use to be on PT but no longer is due to not improving in function ability. PT M indicated that R7 was placed on a restorative program for ROM and walking. PT M indicated to Surveyor that PT M would gather information from Restorative Coordinator (RC) G and find copies. On 02/11/25 at 10:10 AM, Surveyor interviewed RC G and asked what RC G's process was for R7's restorative program and to provide the documentation as Surveyor could not find the documentation since 02/06/25 of completion of R7's restorative ROM and walking. RC G stated, Honestly, we are the first to get 'pulled' out of restorative and unto the floor when we are short. I was pulled all last week, and my other help was pulled over the weekend. Surveyor asked RC G if anyone has completed restorative with R7 since 02/06/25. RC G indicated that RC G knows that R7 did not receive restorative exercises this last weekend, and RC G will need to review notes in office and get back to Surveyor about other dates. On 02/11/25 at 11:04 AM, RC G delivered restorative charting from missing documentation not in the EHR (electronic health record). Surveyor reviewed documentation and noted that it was late charted. Surveyor asked RC G if this was just entered. RC G indicated that RC G did just document the missed documentation in the EHR. RC G indicated that she does not chart this on a day-to-day basis. Surveyor asked RC G how RC G remembers what to document from weeks ago. RC G indicated that CNAs or RC G checks off on a paper with all who are on restorative plans and then writes how far and how long R7 walks or when exercises were completed. Surveyor requested documentation of the notes that RC G charted as a late entry. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/25 at 3:20 PM, RC G delivered paper copies of restorative program for all residents in the building. RC G indicated that if Surveyor reviews and finds the exercise labeled 'resident not available' it means 1 of 4 things; Resident at an activity, therapy, out of building for appointments, or staff did not get to the 'said' resident. Surveyor asked RC G if the documentation specifies which reason the resident was unavailable. RC G stated, No it does not, just resident unavailable. Surveyor reviewed restorative schedule documentation paper forms from 02/01/25-02/11/25. -On 02/01/25 and 02/02/25, no documentation on paper forms. -On 02/05/25, resident not available. -On 02/07/25, no documentation on paper forms. -On 02/08/25, resident not available. Restorative Coordinator G was pulled to floor and did not complete restorative program for any residents. -On 02/09/25, resident not available. Restorative Coordinator G was pulled to floor and did not complete restorative program for any residents. On 02/12/25 at 8:01 AM, Surveyor interviewed Director of Nursing (DON) B and asked expectation for R7's restorative program. Surveyor indicated that PT recommended R7 ambulate daily and complete ROM on the Nustep machine. Surveyor indicated to DON B that through observation, record review, R7's complaint of no exercise, and interview with RC G, R7 had not been receiving restorative exercises on a consistent basis. DON B indicated that it is DON B 's expectation that R7 receive R7's exercises and is walked often to keep R7's body strong. Surveyor indicated to DON B that through interview with RC G, RC G gets pulled from the floor and then is not able to complete restorative programs for all residents. DON B indicated to Surveyor that RC G has not been pulled that much. Surveyor indicated to DON B that RC G has been documenting Resident not available and that means many things such as resident at an activity, therapy, out of building for appointments, or staff did not get to the said resident. Surveyor asked DON B if the documentation was appropriate or did it need more detail as to why R7 did not receive restorative. DON B indicated the vague documentation is not acceptable, and that documentation needs to specify why R7 did not receive restorative exercises.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure that 1 of the 4 residents reviewed for falls (R7), received adequate supervision and assistance to prevent accidents. The facility did not follow R7's care plan: -CNA did not apply gait belt to R7 during transfer to toilet as care planned. -CNA did not lock R7's wheelchair brakes during transfer from wheelchair to bed. -Staff did not apply pressure alarm in recliner as care planned. -R7 was observed self-transferring to toilet without staff assistance for 2 different events. This is evidenced by: R7 was admitted to the facility on [DATE]. R7's diagnoses included cerebral infarction unspecified, type 2 diabetes mellitus, history of falling, essential hypertension, and unspecified diastolic congestive heart failure. R7's Minimum Data Set (MDS), dated [DATE], confirmed R7 scored 12 out of 15 during Brief Interview for Mental Status (BIMS), indicating moderate impaired cognition. R7 understands and is understood by others, and he can make his needs known. R7 needs partial to moderate assistance with toileting, sit to stand, and ambulation. Surveyor reviewed R7's Physical Therapy (PT) recommendations titled, Restorative Program dated on 12/06/24, which states in part . -Walking program; gait belt, contact guard assist, 100-150 feet with front wheel walker. Surveyor reviewed R7's impaired mobility and high risk for falls care plan, which states in part . -Alarms in place. Pressure seated areas, laser in bed, recliner, and bathroom. - Ambulation assist of one with two-wheel walker with wheelchair to follow . R7's physician orders state in part . -Alarms in place; see CNA care plan every shift, ordered on 12/12/2024. Surveyor reviewed fall risk assessments which state in part . .-On 10/22/24- Fall risk assessment completed: Scored High risk 18.0 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/21/25- Fall risk assessment completed: Scored High risk 11.0 . Surveyor made the following observations: On 02/10/25 at 10:13 AM, Surveyor observed floor alarm on R7's bedside table near recliner. Floor alarm was not turned on. Surveyor observed recliner alarm attached to recliner but not on. On 02/10/25 at 10:34 AM, Surveyor observed R7 get out of recliner and use R7's walker to walk to bathroom. Of note: Surveyor did not hear recliner alarm go off. On 02/10/25 at 10:37 AM, Surveyor observed Restorative Coordinator G walk by R7's room and observed R7 walking in bathroom. Restorative Coordinator entered R7's room to assist R7. On 02/10/25 at 10:49 AM, Surveyor interviewed CNA K and asked about R7's pressure alarm in recliner and floor alarm in room. CNA K indicated that R7 sometimes will turn alarms off himself and transfer. Surveyor indicated to CNA K that Surveyor observed floor alarm turned off and on bedside table next to R7's recliner. CNA K indicated that a staff member probably put it on bedside table and turned it on and R7 probably turned it off. CNA K indicated that staff need to put floor alarm down on the floor and not in reach of R7. CNA K indicated that R7 is unstable while walking alone and becomes wobbly. Surveyor indicated to CNA K that Surveyor observed R7 transferring out of recliner and into bathroom for two minutes before Restorative Coordinator G was walking by and caught R7 up walking to bathroom. Surveyor indicated to CNA K that Surveyor did not hear the recliner pressure alarm go off either. CNA K indicated that R7 should not be ambulating by R7's self and that R7 needs assistance of one to transfer. On 02/11/25 at 7:00 AM, Surveyor observed R7 sitting in recliner sleeping. Surveyor did not observe recliner pressure alarm attached to recliner. Recliner alarm was located across room on R7's wheelchair. On 02/11/25 at 8:03 AM, Surveyor observed R7 self-propelling back to room after breakfast. R7 wheeled into R7's room and decided to stand up and self-transfer. R7 was standing up from wheelchair and started walking to bathroom. Surveyor did not observe wheelchair alarm go off. On 02/11/25 at 8:04 AM, Surveyor observed CNA K enter R7's room. CNA K immediately asked R7 to hang on while CNA K grabbed wheelchair to assist R7. R7 stated, No I need to go to bathroom, and I want to walk there. CNA K grabbed wheelchair and had R7 sit down in wheelchair. CNA K then propelled R7 to bathroom. CNA K had R7 stand up and stand pivot to toilet. Surveyor did not observe CNA K utilize a gait belt around R7. On 02/11/25 at 8:07 AM, Surveyor observed CNA K grab a gait belt after R7 sat down on toilet and placed it on R7. CNA K stated, We should probably have gait belt on when we get up off toilet. Surveyor observed CNA K propel R7 in wheelchair to bed. CNA K did not lock brakes on wheelchair before transferring R7 to bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/25 at 8:18 AM, Surveyor interviewed CNA K and asked what CNA K's process is for transferring R7 from chair to toilet, to toilet to chair and chair to bed. CNA K indicated that CNA K is aware that CNA K did not apply a gait belt to R7 as CNA K should have. Surveyor asked CNA K why R7's recliner alarm has not been placed on recliner when R7 is in recliner and why when it was placed it was not on. CNA K indicated that CNA K did not realize R7's alarms were not on. On 02/12/25 at 11:10 AM, Surveyor interviewed Director of Nursing (DON) B and asked DON B's expectation for R7's pressure alarms and gait belt usage. DON B indicated that R7's care plan states pressure alarms are to be applied to seated areas such as recliner, and wheelchair when R7 is seated. DON B indicated that floor alarm should be on floor anytime R7 is in R7's room. DON B indicated that all staff are to use a gait belt during R7's transfers.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51804

Based on observation, interview and record review, the facility did not provide pharmaceutical services, including procedures that ensured the accurate acquiring, dispensing, administering and disposal of all drugs and biologicals.

The facility did not ensure controlled medications were disposed of timely for 11 out of 11 residents (R) observed during medication storage observation. (R1, R2, R289, R290, R291, R292, R293, R294, R295, R296, R298).

The facility did not ensure proper dose of topical medication was administered for 1 out of 1 resident (R9).

Findings include:

Example 1

The facility policy titled Controlled Substance Accountability, dated June 2023, states in part:

.Disposing of Narcotics

1. All narcotics will be destroyed according to Pharmacy and Regulatory timelines .

The Statute DHS 132.65 Pharmaceutical Services refers to the handling of medication in Wisconsin facilities, including hospitals and nursing homes. It states in part:

.(c) Destruction of medications.

1. 'Time limit.' Unless otherwise ordered by a physician, a resident's medication not returned to the pharmacy for credit shall be destroyed within 72 hours of a physician's order discontinuing its use, the resident's discharge, the resident's death or passage of its expiration date. No resident's medication may be held in the facility for more than 30 days unless an order is written every 30 days to hold the medication .

On 02/12/25 at 8:34 AM, Surveyor observed the medication room with Director of Nursing (DON) B. DON B opened a locked cabinet that had a basin with 11 prescription (RX) prefilled medication cards and a vial of a liquid narcotic waiting to be destroyed. There were 188 pills and 25 ml of controlled substance.

Surveyor observed the following list of prescription prefilled cards in the basin belonging to the following residents, R1, R2, R289, R290, R291, R292, R293, R294, R295, R296, and R298.

Medications observed in bin for destruction include:

(continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydromorphone 2mg was for R295. Per documentation 2 tablets were signed out for administration leaving 10 tablets to be destroyed when placed in bin on 12/2/2024. This is reconciled with the receipt of card originally containing 12 tablets. Oxycodone 2.5 mg was for R298. Per documentation the unused card of 16 tablets was placed in bin to be destroyed 11/13/24. APAP/Codeine Tab 300-30mg was for R1. Per documentation the unused card of 12 tablets was placed in bin to be destroyed 11/20/24. Oxycodone 5mg was for R296. Per documentation 16 tablets were signed out for administration leaving 14 tablets to be destroyed when placed in bin on 11/20/24. This is reconciled with the receipt of card originally containing 30 tablets. Oxycodone 5mg was for R294. Per documentation the unused card of 10 tablets was placed in bin to be destroyed 12/3/24. Oxycodone 5mg was for R291. Per documentation the unused card of 30 tablets was placed in bin to be destroyed on 12/17/24. Oxycodone 5mg was for R293. Per documentation the unused card of 10 tablets was placed in bin to be destroyed 12/22/24. Oxycodone 2.5mg was for R292. Per documentation 14 tablets were signed out for administration leaving 16 tablets to be destroyed when placed in bin on 1/2/25. This is reconciled with the receipt of card originally containing 30 tablets. Oxycodone 5mg was for R289. Per documentation the unused card of 10 tablets was placed in bin to be destroyed on 1/1/7/25. Oxycodone 5mg was for R290. Per documentation the unused card of 30 tablets was placed in bin to be destroyed 1/17/25. Morphine 100mg/5ml (30ml bottle) was for R2. Per documentation 5. signed out for administration and Surveyor noted the line on side of bottle was filled to just over 25 was placed in the bin to be destroyed on 1/28/25. Zolpidem 5mg 30 was for R289. Per form the full card of 30 tablets was placed in bin to be destroyed 2/4/2025 after pharmacy returned it reporting they do not take back and destroy medications. On 02/12/25 at 8:38 AM, Surveyor interviewed DON B and asked DON B's process for destruction of controlled medications. DON B indicated there are two licensed staff that destroy the controlled substances. DON B indicated that destruction of medications should be destroyed at least weekly, but facility has been so busy that the controlled substances noted back to November 2024 have not been destroyed and needs to be. DON B indicated the process for destroying controlled substances is two licensed staff count and verify that correct amount is there and coincides with the controlled substances sheets and then placed in a biohazard bag with kitty litter and thrown in the garbage. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Christian Community Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1320 Wisconsin St Hudson, WI 54016	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 2 The facility policy, titled Medication Administration, dated January 2014, states: Purpose: To ensure an accurate and effective medication administration process that is in compliance with state and federal regulations. Medications must be administered in accordance with the written orders of a physician. Manufacturer's directions, titled Voltaren The [NAME] of Movement, states: The amount of gel applied (2g (gram) for each application) should be measured using the dosing card supplied in the product carton. For each application the gel should be squeezed from the tube and measured up to the 2gm line on the dose card. The generic name for Voltaren is Diclofenac. R9 was admitted to the facility on [DATE] and has the diagnoses that include but are not limited to presence of right artificial shoulder joint, personal history of healed traumatic fracture, and mild cognitive impairment of unknown etiology. R9's Minimum Data Set (MDS) assessment, dated 10/30/24, indicated that R9's Brief Interview of Mental Status (BIMS) score was 15 out of 15 and is cognitively intact. R9 has minimal range of motions and needs substantial/maximum assist to dependent for assistance for movement and cares. R9 has pain in her left shoulder and right knee that she rates as a 9 out of 10 but verbally states as mild. R9's care plan states: R9 has potential for pain r/t (related to) arthritis, bilateral arthroplasty. Apply topical analgesics per MD (Medical Doctor) order. Monitor for effectiveness and adverse effect and notify MD as necessary. MD order dated 1/22/2024 states, Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical)) Apply to Left shoulder topically two times a day for pain 2 grams. On 02/11/25 at 8:32 AM, Surveyor observed Registered Nurse (RN) D take Diclofenac 1% topical, squirt some in RN D's hand and apply to patient's left shoulder. On 2/11/25 at 8:35 AM, Surveyor interviewed RN D regarding dosing of Diclofenac. RN D stated, I just put some in my hand. (pause) Less than a quarter. RN D then looked at the label and reported it says 2 grams. When asked how she knew she gave 2 grams, RN D stated I don't know, she does not need a lot. On 2/11/25 at 2:24 PM, RN D stated to Surveyor, I found the measurement thing in the drawer. Surveyor clarified the statement RN D made to Surveyor that RN D meant the Diclofenac measurement card. RN D stated, Yes, I should have used the measuring device.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 16692 Based on interview and record review, the facility did not ensure each residents' drug regimen was free from unnecessary medications for 1 of 13 sampled residents (R4). R4 was prescribed a prophylactic antibiotic without adequate indications for use. R4 at times was prescribed excessive dose (duplicate drug therapy) when two antibiotics were given at the same time. This is evidenced by: R4 was admitted to the facility in 2022 with diagnoses including chronic kidney disease, urinary retention, multiple sclerosis, prostate cancer, neurogenic bladder, and reoccurring urinary tract infections (UTIs). R4's physician orders dated 06/18/24, state in part: Macrodantin 100 mg daily for reoccurring UTIs. R4's physician had changed his orders from Doxycycline prophylactically for recurrent UTIs to Macrodantin. R4 had been on Doxycycline since admission. R4 was last seen by urology in 2022. The urology note from 2022 makes no mention of the use of prophylactic antibiotics, at that time, even though R4 was receiving daily Doxycycline prophylactically. R4 was diagnosed with a UTI on 12/06/24 and treated with Cipro 500 MG two times a day for 7 days. R4 received the last dose of Cipro on 12/12/24. During this time R4 also received Macrodantin 100 MG daily prophylactically for recurrent UTIs. R4 received 7 days of duplicate drug therapy. R4 was diagnosed with a UTI again on 02/08/25 and treated with Cipro 500 MG two times a day for 7 days. During this time R4 also received Macrodantin 100 MG daily on 02/08-10/25. On 02/10/25, an order was received by the physician to hold the Macrodantin until the completion of the Cipro order and then to re-start the Macrodantin. R4 received 3 days of duplicate drug therapy. On 02/11/25 at 2:22 PM, Surveyor interviewed Director of Nursing (DON) B, who is also the Infection Preventionist (IP). DON B stated that she had taken the IP role in December 2024 and noticed immediately that an effective antibiotic stewardship program was not in place to monitor, track, and follow-up on antibiotic use. DON B acknowledged residents being administered antibiotics without appropriate indication. DON B stated she is working with administration and QAPI to improve this process as it has the potential of harm to residents. On 02/11/25 at 3:30 PM, Surveyor requested the facility's policy on prophylactic antibiotic use, and on duplicate antibiotic therapy from DON B. None was provided. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/25 at 10:03 AM, Surveyor interviewed DON B related to R4's antibiotic use. DON B stated that R4's antibiotic use in December was before she was at the facility, so she could not speak to that. When asked about R4's current antibiotic treatment, DON B stated the antibiotic was started for the UTI on Friday, and she noticed it when she arrived on Monday, so she contacted the physician and got the hold order for the prophylactic antibiotic on Monday. DON B acknowledged R4 did receive both antibiotics on a few days. DON B stated she understands concerns about duplicative antibiotic use, and that one antibiotic should have been stopped prior to the start of the other one. Surveyor asked about R4 having a history of sepsis or other complications that may justify prophylactic antibiotic use, as a clear reason for use was not located within the medical record. DON B stated she would prefer it if they were to discontinue the prophylactic antibiotic as it is proven not to be effective. DON B added that R4 used to straight cath himself, with staff assistance, and did not have the best technique. DON B stated that R4 recently switched to an indwelling catheter and the hope is to discontinue the prophylactic antibiotic use as DON B was unable to locate a clear indication for use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49353 Based on observation, record review and interview, the facility failed to ensure the chemical sanitation used in the 3-compartment sink for dishwashing was the correct concentration per manufacturer's guidelines. This had the potential to affect all 36 residents who are served food from the facility's kitchen. This is evidenced by: Facility policy titled, Resource: Sanitation of Dishes/Manual Washing, dated 2021, states in part: Manual washing using chemical to sanitize: - An exposure time of at least 10 seconds for a chlorine solution of 50mg/L that has a pH of 10 or less and a temperature of at least 100 degrees Fahrenheit; -Or a pH of 8 or less and a temperature of at least 75 degrees Fahrenheit; - An exposure time of at least 30 seconds for other chemical sanitizing solutions per manufacturer. Quaternary Ammonium Compound Solutions - Minimum 75 degrees Fahrenheit - Concentration as indicated by manufacturer - Used only in water with 500 mg (milligrams)/L (Liter) hardness or less, or in water with a hardness no greater than specified by the manufacturer. The facility did not have a policy/procedure in place to document quaternary concentration testing results. On 02/11/25 at 10:00 AM, Surveyor observed kitchen staff using the 3-compartment for manual dishwashing prior to lunch meal service. On 02/11/25 at 10:22 AM, Surveyor interviewed Dietary Director (DD) C. Surveyor asked what kind of disinfection is used for dishwashing in the 3-compartment sink. DD C stated that a quaternary solution is used. Surveyor asked DD C how the concentration was measured for appropriate levels. DD C stated that prior to January 2025, there was not a process in place to check and a new process was initiated to use the quaternary strips. Surveyor asked DD C to demonstrate use of the quaternary strip testing. DD C stated that they currently did not have any strips to do this. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor asked DD C how long they have been out of quaternary strips. DD C stated since 01/26/25, but they are currently waiting for an order. Surveyor then asked DD C for the documentation logs of measuring the quaternary concentration for the last 30 days. DD C stated that they do not keep track of this. DD C then stated that after review of kitchen procedures for infection control a new practice was recently initiated for monitoring quaternary concentrations for each meal service and would start as soon as the shipment of strips arrived. DD C stated no recent food-borne illness has occurred but recognized the risk this produced by not ensuring the chemical solution was at the recommended level to sanitize dishes.