STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525630	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Glarus Home	600 2nd Ave New Glarus, WI 53574

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 38882 Based on interview and record review, the facility did not ensure grievances and recommendations discussed during resident group meetings (Resident Council) were acted upon promptly, according to facility policy, and that residents were allowed to meet without staff present. This has the potential to affect more than a limited number of residents residing in the home. During Resident Council Task, 10 of 12 members voiced concerns that they do not receive follow up from voiced concerns, complaints, or suggestions for a whole month, until the next meeting. These residents indicated the facility policy states the management team will get back to them in 10 business days. During Resident Council Task, 10 of 12 members indicated the management team comes when they are not invited and at times the council wants to meet without staff present. Evidenced by: Facility policy, entitled Resident Council, undated, includes: All residents become members of Resident Council when they are admitted to the (facility named) . Resident Council is a formal advisory body, independent of the facility and other councils. Resident Council meetings provide the opportunity for residents to actively participate in matters that affect their daily lives and where they can exercise decision making autonomy. Our facility recognizes the value and influence of our Resident Council in sustaining a mutually supportive community where residents have a stronger collective voice and a reciprocal cooperative relationship with their home's management team . Resident Council objectives are to: . identify actual or potential issues early on when it is easier to address them . The home's management team is required to document, investigate and respond to the Resident Council representative within 10 business days of receiving a concern, complaint, or recommendation. If the situation cannot be investigated and resolved within the time frame, the homes management team needs to inform the resident council in writing within 10 business days of receiving the concern or complaint or recommendation, indicating that they are aware of the issue and detailing a plan or steps involved, in attempt to work together toward resolution. Then give a date before the next scheduled council meeting as to when the council can expect a solution and follow up response. A written response, along with any further updates will be shared at the next resident council meeting. Both parties are working together proactively in good faith to deal with the issue together . staff and the management team only attend council meetings when invited . (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/3/24 at 2:00 PM, during Resident Council Task/Resident Council Meeting with Surveyors, 12 residents were in attendance. 10 of the 12 residents in attendance voiced concerns with the facility not reporting resolutions to the committee in 10 business days per the facility policy. Residents indicated staff report resolutions at the following Resident Council meeting which is the following month. During this meeting, 10 of 12 residents voiced concerns that they are not allowed to meet without staff present and the previous administrator came to meetings he was not invited to attend. Resident Council Minutes, dated 9/9/24, does not include how many residents were in attendance or who was in attendance. It does include the following: Residents not getting their water or drinks with the meal. Would like water available right away at meals and programs involving food . resident commented on the newer help getting (medication) very early or very late and it is not consistent. Worried that is not what the doctor ordered . agency staff in particular mentioned as the perceived issue . Grievance Form, dated 9/9/24, includes: Residents stated at resident council that they do not get their drinks with their meals . they arrive 10 to 15 minutes after the meal . Summary of investigation- staff educated to provide drinks prior to or with delivery of meal not after meal is served . Resolution- staff educated to provide drinks prior to or with delivery of meal not after meal is served . Resident and or representative notified of resolution- yes . on 10/7/24. Grievance Form, dated 9/9/24, includes: at resident council residents were concerned that they are getting their medications way too early or way too late. R34 stated that she is concerned she gets her evening medications late. Summary of investigation/Resolution- nurses reeducated on time frames for giving medications. One hour before to one hour after the scheduled times unless the order states differently . Resident and or representative notified of resolution- yes . on 10/7/24. Resident Council Minutes, dated 10/7/24, include: 14 residents in attendance . Residents state that it takes 30 to 55 minutes after getting call light turned on before someone responds. Having to sit on the toilet for 2 1/2 hours to have someone return to get off . it is hurting residents when they sit that long . residents concerned about the length of fingernails caregivers have . residents are concerned about caregivers not washing their hands or putting hand sanitizer on . when you go to the kitchen to get a meal it can take anywhere from 15 to 55 minutes to get their meal . residents state that they have been asking for over six months and nothing is done about distributing alexas around the building . Residents feel that administration wants to change resident council and how it is run. Residents state that they feel they are a number here and not a person. Residents state that everything they say does not matter. Residents are upset that they live here and they don't get what they would like. Administration came to the last meeting that he was not invited. Resident feels that drinks need to be served before any food is served for meals, snacks, and activities. Snack cart is not going around right now. Residents feel that activities should help with doing the snack cart. Residents feel that we are understaffed on the floor and they want to know why there are not enough staff to care for them. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Council Minutes, dated 11/4/24, include: 15 residents in attendance . Residents feel it takes a lot longer than it used to for people to respond to call lights. It used to take 3 to 5 minutes and now it can take up to an hour. When on the toilet should not have to listen to 45 minutes of people talking out in the hallway and not responding to them. Resident was given a hard time for yelling out when water was spilt over him and on to the floor and they did not take care of cleaning it up. CNA (Certified Nursing Assistant) told him to keep his mouth shut. Neighbor of resident heard everything that transpired and how resident was treated. Grievance Form, dated 11/5/24, includes: reporting individual- resident council . call lights can take up to one hour for staff to respond . Summary of investigation-call light audit done and found some lights on longer than others . staff educated to answer call lights in a timely manner . Resolution- random call l audits will be completed . Resident and or representative notified of resolution- yes . on 12/2/24. Grievance Form, dated 11/5/24, includes: reporting individual- resident council . activities staff that are CNA's did not help a resident when she needed help when the activity staff member was asking the resident if she wanted to go to an activity . Summary of investigation- discussed with activity staff and stated that when activity staff are gathering residents for activities they cannot stop to provide activity of daily life assistance for residents. They can put on the call light to alert CNA staff of need for assistance. Resolution- responded to resident council on resolution of grievance. Resident and or representative notified of resolution- yes . on 12/2/24. Grievance Form, dated 11/5/24, includes: reporting individual- resident council . resident on toilet for 45 minutes and can hear people talking in the hallway and not responding to her . Summary of investigation-spoke with staff and reeducated to check on residents they assist to toilet and to answer call lights in a timely manner . Resolution- remedy staff to answer call lights promptly . Resident and or representative notified of resolution- yes . on 12/2/24. On 12/4/24 at 2:08 PM, SW F (Social Worker) indicated resolutions are shared with the Resident Council at the next monthly meeting. SW F and Surveyor reviewed the facility's policy, titled Resident Council. SW F indicated the facility should follow the facility policy of notifying residents within 10 business days. SW F indicated residents have the right to meet without staff present. On 12/5/24 at 8:09 AM, NHA A (Nursing Home Administrator) indicated the residents have the right to organized meetings without staff present and it was the previous administrator who attended the Resident Council Meeting without being invited and residents were not happy with this. NHA A indicated the facility should follow the facility's policy of notifying residents and/or representatives within 10 business days if that is how the policy reads. The facility failed to allow residents to organize meetings without staff present and failed to notify residents/representatives within 10 business days of complaint/concern resolutions, in accordance with facility policy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50698 Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for 1 of 21 total sampled residents (R42) and 1 of 6 supplemental residents (R391) reviewed. R42 and R391 voiced concern the water is cold when they take a shower. Evidenced by: The facility policy titled, Safe Water Temperatures Policy and Procedure, dated 12/4/24, states, in part; .6. Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed. 7. Documentation of testing will be maintained for 3 years and kept in the maintenance office . Example 1 R391 was admitted to the facility on [DATE] with diagnoses including: age-related osteoporosis with current pathological fracture, history of falling, muscle weakness, type 2 diabetes mellitus, major depressive disorder, generalized anxiety disorder, chronic pain, and glaucoma. R391's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/17/24, indicates R391 has a Brief Interview for Mental Status (BIMS) score of 11 indicating R391's cognition is moderately intact. On 12/3/24 at 1:55 PM, R391 indicated during an interview with Surveyor her showers have been cold since she's been at the facility and indicated the water was uncomfortable being cold. Surveyor took the temperature of the water in the shower room on the wing where R391 resides. Surveyor noted the temperature of the shower room water to be 67.7 F (degrees Fahrenheit) at 2:32 PM. Surveyor let the water run for 6 minutes and at 2:38 PM, the water temperature in the shower was 64.4 F and was cold to the touch. Surveyor observed a sign in the shower/tub room on 500 wing on the wall which reads: If the water is not getting warm for showers turn on the sink to (sic) with shower!!! If it still doesn't get warm go to shower room and turn on water in there or go across hallway to another room and turn water on in there to send warm water down here!!! Of note, Surveyor had the sink in the shower room running along with the shower like the sign reads but the water temperature did not increase. Example 2 R42 was admitted to the facility on [DATE] with diagnoses including: chronic kidney disease, depression, low back pain, pain in left hip and shoulder, and vascular dementia. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/20/24, indicates R42 has a Brief Interview of Mental Status (BIMS) score of 13 indicating R42 is cognitively intact. On 12/4/24 at 4:17 PM, R42 indicated during an interview with Surveyor that R42's showers are usually cold. R42 indicated the water was uncomfortable because it was cold. On 12/4/24 at 3:19 PM, Surveyor interviewed MD N (Maintenance Director) about what the process is for checking water temperatures in the shower rooms. MD N indicated he has worked at the facility for about 8 months, is still learning, and didn't know. MD N called one of his staff while Surveyor was still in the room and asked if he knew the process for checking water temperatures and if the testing was recorded somewhere. MD N then told Surveyor, We have no records of checking water temperatures. On 12/4/24 at 3:56 PM, Surveyor interviewed NHA A who indicated she would expect maintenance staff to know what appropriate water temperatures should be set at. NHA A also indicated she would expect maintenance to know the contents of the policy and procedure for safe water temperatures. The facility failed to ensure water temperature was appropriate and at a comfortable temperature for all residents.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility did not make prompt efforts to resolve resident grievances for 1 sampled resident (R40) and 1 supplemental resident (R34) reviewed for grievances. R40 voiced a grievance to NHA E (Nursing Home Administrator) and DON B (Director of Nursing) in August that she would like her morning catheter flush to be scheduled at 8:00 AM (note, the facility has an acceptable range to complete this between 7:00 AM - 9:00 AM) so that she is able to attend activities and church on time. Currently, R40 stated the facility is flushing the catheter after 9:00 AM resulting in her missing activities and being late for church. R40 stated, That should not be. R34 voiced a grievance of receiving her bedtime medications late. The facility did not notify her of a resolution to her grievance until 4 weeks after she voiced the concern. Evidenced by: The facility's policy and procedure, Grievances, updated 8/6/24, indicates, in part, as follows: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Definitions Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance. SS Dir F (Social Services) is the Grievance Officer for the facility. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (Long Term Care) facility stay. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgement of complaint/grievances and actively working toward a resolution of that complaint/grievance. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. Example 1: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40 was admitted to the facility on [DATE] with diagnoses including, but not limited to: multiple sclerosis, quadriplegia, neuromuscular dysfunction of bladder, muscle weakness, lack of coordination, and need for assistance with personal care. R40's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/30/24 indicates a Brief Interview of Mental Status (BIMS) score of 15 indicating she is cognitively intact. GG of the MDS indicates R40 is Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity for all cares. R40's Resident Care Kardex documents the following intervention: Allow the resident to make decisions about treatment regime, to provide sense of control. On 12/3/24 at 9:40 AM, Surveyor spoke with R40. R40 stated her catheter is scheduled to be flushed at 8:00 AM. R40 stated, staff have 1 hour before and 1 hour after (from 7:00 AM-9:00 AM) to flush the catheter. R40 stated, she sometimes misses activities and is consistently late for church every week waiting for staff to flush her catheter before she leaves her room. R40 stated, That should not be. R40 indicated she reported this to staff. R40's Physician Orders, signed by the physician 12/5/24, document the following: Renacidin Irrigation Solution (Citric Acid-Gluconolactone-Magnesium Carbonate) Use 30 ml (milliliters) via irrigation one time a day for Suprapubic catheter patency Clamp for 20 minutes. May replace with Acetic Acid 0.25% irrigate if Renacidin is unavailable. Order Date: 5/3/24 Start Date: 5/4/24 On R40's Medication Administration Record (MAR) documents the above referenced order is scheduled for 8:00 AM. On 12/5/24 at 11:00 AM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, can you share with me why R40's catheter flushes are scheduled at a specific time. DON B stated, she is sure it is due to R40's preference. DON B stated, R40 has a preference to not be disturbed from 11:00 PM - 7:00 AM (Surveyor observed a sign on R40's room door indicating this). Surveyor asked DON B, when would you expect R40's catheter flushes to be completed. DON B stated, between 7:00 AM - 9:00 AM unless the resident refuses because she has a very particular routine. DON B stated, R40's flushes were just changed to twice daily. Surveyor asked DON B, would you expect staff to follow the administration time of 7:00 AM - 9:00 AM. DON B stated, yes. DON B stated, she considers this to be a resident right/resident choice. DON B added, R40 brought this concern up before and she though the facility had it under control. Surveyor asked DON B, when did R40 bring this concern to your attention. DON B stated, in August when NHA E (Nursing Home Administrator), the previous NHA, was still at the facility. Surveyor asked DON B if there is any documentation that R40 brought this concern up previously. DON B checked R40's medical record and stated, I am not seeing any documentation that he put in there. Surveyor asked DON B, what was R40's specific grievance that she shared previously. DON B stated, That she wasn't getting to activities on time. Surveyor asked DON B, should staff be honoring R40's request for a catheter flush between 7:00 AM - 9:00 AM. DON B stated, yes, she expects staff to be following residents' preferences. On 12/5/24 at 11:25 AM, Surveyor spoke with SS Dir F (Social Services Director). SS Dir F stated, R40 has not reported any grievances to her. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R40's MAR for October, November and December. R40's MAR documents the following late catheter flushes: October (late administration times) 10/21/24: 9:09 AM 10/22/24: 9:18 AM 10/23/24: 9:19 AM 10/24/24: 9:19 AM 10/26/24: 10:56 AM 10/27/24: 9:06 AM 10/28/24: 9:21 AM 10/29/24: 9:31 AM 10/30/24: 9:31 AM 10/31/24: 9:14 AM November (late administration times) 11/1/24: 9:31 AM 11/4/24: 9:19 AM 11/5/24: 9:18 AM 11/6/24: 9:19 AM 11/8/24: 9:21 PM 11/12/24: 9:20 AM 11/13/24: 9:13 AM 11/17/24: 9:28 AM 11/19/24: 9:12 AM 11/20/24: 9:35 AM 11/21/24: 9:15 AM (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/22/24: 1:03 PM 11/23/24: 9:01 AM 11/25/24: 9:11 AM 11/27/24: 9:04 AM 11/28/24: 9:03 AM 11/29/24: 9:14 AM December (late administration times) 12/2/24: 9:32 AM In summary, R40 voiced a grievance in August, that was not documented, per interview with DON B. DON B stated, R40 voiced the grievance that she was not getting to activities on time due to late catheter flushes. R40 shared this concern with NHA E and DON B. There is no grievance documented for this concern and there is no documentation of follow up with R40 related to her grievance. 38882 Example 2 Grievance Form, dated 9/9/24, includes: R34 stated that she is concerned she gets her evening medications late. Summary of investigation/Resolution- nurses reeducated on time frames for giving medications. One hour before to one hour after the scheduled times unless the order states differently . Resident and or representative notified of resolution- yes . on 10/7/24. (It is important to note R34 was not notified of the resolution to her concern until 4 weeks later.) On 12/5/24 at 1:36 PM, SW F (Social Worker) indicated the Resident Council policy states residents are to be notified of resolutions within 10 days of voicing concerns at Resident Council and the Grievance policy states residents will be informed timely of resolutions voiced. SW F indicated 4 weeks is not timely.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported to the State Survey Agency for 1 of 3 residents reviewed for abuse (R16). R16 and R19 reported an allegation of abuse when staff told R16 to keep his mouth shut. The facility staff failed to report the allegation of abuse to NHA A (Nursing Home Administrator) and to the state agency. Findings include: The facility's abuse policy, titled Abuse, Neglect, and Exploitation, reviewed 2/25/23, includes: . Verbal abuse means the use of oral . communication . that willfully includes disparaging and derogatory terms to residents . or within hearing distance . Reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes: Immediately, but no later than 2 hours after allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury . R19 was admitted to the facility on [DATE] and has diagnoses that include polymyalgia rheumatica (inflammatory disorder that causes muscle pain and stiffness) and osteoporosis (disease that causes bones to become weak and more likely to break). Her most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/1/24 includes a Brief Interview of Mental Status (BIMS) score of 12 out of 15, indicating R19's cognition is moderately impaired. R19's MDS also indicates R19 makes herself understood and understands others. On 12/3/24 at 2:00 PM, during the Resident Council Task with Surveyors, R19 indicated staff yell at residents at times. R19 indicated about a month ago she overheard staff tell R16 to keep his mouth shut. R19 indicated the tone was louder than a normal conversation and she thought the staff was yelling at R16. R19 indicated she reported this to staff right away and then again at the November Resident Council Meeting. R16 was admitted to the facility on [DATE] and has diagnoses that include monoplegia (paralysis that affects a single limb) of upper limbs following unspecified cerebrovascular disease affecting right non-dominant side, weakness, and bilateral age related cataracts. His most recent MDS, with ARD of 11/7/24 includes a BIMS score of 15 out of 15, indicating R16's cognition is intact. On 12/3/24 at 2:00 PM. during the Resident Council Task with Surveyors, R16 indicated water was spilled on him and on the floor. It was at this time he was yelling out and staff told him to keep his mouth shut. R16 indicated he felt like the staff member was yelling at him and scolding him. R16 indicated he reported this at the November Resident Council Meeting. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Grievance Investigation, dated 11/5/24, includes: Resident Council Meeting on 11/4/24 . Type of concern: cares . R16 was given a hard time for yelling out when water was spilled over him and onto the floor . Staff did not help him clean it up. CNA (Certified Nursing Assistant) told him to keep his mouth shut. Neighbor (R19) of R16 heard everything . Summary of investigation: R16 couldn't remember who gave him a hard time. All core staff educated to assist residents clean up spills and not to give them a hard time about it . Resolution: continual education to all staff . Resident and or representative notified of resolution: Yes . Date: 12/2/24 . Time: 2:45 PM . On 12/4/24 at 12:45 PM, DON B (Director of Nursing) indicated a staff member telling a resident to keep their mouth shut is an allegation of verbal abuse or mental abuse. DON B and Surveyor reviewed the grievance form dated 11/5/24. DON B stated, I did not do anything with that. That would be SW F (Social Worker). DON B indicated the facility did not report this allegation to the state agency. On 12/4/24 at 2:53, PM SW F indicated a staff member telling a resident to keep their mouth shut is an allegation of verbal abuse. SW F and Surveyor reviewed the grievance form dated 11/5/24. SW F indicated the facility did not report this allegation to the state agency. On 12/5/24 at 8:09 AM, NHA A and Surveyor reviewed the grievance form, dated 11/5/24. NHA A indicated staff should have reported this allegation of abuse to the state agency. NHA A indicated she was unaware of this allegation and it is her expectation that staff will notify her of all allegations of abuse.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Glarus Home	600 2nd Ave New Glarus, WI 53574

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported to the State Survey Agency for 1 of 3 residents reviewed for abuse (R16). R16 and R19 reported an allegation of abuse when staff told R16 to keep his mouth shut. The facility staff failed to report the allegation of abuse to NHA A (Nursing Home Administrator) and to the state agency. Findings include: The facility's abuse policy, titled Abuse, Neglect, and Exploitation, reviewed 2/25/23, includes: . Verbal abuse means the use of oral . communication . that willfully includes disparaging and derogatory terms to residents . or within hearing distance . Mental abuse includes but is not limited to humiliation nursing home staff . in any manner that would demean or humiliate a resident . Investigation of alleged abuse .: An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation or reports of abuse, neglect, or exploitation occur. Written procedure for investigation include- identify staff responsible for the investigation, exercise caution in handling evidence ., identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who may have knowledge of the allegations . Providing complete and thorough documentation of the investigation . R19 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/1/24 includes a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R19's cognition is moderately impaired. R19's MDS also indicates R19 makes herself understood and understands others. On 12/3/24 at 2:00 PM, during the Resident Council Task with Surveyors, R19 indicated staff yell at residents at times. R19 indicated about a month ago she overheard staff tell R16 to keep his mouth shut. R19 indicated the tone was louder than a normal conversation and she thought the staff was yelling at R16. R19 indicated she reported this to staff right away and then again at the November Resident Council Meeting. R16 was admitted to the facility on [DATE]. His most recent MDS, with ARD of 11/7/24 includes a BIMS score of 15 out of 15, indicating R16's cognition is intact. On 12/3/24 at 2:00 PM, during the Resident Council Task with Surveyors, R16 indicated water was spilled on him and on the floor. It was at this time he was yelling out and staff told him to keep his mouth shut. R16 indicated he felt like the staff member was yelling at him and scolding him. R16 indicated he reported this at the November Resident Council Meeting. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Grievance Investigation, dated 11/5/24, includes: Resident Council Meeting on 11/4/24 . Type of concern: cares . R16 was given a hard time for yelling out when water was spilled over him and onto the floor . Staff did not help him clean it up. CNA (Certified Nursing Assistant) told him to keep his mouth shut. Neighbor (R19) of R16 heard everything . Summary of investigation: R16 couldn't remember who gave him a hard time. All core staff educated to assist residents clean up spills and not to give them a hard time about it . Resolution: continual education to all staff . Resident and or representative notified of resolution: Yes . Date: 12/2/24 . Time: 2:45 PM . On 12/4/24 at 12:45 PM, DON B (Director of Nursing) indicated a staff member telling a resident to keep their mouth shut is an allegation of verbal abuse or mental abuse. DON B and Surveyor reviewed the grievance form dated 11/5/24. DON B stated, I did not do anything with that. That would be SW F (Social Worker). DON B indicated the facility did not conduct a thorough investigation regarding this allegation of abuse. On 12/4/24 at 2:53 PM, SW F indicated a staff member telling a resident to keep their mouth shut is an allegation of verbal abuse. SW F and Surveyor reviewed the grievance form dated 11/5/24. SW F indicated the facility did not conduct a thorough investigation of this allegation of abuse. On 12/5/24 at 8:09 AM, NHA A and Surveyor reviewed the grievance form, dated 11/5/24. NHA A indicated the facility did not conduct a thorough investigation of this allegation of abuse.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 38882 Based on interview and record review, the facility did not complete the Preadmission Screening and Resident Review (PASRR) Level II when it was realized that a resident would reside in the facility for more than 30 days. This affected 1 of 19 residents reviewed (R65). R65's PASRR level 1 screen indicated he would only be residing in the facility for 30 days or less and was exempt from needing a PASRR level 2 screen. R65 resided in the facility for longer than 30 days and a PASRR level 2 screen was not performed. Evidenced by: The PASARR Level 1 Screen directions include, in part, the following: 42 CFR 483.128(a) requires that the resident or his/her legal representative receive a written notice (copy of this front page) if the resident is suspected of having a serious mental illness or a developmental delay, and therefore, will require a Level II Screen. You may tell the resident or his/her legal representative that the Level II Screen will determine if the resident does have a serious mental illness or developmental disability, as defined in the federal regulations, and if so, if the resident is appropriate for nursing facility placement and if the resident needs specialized services or specialized psychiatric rehabilitative services to address his/her disability needs .The following situations, which are all for short-term admissions, are the only exemptions from Level II Screening . Hospital Discharge Exemption- 30 Day Maximum If, during the short-term stay, it is established that the person will be staying for a longer period of time than permitted above, the person must be referred for a Level II Screen on or before the last day of the permitted time period . R65 was admitted to the facility, on 9/13/23, with diagnoses that include: Schizotypal disorder (mental health condition marked by a consistent pattern of intense discomfort with relationships and/or social interactions.), Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, and Major Depressive Disorder (MDD). R65's Physician's Orders for 12/2024 states R65 is prescribed Mirtazapine (anti-depressant) for Mood Disorder and Methylphenidate (stimulant) for MDD. R65's PASARR Level 1 Screen was completed on 9/12/24 and indicated that R65 has a major mental diagnosis and is on medication to treat symptoms or behaviors of a major mental diagnosis. R65's County Review of Nursing Home, IMD (Institution for Mental Diseases), or ICF/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities) referrals, dated 10/2/23, includes nursing facility admission recommendation- a short-term exemption from level 2 screening applies. Note short term exemptions may not be used consecutively to extend the time in a facility without a PASRR level 2 screen. (It is important to note R65 still resides in the facility on 12/4/24, more than the maximum 30 days the exemption allowed.) (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 2:53 PM, SW F (Social Worker) indicated the facility should have had a PASRR level 2 screen completed on R65 but didn't. SW F indicated she would send in a new level 1 screen today to fix this SW F indicated the department had experienced some turnover and the facility changed electronic charting system so this one was missed. On 12/4/24 at 3:57 PM, NHA A (Nursing Home Administrator) indicated the facility should have followed through with getting R65 a PASRR level 2 screen. the facility failed to redo R65's PASRR when they realized R65 was staying longer than a short term stay, and failed to have a PASRR level 2 screen completed.

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 30992 Based on observation, interview, and record review, the facility did not ensure 1 resident (R2) of 2 sampled residents reviewed for pressure injuries received the necessary care and services to promote healing and/or prevent pressure injuries from developing. R2 was at risk for pressure injury (PI) development. R2 developed a Stage 3 PI to the right ischium. Facility staff did not ensure PI interventions were in place and did not implement appropriate offloading interventions until after the PI was discovered. The facility policy, Pressure Injury Prevention and Management, updated 7/18/23, indicates, in part, as follows: The facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to health [sic] the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Definitions: Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, residents goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. Procedure: There are multiple terms used to describe this type of skin damage, including pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. For purposes of this policy, pressure injury, as the current standard terminology, will be used. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Interventions for Prevention and to Promote Healing: After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g. moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: Redistribution pressure (such as repositioning, protecting and/or offloading heels, etc.); Minimize exposure to moisture and keep skin clean, especially of fecal contamination; Provide appropriate, pressure-redistributing, support surfaces . Findings Include: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2 was admitted to the facility 5/15/13 with diagnoses including, but not limited to: cerebral palsy (group of movement disorders that affect movement, muscle tone, and/or posture), schizophrenia (mental illness characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and malignant neoplasm of endometrium (cancer of the uterine lining). R2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/25/24 indicates a Brief Interview of Mental Status (BIMS) score of 10 indicating she is moderately cognitively impaired. Section GG of the MDS indicates R2 is dependent on staff to roll left and right. Section M of the MDS indicates R2 has a facility acquired Stage 3 PI. R2 is at risk for pressure injuries. Surveyor attempted to speak with R2. R2 did not respond. R2 has an Activated Power of Attorney for Health Care (APOAHC). R2's comprehensive care plan with discontinued entries, dated 12/5/24, documents R2 had no skin interventions in place prior to the development of a Stage 3 PI. On 1/2/24. R2's Progress Notes document the following: Admission: Skin Problems: has no skin condition. R2's Braden Scale for Predicting Pressure Sore Risk are as follows: 1/12/24: 12 (10-12=High Risk) - On 1/12/24 the facility determined R2 is at high risk of PI and did not implement skin interventions until after the PI is discovered at a Stage 3 on 1/18/24. Braden Scale: Sensory Perception: slightly limited - responds to verbal commands, can't alwayscommunicate pain or need to reposition. Moisture: constantly moist - related to perspiration, urine, etc. - dampness noted every time resident is moved or turned. Activity: chairfast - ability to walk is severely limited or none, can't bear weight and/or is assisted to chair or wheelchair. Mobility - very limited - makes occasional slight changes in body/extremity position, can't make frequent/significant changes alone. Nutrition: Adequate - eats more than 1/2 of most meals, eats 4 proteins per day, occasionally refuses a meal, usually take a supplement. Friction/Shear: poblem - moderate/maximum assistance to move, can't lift without sliding on sheets, slides in bed/chair, constant fiction. Score: 12 Risk Category: 10-12= high risk of skin breakdown. It is important to note, on 1/12/24, the facility is aware that R2 is at high risk for developing a pressure injury. The facility did not implement skin interventions until after the PI developed. 3/21/24: 13 (13-14=Moderate Risk) 4/25/24: 12 (High Risk) 7/21/24: 9 (9 or below=Very High Risk) 10/22/24: 14 (Moderate Risk) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/18/24 at 10:20 PM, R2's Progress Notes document the following assessment by a Registered Nurse: Area 1: Right ischial area; Assessment Type: Initial assessment; Onset/Discovery Date: 1/18/24; Origin: Noted after admission; Initial Stage: stage 3; Tissue Type: granulation; Wound Tissue: pink; Granulation Tissue: Percentage is blank; 100% NECROTIC TISSUE: none viable; Shape of Wound: Irregular; Wound Edges: Distinct, outline clearly visible, attached, even with wound base; Undermining: none present; Tunneling: no tunneling; Surrounding Wound Tissue: Macerated; Surrounding Wound Edema: No swelling or edema; Surrounding Wound Induration: none present; Exudate: Serosanguineous; Exudate Amount: moderate - wound tissues are wet; drinage involves more than 25-75% of the dressing; Condition of the dressing: No dressing; Pain at Pressure Injury Site: unable to answer, no non-verbal signs or symptoms of pain present; Healing Progress: not applicable (new area); Depth/Thickness: depth 0.3 cm Length 2.7 cm Width: 3.0 (Standard Charting: 2.7 cm x 3.0 cm x 0.3 cm) Pressure Injury Infection: non s/s (signs/symptoms) of infection present. Action: Call placed to POA (Power of Attorney) without answer-will await a return response. Therapy referral made for positioning. On 1/19/24 at 11:03 PM, R2's Progress Notes document the following assessment: Incident type: other: skin integrity r/t issues. New open area to R (right) gluteal area to buttock. Ruddy colored skin patchy white colored superior side and inferior lateral side of irregular shaped 2.7 cm x 3.0 cm x 0.3 cm. RN (Registered Nurse) staff nurse also view redness and curled skin edges per circumference. Serosang (Serosanguineous) drainage; Measurement: 2.7 x 3.0. Location on Body: R (right) gluteal cleft/fold of buttock 0.3 depth Stage 3 ulcer per Physician (Physician V). Witnesses: none; Functional Level: visual impairment; Impulsive decision maker, cognitive impairment; Derm incontinence and circulation r/t (related to) issues; Transfer/Assistive Devices: EZ lift; Resident Interviewable: no; Pertinent Diagnosis/Meds/Labs: fragile skin, derm incontinence. Root Cause of Injury: fragile skin and derm incontinence brief irritated skin; Interventions in place to prevent further injury: Resident to lay down off R (right) side post meal time and HS (bedtime). No brief while in bed. Follow up with wound care MD (Medical Doctor) and Primary MD. MD Notification: Physician V; Date Notified: 1/18/24; Time Notified: 10:22 PM; .Teaching Done: none/not applicable. New orders received. R2's current wound care order: Rt (right) ischium - cleanse/dry, apply collagen sheet to wound bed, cover with calcium alginate, cover with gauze island dressing every evening and night shift AND as needed for missing or soiled dressing On 2/8/24, the wound physician assessed R2 for the first time. The physician's assessment is as follows: 2/8/24: Stage 3 Pressure Wound of the Right Ischium Full Thickness Etiology: Pressure Stage: 3 Duration: Greater than 18 days Objective: Healing/Maintain Healing Wound Size: 2.5 x 3.0 x 0.2 cm (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Exudate: Moderate Sero-sanguinous Thick adherent devitalized necrotic tissue: 20% Granulation tissue: 80% Wound Progress: Not at goal Surgical Excisional Debridement Procedure completed Dressing Treatment Plan: Primary Dressing: Alginate calcium with silver apply once daily for 30 days. Secondary Dressing: Gauze island with bdr (border) apply once daily for 23 days. On 11/4/2024 at 10:42 PM, R2's Progress Notes document the following: Administration Note Note Text: wound care: Rt ischium - cleanse/dry, apply iodosorb to wound bed, cover with calcium alginate, cover with gauze island dressing every evening and night shift wound left open to air this PM shift. Wound dressing becomes saturated with urine and the urine is trapped against skin. Resident is demonstrating greater skin break down at this time. On 12/4/24 at 10:15 AM, Surveyor observed R2's PI. Surveyor asked LPN D (Licensed Practical Nurse) if R2's PI has improved. LPN D stated, it has improved quite a bit and the physician just changed the treatment. LPN D stated, R2 had a foley catheter in for a while as urine would keep going into that area. LPN D stated, R2 was previously on a chux in bed and now they put briefs on R2 while in bed and that seems to be pulling more moisture away from her skin. LPN D added, R2 has a cyst that also drains and she may have cancer. LPN D stated, R2's APOAHC does not want any further interventions done. On 12/5/24 at 1:47 PM, Surveyor spoke with CNA C (Certified Nursing Assistant). CNA C has worked at the facility for one (1) year. Surveyor asked CNA C, did you get R2 up this morning. CNA C stated, yes. Surveyor asked CNA C, was R2's dressing in place when you got her up. CNA C stated, no. Surveyor asked CNA C, did you tell anybody. CNA C stated, it was at shift change and she told both the NOC (night) nurse and LPN D (Licensed Practical Nurse), the AM shift nurse. CNA C stated, usually R2's dressing is on but she has noticed an issue with NOC shift and the dressing not being on when she comes on for the AM shift. CNA C stated, sometimes when she arrives at 6:00 AM, R2 is already up and dressed for the day and we don't realize her dressing is off until later that day. CNA C stated, she does not know if there's miscommunication on the NOC shift or they forget. CNA C stated, usually throughout the day if the dressing is soiled or off we tell the nurse on duty. CNA C stated, the nurse will put the dressing on before the next meal or whenever she has time. Surveyor asked CNA C, how often do you notice that R2's dressing is off. CNA C stated, 2-3 days out of the week R2's dressing is not on. CNA C added, it varies depending on the nurse on. Surveyor asked CNA C, if she has noticed any correlation with the dressing being off and the nurse on duty. CNA C stated, yes, most often when agency staff are working that's when she notices the dressing off. CNA C added, there's more agency on NOC shift than other shifts. On 12/5/24 at 1:50 PM, Surveyor observed R2's dressing in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/5/24 at 1:15 PM and 4:20 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, when was R2's PI discovered. DON B stated, 1/18/24. Surveyor asked DON B, when was the physician notified. DON B stated, 1/18/24. Surveyor asked DON B, if a resident is at risk of PI's (Braden) would you expect interventions to be in place. DON B stated, yes. Surveyor asked DON B, what stage was R2's PI when it was discovered. DON B stated, a Stage 3. Surveyor asked DON B, did the facility complete a root cause analysis for R2's PI. DON B stated, she has no idea it was before she was working at the facility. Surveyor asked DON B, what skin interventions were in place prior to the PI being discovered. DON B stated, none. DON B stated, that's not a good thing. Surveyor asked DON B, would you expect staff to find a PI before it reaches this point. DON B stated, yes. DON B checked to see if R2 had gone out to the hospital prior to the PI being discovered and stated the resident had not been out to the hospital. Surveyor asked DON B if their wound care nurse is wound care certified. DON B stated, yes, she is. Surveyor asked DON B, did the facility provide education to staff following this PI being discovered. DON B stated, she hasn't seen anything and she has been through the file cabinet in her office. DON B reached out to the facility's wound care nurse regarding training. The facility did not provide any additional information. Surveyor asked DON B, when was R2's last skin assessment prior to the PI being discovered on 1/18/24. DON B stated, the facility does not complete bath sheets and she is unsure. DON B stated, she will check. Surveyor showed DON B the progress note from 11/4/24 indicating, .wound left open to air this PM shift. Wound dressing becomes saturated with urine and the urine is trapped against skin. Surveyor asked DON B, is it acceptable for staff to leave a PI uncovered. DON B stated, no. Surveyor asked DON B, why is it important to keep PI's covered. DON B indicated for infection control. Surveyor asked DON B, is it also important for wound healing. DON B stated, absolutely. DON B stated, she has been told that this nurse doesn't like to change R2's dressing. Surveyor asked DON B, have you provided education to this nurse. DON B stated, no, she has not had a chance.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on observation, interview, and record review, the facility did not ensure that the residents environment remained as free of accident and hazards as possible for 1 of 1 sampled resident (R56) and 2 of 2 supplemental Residents (R54 & R141). Surveyor observed R54's motorized wheelchair (Motorized Assistive Devices) being charged in the 600 hall dining room and not behind a fire safe door. DON B stated, R141's motorized wheelchair battery is charged in the recreational/activity area on the 300 hall. Surveyor observed staff transfer R56 without a gait belt when he was feeling ill and dizzy. Evidenced by: Example 1 The facility does not have a policy and procedure for charging motorized wheelchairs. On 12/4/24 at 10:05 AM, Surveyor observed R54's motorized wheelchair battery being charged in the 600 hall dining room and not behind a fire safe door. On 12/4/24 at 10:40 AM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, where should batteries be charged. DON B stated she believes they are charged in the utility room. DON B stated, we have two (2) power wheelchairs on 300 and 600 halls. DON B stated, the electric wheelchair on the 300 hall is charged in the rec area (recreational/activity) and is not sure where the other is electric wheelchair is charged. DON B added, they are not charging batteries in resident rooms. Surveyor asked DON B, should electric wheelchairs be charged behind a fire safe door. DON B stated, yes. Surveyor asked DON B to walk with Surveyor to the 600 hall dining room. Surveyor showed DON B the battery plugged into the wall and charging. DON B stated, that battery (with the electric wheelchair a few feet away) belongs to R4, who passed away two (2) days ago. DON B stated, the family is finding a place to donate the electric wheelchair. Surveyor asked DON B, should this battery be charged behind a fire safe door. DON B stated, yes. Surveyor asked DON B, why is it important to charge batteries behind a fire safe door. DON B stated, due to shock or spark. Surveyor asked DON B, is this be a fire hazard. DON B stated, yes. DON B stated she did not realize staff were charging the electric wheelchair in the activity area until this morning. DON B stated, she will go have staff move it. DON B stated, she has not had an opportunity to address this yet. Example 2 R56 was admitted to the facility on [DATE] with diagnoses including, but not limited to, as follows: dementia, anxiety, and muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/6/24 indicates a Brief Interview of Mental Status (BIMS) score of 6 indicating he is severely cognitively impaired. Section GG of the MDS indicates R56 requires supervision or touching - Helper to provide VERBALS CUES or TOUCHING/STEADYING assist as resident completes activity. On 12/3/24 at 9:25 AM, Surveyor observed R56 the breakfast table repeatedly stating he didn't feel well. R56 stated, I feel terrible. A Certified Nursing Assistant (CNA) proceeded to assist R56 to stand and start walking with his walker. Surveyor observed R56 walk 1-2 feet and R56 stated, I'm dizzy. CNA C, came to assist R56 to turn and sit on his walker seat. Surveyor observed R56 to be unsteady and R56 stated, I'm scared. The two CNA's then assisted R56 to sit in a dining room chair. Despite R56 feeling unwell and dizzy the CNA's did not use a gait belt. On 12/3/24 at 9:27 AM, Surveyor asked LPN D (Licensed Practical Nurse), who witnessed the transfer without a gait belt, should staff have used a gait belt. LPN D stated, yes, they should have. R56's care plan documents for transfers and walking R56 requires CGA x1 4ww (caregiver assist of 1 with a four wheeled walker). On 12/5/25 at approximately 5:30 PM, Surveyor asked DON B (Director of Nursing) if she would expect CNA's to use a gait belt when transferring R56. DON B stated, yes.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Glarus Home	600 2nd Ave New Glarus, WI 53574

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview, and record review, the facility did not ensure residents maintain acceptable parameters of nutritional and hydration status for 1 of 1 Residents (R11) reviewed for nutritional status. R11 did not have appropriate interventions put into place to prevent continued weight loss. R11 had a weight loss of 20.6 pounds/12.86% over 2 months and 10 days, indicating a severe weight loss. This is evidenced by: Facility policy titled, Weight Policy, undated, states in part, Goal: To evaluate and meet the nutritional needs of our residents. Objective: Obtain weights as ordered or specified by this policy to monitor changes in weight, weight patterns, and implement appropriate interventions as needed. Procedure: . 3. Each resident will have weight measured at least monthly, unless on hospice. Weight may be obtained weekly, bi-weekly, or daily, depending on the specific needs of an individual resident . 5. If the current weight is +/- 4# (pounds) different than previous weight, resident must be re-weighed. Re-weight must be noted on the weight sheet. If weight changes persist, assess: . For Loss: Changes in condition, chewing or swallowing difficulty, change in diet/appetite/intake, denture fit, oral problems, changes in diuretic medications . 8. Weights are to be recorded on the daily/weekly/monthly weight sheets, located at the nurses station. 9. Each month, the RN (registered nurse) and RD (registered dietician) will assess the weights of the resident's and document this If unexplainable or not anticipated weight changes are significant, (resident gains or loses 5% of their body weight in 30 days or 10% in 180 days) they will be added to New Glarus Home: Critical At Risk monitored to be reviewed by RN/RD. R11 was admitted to the facility on [DATE], with diagnosis that include, in part: Bipolar II disorder (mental illness that cycles through high and low moods), weakness, Major Depressive Disorder, morbid obesity, aortic aneurysm (weak spot in the aorta that begins to bulge), and Type 2 Diabetes Mellitus (chronic insulin resistance or insufficient insulin production). R11's most recent Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/24 states in part, R11 has a Brief Interview for Mental Status (BIMS) of 9 out of 15, indicating that R11 has a moderate cognitive impairment. E0100 indicates the resident does not exhibit symptoms of hallucinations or delusions. E0800 also indicates that the resident did not refuse cares during the observation period. GG0115 indicates the resident has no impairment in her upper extremities with bilateral lower extremity impairment. GG0130A states the resident only requires assistance with setup or clean-up. K0100 indicates the resident did not exhibit signs of a possible swallowing disorder. K0300 indicates the resident has had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months that was not a physician-prescribed weight-loss regimen. R11's Comprehensive Care Plan, states, in part: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Focus: [Resident Name] has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) arthritis, I am overweight, hx (history) of bipolar, depression, diabetes. Goal: The resident will maintain current level of function in my ADLs through the review date. Date Initiated: 1/29/24. Revision on: 9/11/24. Target Date: 12/8/24. Interventions/Tasks: . EATING: without help if you set out what I need I would like small portions. Help me to put my glasses on before I eat. Date initiated: 2/8/24. (Of note: After all of R11's weight changes and being added to the facility's Critical at Risk Monitoring meetings, R11's care plan still indicates she is overweight. Additionally, R11 does not have a specific care plan related to her nutrition status or nutrition risk,) R11's Physician Orders state, in part: High Protein/High Calorie diet, Regular texture, Regular/Thin consistency. Start date: 8/29/24. House Supplement (Shakes). Start date: 2/1/24. R11's Meal Card for breakfast on Friday, 12/6/24, indicates the resident has a regular diet, with regular texture and thin fluids. (Of note: R11's previous diet was a carbohydrate control diet as treatment for her type 2 diabetes). R11's weights were documented as follows: 7/1/24: 160.2 lbs. (pounds) 8/22/24: 144.9 lbs. 9/11/24: 139.6 lbs. 10/1/24: 140.9 lbs. 10/2/24: 140.9 lbs 10/19/24: 142 lbs. 10/28/24: 137.8 lbs. 10/31/24: 139 lbs. (Of note: from July 2024 through survey entrance date of 12/2/24, these are all the weights that had been assessed for R11. Facility policy states the resident should be weighed at least monthly, however R11 did not have a recorded weight for November). R11's meal intake documentation indicates, in part: 11/6/24 at 1:58 PM: 51%-75% 11/7/24 at 1:57 PM: 75%-100% (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/7/24 at 9:09 PM: 25%-50% 11/8/24 at 9:00 AM: 51%-75% 11/8/24 at 1:00 PM: 51%-75% 11/9/24 at 11:28 AM: 51%-75% 11/9/24 at 1:00 PM: 51%-75% 11/10/24 at 10:00 AM: 51%-75% 11/10/24 at 1:00 PM: 51%-75% 11/10/24 at 9:56 PM: 75%-100% 11/11/24 at 9:00 AM: 25%-50% 11/11/24 at 1:00 PM: 25%-50% 11/12/24 at 10:20 AM: 51%-75% 11/12/24 at 1:00 PM: 75%-100% 11/13/24 at 9:00 AM: 75%-100% 11/13/24 at 1:00 PM: 75%-100% 11/14/24 at 11:19 AM: 25%-50% 11/14/24 at 1:00 PM: 25%-50% 11/14/24 at 6:00 PM: 51%-75% 11/15/24 at 10:31 AM: 25%-50% 11/15/24 at 1:39 PM: 51%-75% 11/16/24 at 11:00 AM: 51%-75% 11/16/24 at 1:51 PM: 51%-75% 11/16/24 at 8:36 PM: 0%-25% 11/17/24 at 1:35 PM: 75%-100% 11/18/24 at 10:26 AM: 51%-75% (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/18/24 at 12:00 PM: 51%-75% 11/18/24 at 6:00 PM: 25%-50% 11/19/24 at 10:16 AM: 51%-75% 11/19/24 at 1:00 PM: 0%-25% 11/19/24 at 6:00 PM: 25%-50% 11/20/24 at 1:59 PM: 51%-75% 11/20/24 at 9:09 PM: 75%-100% 11/21/24 at 8:54 AM: 25%-50% 11/21/24 at 1:29 PM: 25%-50% 11/21/24 at 9:46 PM: 25%-50% 11/22/24 at 10:35 AM: 0%-25% 11/22/24 at 1:30 PM: 25%-50% 11/22/24 at 6:00 PM: 25%-50% 11/23/24 at 9:56 AM: 51%-75% 11/23/24 at 1:00 PM: 25%-50% 11/23/24 at 9:32 PM: 51%-75% 11/24/24 at 10:44 AM: 25%-50% 11/24/24 at 1:00 PM: 0%-25% 11/24/24 at 8:49 PM: Resident Refused 11/25/24 at 6:00 PM: 75%-100% 11/26/24 at 1:44 PM: 51%-75% 11/26/24 at 7:40 PM: 51%-75% 11/27/24 at 9:42 AM: 51%-75% 11/27/24 at 1:22 PM: 51%-75% (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/27/24 at 6:00 PM: 51%-75% 11/28/24 at 1:47 PM: 75%-100% 11/29/24 at 9:48 AM: 75%-100% 11/29/24 at 1:32 PM: 75%-100% 11/30/24 at 9:00 AM: 25%-50% 11/30/24 at 1:00 PM: 25%-50% 11/30/24 at 6:00 PM: 0%-25% 12/1/24 at 10:28 AM: 0%-25% 12/1/24 at 1:47 PM: 25%-50% 12/1/24 at 6:00 PM: 0%-25% 12/2/24 at 9:00 AM: 25%-50% 12/2/24 at 1:00 PM: 0%-25% 12/2/24 at 9:12 PM: 25%-50% 12/3/24 at 9:31 AM: 51%-75% 12/3/24 at 1:22 PM: 75%-100% 12/3/24 at 9:01 PM: 25%-50% 12/4/24 at 11:00 AM: 0%-25% 12/4/24 at 1:55 PM: 25%-50% (Of note: The facility was only able to provide meal intake data for the past month. Data provided included all recorded meals from 11/6/24 through a partial day on 12/5/24. 16 meals provided to this resident had no recorded intake. 32 of the 84, or 38% of the recorded meals indicated R11 consumed less than 50% of the meal. No dietary interventions were added in November 2024 or December 2024.) On 7/29/24 at 10:59 AM, a Progress Note was written by RD O (Registered Dietician). This note states, Ate 50% or less for 2 or more meals in the day. RD aware. Weight continues to remain stable and within baseline weight range. Will continue to monitor. (Of note, the last recorded weight for this resident was 7/1/24, limiting the RD's ability to determine if R11's weight was stable or not.) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 7/29/24 at 2:22 PM, a Progress Note was written by RD O. This note states: Ate 50% or less for 2 or more meals in the day. RD aware and continues to monitor. On 8/5/24 at 1:13 PM, a Progress Note was written by RD O. This note states: Ate 50% or less for 2 or more meals in the day. RD aware and is continuing to monitor her weight status. (Of note: Even after three notes within seven days regarding R11's poor oral intake, R11 was not reweighed until 8/22/24. Additionally, no notes were written regarding R11 refusing to be weighed.) On 8/22/24 at 10:29 AM, a Progress Note was written by RD O. The note states: Ate 50% or less for 2 or more meals in the day. RD continues to remain aware and following weight status. On 8/22/24 R11 weighed 144.9 lbs. (This is a 15.3 pound or 9.55% loss since 7/1/24, this amount of weight loss is considered severe.) On 8/26/24 at 4:03 PM, a Progress Note was written by RD O. The note states: Ate 50% or less for 2 or more meals in the day. RD continues to monitor and follow. On 8/26/24 at 4:08 PM, a Progress Note was written by RD O. This note indicates R11 has had a weight of 144.9 which is a 15.3 lbs. change from her previously recorded weight. The note also states: RD noting significant weight loss over the last 1.5 months. RD updating MD (medical doctor) now, along with requesting the start of House Supplements BID (twice a day) and ordering a High Protein/High Calorie diet. Will additionally add to CAR (Critical At-Risk) monitoring. On 8/29/24 at 10:38 AM, a Progress Note was written by RD O. The note indicates that the reason for monitoring is R11's significant weight loss. It also indicates that the resident has been noted to have lower meal intakes between 25-75% for most recorded meals. RD O recommends offering R11 alternative options if she does not eat enough of her meal. RD O also indicates she has no concern for R11's ability to swallow and make meal preferences known. On 8/29/24 at 10:39 AM, an assessment titled, Mini Nutritional Assessment is conducted in which R11 scores an 8 out of 14, indicating she is at risk for malnutrition. This assessment was completed by RD O. (Of Note, nothing additional was put into place after assessing R11 as being at risk for malnutrition.) On 9/11/24 R11 weighed 139.6 lbs. (12.85% weight loss in a little over 2 months.) On 9/12/24 at 7:31 AM, a Progress Note was written by RD O. The note indicates that the reason for monitoring is R11's significant weight loss. It also indicates R11's meal intakes continue to be lower, between 25%-75%. Additionally, RD O recommends Mirtazapine (antidepressant and appetite stimulant medication). This note indicates RD O sent this recommendation to the MD to consider. (Of note: This medication recommendation never comes up again in RD O notes, MD notes, or NP notes.) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 9/12/24 at 7:32 AM, a Progress note is written by RD O. The note indicates R11 has a weight of 139.6 lbs. , which is an additional weight loss of 5.3 lbs. since the previous weight on 8/22/24. The note states, in part: RD aware and continuing to monitor closely at Critical At Risk. RD did fax MD with update. On 9/12/24 at 7:33 AM, a Progress note is written by RD O. This note states: Ate 50% or less for 2 or more meals in the day. RD aware and continues to monitor. On 9/12/24 at 7:31 AM, a Progress Note was written by RD O. This note states, in part: . Current weigh is at 139.6# (from 9/11, however no new weight checks since this time) . On 10/14/24 at 11:05 AM, a Progress Note was written by RD O. This note states: Ate 50% or less for 2 or more meals in the day. RD aware. Continue to monitor resident closely at Critical At Risk. On 10/17/24 at 10:26 AM, a Progress Note was written by RD O. This note states, in part: . Current weigh is at 140.9# (10/2) . On 10/21/24 at 12:56 PM, a Progress Note was written by RD O. This note states: Ate 50% or less for 2 or more meals in the day. RD aware, with resident continuing to be monitored at weekly Critical At Risk. On 10/24/24 at 10:58 AM, a Progress Note was written by RD O. This note states, in part: . Her family does desire comfort for her, however comfort care measures have not been ordered. RD will continue to monitor and follow closely at Critical At Risk, until nutritional status stabilizes. On 10/24/24 at 10:58 AM, a Progress Note was written by RD O. This note states, in part: . Current weight is at 137.8# (down 5# x 1 wk (week)) . She does continue with weekly weight check orders . On 10/31/24 at 11:13 AM, a Progress Note was written by RD O. The note indicates R11 has a weight of 137. 8 lbs., which is a weight loss of 10.4% over 180 days. The note states, in part: RD aware and continues to monitor resident closely at Critical At Risk monitoring. On 10/31/24, R11 weighed 139 lbs. which is a 13.23% weight loss in less than 120 days. No documentation/evidence that new interventions were put in place to prevent further unintentional weight loss from occurring for R11 despite being monitored weekly by the RD and IDT team. On 11/8/24 at 9:39 AM, a Progress Note was written by RD O. This note states, in part: . Current weight is at 139.8# . She does continue with weekly weight check orders . R11 was not weight the week of November 3rd thru the 9th. On 11/11/24 at 11:24, a Progress Note was written by RD O. This note states: Ate 50% or less for 2 or more meals in the day. RD aware, with resident continues to monitor resident closely at Critical At Risk. R11 was not weighed the week of November 10th thru the 16th (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 11/14/24 at 9:55 AM, a Progress Note was written by RD O. This note states, in part: . Current weight is at 139.8# (from 10/31/24), . She does continue with weekly weight check orders . R11 was not weighed the week of November 17th thru the 23rd On 11/21/24 at 10:24 AM, a Progress Note was written by RD O. This note states, in part: . Last obtained weight check was at 139.8# (from 10/31/24, no new weight checks), . She does continue with weekly weight check orders . On 11/25/24 at 12:24 PM, a Progress Note was written by RD O. This note states, in part: . Last obtained weight check was at 139.8# (from 10/31/24, no new weight checks), . She does continue with weekly weight check orders . R11 was not weighed the week of November 24th thru the 30th. On 12/2/24 at 10:41 PM, a BIMS evaluation is conducted on R11 that indicates she has a score of 4 out of 10 indicating severe cognitive impairment. On 12/2/24, an assessment titled, Mini Nutritional Assessment is conducted in which R11 scores a 9 out of 14, indicating she is at risk for malnutrition. This assessment was completed by RD O. (Of note: At no point was the facility recording weekly weights or documenting resident refusals to obtain weekly weights. RD O made no further recommendations besides the mirtazapine in which there is no documented follow-up.) Surveyor reviewed nutritional assessments located in R11's current electronic medical record and can find no indication of R11's preferred foods or a repeat ability assessment following the change in her BIMS score from 9 (moderate cognitive impairment) to 4 (severe cognitive impairment) on 12/2/24. (Of note: Surveyor has concerns with R11's ability to state meal preferences due to the recent BIMS decline and Surveyor's observations of R11 feeding herself.) On 12/5/24 at 9:44 AM, Surveyor interviewed CNA P (Certified Nursing Assistant). Surveyor asked CNA P how she knows which residents need to be weighed each day. CNA P indicates the nurses tell her who needs to get weighed, but they are also on sheets at the nurses' station. CNA P also indicates she is aware every resident is weighed at least monthly and knows every resident needs to be weighed the first of the month. On 12/5/24 at 10:00 AM, Surveyor interviewed CNA Q. Surveyor asked CNA Q how she knows which residents need to be weighed each day. CNA Q indicates the nurses give the CNAs the list before breakfast and does not think it is written down anywhere. Surveyor asked CNA Q if there is a list or any written papers that list which residents need to be weighed. CNA Q states she does not think so. On 12/5/24 at 10:10 AM, a Progress Note was written by RD O. This note states, in part: . Last obtained weight check was at 139.0# (from 10/31/24, no new weight checks), . She does continue with weekly weight check orders . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 12/5/24 at 10:15 AM, Surveyor observed two binders on the nurse's station desk. The first binder, titled, 300 CNA Binder contained information about resident transfer statuses, and special instructions, however Surveyor could not locate weight frequency in this binder for any resident. The second binder, titled, 300 Wing- Nurse Report Book had residents listed with different weight schedules, such as daily weights. However, no special instruction was given to provide weekly weights to R11. R11 was not weighed December 1st through December 5th, until Surveyor asked staff to weigh R11. On 12/5/24 at 10:28 AM, Surveyor observed CNA P and CNA R weigh the resident utilizing a Hoyer lift. R11 was agreeable to getting weighed and the process was conducted following current standards of practice. R11 weighed 133.7 lbs. at this time, which is another 5.3 lbs. of weight loss since her last weight on 10/31/24. On 12/5/24 at 10:30 AM, Surveyor interviewed CNA R. Surveyor asked CNA R how she knows which residents need to be weighed each day. CNA R indicates the nurses give the CNAs the list. CNA R also indicates she knows every resident is weighed at least monthly and knows every resident needs to be weighed the first of the month. On 12/5/24 at 10:34 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what interventions the facility has in place to prevent R11 from losing more weight. DOB B indicates R11 is involved in facility Clinical At Risk meetings and has been for the past 13 weeks, she is receiving a house supplement three times a day and is consuming 75%-100% of those. Surveyor asked DON B to describe the Critical At Risk meetings. DON B indicates herself, the registered dietician, the MDS coordinator, and wound nurse are involved in the meetings and they monitor wounds and weight loss in the meetings. Surveyor asked DON B how recommendations from the registered dietician are communicated and put into the electronic medical record. DON B indicates the registered dietician will email her with the recommendation, and if it is a standing order they can approve it right away and then the registered dietician will also fax the doctor for order approval, if required. Surveyor asked DON B how frequently R11 should be weighed. DON B states she should be weighed weekly. DON B indicates she believed R11 had weekly weights scheduled for Fridays, but searched the electronic medical record and was unable to locate the order. Surveyor asked DON B if R11 should have been weighed weekly. DON B states, yes. On 12/5/24 at 12:56 PM, Surveyor observed R11 eat her lunch meal in her room. R11 received her tray placed on her bedside table, over her lap so that it was accessible, at 12:59 PM. R11 was able to pick up, open, and eat a package of crackers by herself. After eating all her crackers, R11 began sticking her fingers into her cake, swirling her fingers around in the frosting, and periodically licking the frosting from her fingers. After two minutes, CNA S walked into the room. When the CNA introduced herself to the resident, R11 asked what the cake was, and CNA S explained to the resident that it was cake, and asked R11 if she needed help. R11 repeated the phrase, I don't think I need it, whenever CNA S asked if she needed help. CNA donned gloves and stood over the resident asking if R11 wanted any of her stew or vegetables. R11 could not see or did not realize there were vegetables on the plate to the side of her bowl of stew, as she asked, What are those? CNA S explained there was broccoli and cauliflower on her plate and assisted R11 with rearranging the tray so that the vegetables were visible to R11, moving the vegetables from the side of the bowl to the front of the bowl, closer to R11. CNA S then handed R11 her spoon and proceeded to assist R11's roommate. Surveyor observed R11 being able to use the spoon to feed herself the stew, however she appeared to be straining her neck as not to spill stew on her clothes. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 12/5/24 at 1:11 PM, Surveyor interviewed CNA S. Surveyor asked CNA S if R11 needs assistance eating. CNA S indicates that she usually doesn't need help eating, but that there are foods she struggles with eating. Surveyor asked CNA S if she always goes in to assist R11 eat. CNA S indicates she only goes in to check on her periodically. On 12/5/24 at 3:50 PM, Surveyor interviewed RD O. Surveyor asked RD O if R11 was meeting her required nutritional needs. RD O states, no. RD O also indicates the facility has added R11 to the Critical At Risk meetings, added nutritional interventions starting in August 2024, changed R11's diet to high protein and high calorie, and started tracking weekly weights and nutritional intake. RD O also indicates that R11 refuses to eat meals at times and the family is still considering comfort cares. Surveyor asked RD O how often R11 should be getting weighed. RD O states she should be getting weighed weekly, but also notes R11 has a tendency to refuse weights and has refused RD assessments. Surveyor asked RD O if RD O has assessed R11's ability to feed herself. RD O states she has and indicates there are days where R11 is alert and very capable of feeding herself and there are days where R11 is very sleepy and needs more help. RD O also indicates that R11 could use all the encouragement and cues she can get. Surveyor asked RD O if she knew what came of her recommendation for mirtazapine. RD O indicates she is unable to specifically recall, however she believes it was trialed and R11 did not like it or it may have been due to comfort cares. Surveyor asked RD O what she believes is the cause of R11's weight loss. RD O indicates it is a combination of a lack of appetite and overall decline. Surveyor asked RD O if she was aware of the BIMS score of 4 out of 15, obtained on 12/2/24. RD O indicates she was not. Surveyor asked RD O if she would have reassessed R11's capacity to feed herself if she was made aware of the significant decline in BIMS score. RD O indicates she would have reassessed. (Of note, there is no documentation in progress notes or MDS data indicating R11 is refusing weights. There is a single instance of R11 refusing a meal within the 30 days prior to record review. Additionally, Surveyor has reviewed the past 6 months of available nutritional assessments, all of which are complete. There is no documented response to the mirtazapine recommendation.) On 12/5/24 at 4:46 PM, Surveyor interviewed DON B. Surveyor asked DON B if the Mirtazapine recommendation was followed up on with a provider. DON B indicates the physician also saw R11 on 9/12/24, the same day the recommendation was made, however there is no mention of the recommendation in his notes. Surveyor asked DON B if this recommendation should have been followed up on. DON B states, yes. Surveyor described the observation made of R11 eating that is detailed above. Surveyor asked DON B what her conclusion is from hearing this observation. DON B states, somebody should be in there to assist her to eat. Surveyor asked DON B why the house supplement was not increased. DON B states R11 has been three times a day since February 2024 and the facility did not increase this because the supplement they use is ideally given in between meals so it doesn't take up food space in between. Surveyor asked DON B if the facility had assessed R11's preferred foods. DON B searched for a specific nutrition assessment that asked for food preferences. DON B indicates dietary is in charge of this assessment and describes it as a dietary profile, however upon searching, DON B is unable to locate this assessment. (Of note: Some food preferences are listed on a nutrition assessment from 12/8/17, that was found in a different electronic medical record than the one currently being used by the facility. There is no documentation indicating staff are offering R11 her preferred foods to help increase meal intakes.) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Glarus Home	600 2nd Ave New Glarus, WI 53574

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R11 had severe weight loss due to a decline in nutritional intake. Staff were not monitoring R11's weights and did not consistently monitor meal intakes to ensure she was meeting her estimated daily needs. The facility did not implement appropriate interventions or a care plan to prevent R11 from experiencing further weight loss. Recommendations from the registered dietician did not have a documented response, or trial period from R11's physician. The registered dietician was not informed of R11's cognitive decline to allow for further assessment and any new interventions that may be needed. This resulted in R11 experiencing a sever weight loss in less than 6 months.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility did not ensure that a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD), receives appropriate treatment and services to correct the assessed problem or attain the highest practical mental and psychosocial well-being for 2 of 2 residents (R) (R41 and R65) reviewed out of 21 sampled residents. R41's diagnosis list indicates she has a diagnosis of Post Traumatic Stress Disorder (PTSD). R41's Comprehensive Care Plan does not include known triggers, personalized interventions, and/or goals related to her past history of trauma. R65 has a diagnosis of Post Traumatic Stress Disorder (PTSD) and an initial assessment did not include questions of the origin from which diagnosis was given, what it looks like for R65 when it manifests, triggers that cause R65 to experience the affects of the trauma, or interventions for staff to try if R65 has an episode related to past trauma. Therefore R65's care plan does not contain information of manifestation, goals, or interventions related to R65's PTSD. This is evidenced by: Facility policy titled, Comprehensive Care Plans Policy and Procedure, dated 9/23/23, states, in part: Policy Statement: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedure and practices to avoid re-traumatization .3 . g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to mitigate or decrease the effect of the trigger on the resident . Example 1: R41 admitted to the facility on [DATE] with diagnosis that include, in part: Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Type 2 Diabetes, and Unilateral Primary Osteoarthritis. After a hospitalization in September 2024, R41 was also diagnosed with a Suicide Attempt, Poisoning by 4-Aminophenol Derivatives-Intentional Self-Harm, and a personal history of suicidal ideation. R41's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/2/24, indicates R41 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she is cognitively intact. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/24 at 11:33 AM, Surveyor completed initial screening with R41. Surveyor noted R41 has a past history of trauma and R41 indicated it was related to a prior medical procedure, but did not want to discuss it further. Surveyor reviewed R41's History and Physical from her hospitalization in September 2024. This document, dated 9/26/24, states, in part: .[Resident Name] met from July 2015 through March 2016 with [Psychotherapist Name] for major depressive disorder at [Clinic Name]. At that time she described history of depression, binge eating, and significant depression since [sic] 2005 when she had woke from a planned lap band surgery and was told they could not place the band as planned. She was very upset at the time, and [sic] had passive suicidal ideation. She began psychotherapy and started an antidepressant at that time. She states that she had PTSD symptoms related to that surgery for a time . R41's Comprehensive Care Plan, states, in part: Focus: The resident has a mood problem r/t (related to) major depressive disorder. Date initiated: 6/4/24. Goal: The resident will have improved mood state (happier, calmer appearance, no s/sx (signs or symptoms) of depression, anxiety or sadness) through the review date. Date initiated: 6/4/24. Revision on 12/4/24. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated: 6/4/24. Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these. Date initiated: 6/4/24. Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.). Date initiated: 6/4/24. Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. Date initiated: 6/4/24. Monitor/record/report to MD (medical doctor) prn (as needed) acute episode feelings of sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. Date initiated: 6/4/24. Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols. Date initiated: 6/4/24. Provide the resident with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity. Date initiated: 6/4/24. (Of note: R41's care plan is not personalized and does not have a care plan for PTSD. It does not state what sort of trauma R41 experienced, how it manifests, triggers, what staff should monitor, or personalized interventions related to R41's trauma and what they can do if it manifests.) On 12/5/24 at 10:49 AM, Surveyor interviewed DON B about R41's PTSD. DON B confirms R41 has a diagnosis of PTSD. Surveyor asks if there is a specific care plan related to R41's PTSD. DON B searches and indicates there is not. DON B indicates R41 is taking psychotropic medications and has care plans for her other mental health disorders but not for PTSD. Surveyor asked DON B if a resident has a diagnosis of PTSD, should they have a specific care plan that outlines the residents history of trauma and any triggers that may cause re-traumatization. DON B states, yes, they should have a care plan. 38882 Example 2: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65 was admitted to the facility, on 9/13/23, with diagnoses that include: Schizotypal disorder (mental condition that causes a person to have trouble with relationships/odd behaviors and/or unusual thought patterns), Obsessive Compulsive Disorder, Post Traumatic Stress Disorder (PTSD), and Major Depressive Disorder (MDD). R65's Physician's Orders for 12/2024 states R65 is prescribed Mirtazapine for Mood Disorder and Methylphenidate for MDD. R65's PASARR Level 1 Screen was completed on 9/12/24 and indicated that R65 has a major mental diagnosis and is on medication to treat symptoms or behaviors of a major mental diagnosis. R65's County Review of Nursing Home, IMD, or ICF/IID referrals, dated 10/2/23, includes nursing facility admission recommendation- a short-term exemption from level 2 screening applies. Note short term exemptions may not be used consecutively to extend the time in a facility without a PASRR level 2 screen. (It is important to note R65 still resides in the facility on 12/4/24, more than the maximum 30 days the exemption allowed. See F645 for reference.) R65's Initial Assessment, dated 5/13/24, includes: Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example- a serious accident or fire, a physical assault, abuse, an earthquake, or flood, a war, seeing someone killed or seriously injured, or having a loved one die through homicide or suicide. Have you ever experienced this kind of event? Yes. (It is important to note this assessment does not indicate what kind of event lead to R65's diagnosis of PTSD) R65's Comprehensive Care Plan, initiated 2/1/24, is not personalized as it does not include R65's origin of his PTSD diagnosis, what it looks like when it manifests, what triggers it, interventions staff can try if R65's PTSD manifests, or goals related to R65's diagnosis of PTSD. On 12/5/24 at 12:51 PM, CNA K (Certified Nursing Assistant) indicated she is not sure if R65 has a diagnosis of PTSD, what triggers he may have, or what interventions she could try if his PTSD manifests. On 12/5/24 at 12:54 PM, RN W (Registered Nurse) indicated she was unsure if R65 had PTSD, but R65's care plan should contain interventions, goals, and information about R65's PTSD. RN W reviewed R65's care plan and stated, It is not on here. On 12/5/24 at 1:06 PM, DON B (Director of Nursing) indicated R65's initial assessment does not gather specific information related to his diagnosis of PTSD, but it should. DON B indicated it should also collect information of what it looks like for R65 when his PTSD manifests, what triggers he may have, and what interventions work for him. DON B reviewed R65's care plan and indicated his care plan does not contain goals, manifestation description, or interventions related to R65's PTSD. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 1:36 PM, SW F (Social Worker) indicated R65's initial assessment does not include what R65's triggers are, the origin of the diagnosis, or interventions staff can try if R65's PTSD manifests. SW F indicated R65's care plan should include origin, manifestation, triggers, and personalized interventions.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 30992 Based on observation, interview, and record review, the facility did not ensure that its medication error rate was 5% or less for 35 medication pass opportunities. The facility's medication error rate was 5.71% with two (2) errors observed for R31 and R2. This is evidenced by: The facility policy, Medication Administration, dated 7/1/24, states in part, as follows: Policy: Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards Procedure: Ensure the six right of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, f. Right documentation Januvia reference - https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021995s023mg.pdf documents: Take Januvia whole. Do not split, crush or chew. Example 1 R31's Physician Orders, signed 12/3/24, include, in part, the following medication: Januvia Tab 100 mg (milligrams) Give 1 tab by mouth one time a day related to Type 2 diabetes mellitus without complication. On 12/3/24 at 9:00 AM, Surveyor observed LPN D (Licensed Practical Nurse) crush Januvia and administer it to R31. On 12/4/24 at 3:40 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, is it acceptable for staff to crush Januvia. DON B stated, no, it is not acceptable to crush Januvia. This resulted in a dosing error. Example 2 R2's Physician Orders, signed 10/24/24, includes, in part, the following medication: levothyroxine Tab 50 mcg (micrograms) Give 1 tab by mouth one time a day every Mon, Tue, Wed, Thu, Fri, Sat related to hypothyroidism. On 12/3/24 at 9:05 AM, Surveyor observed LPN D (Licensed Practical Nurse) pass R2's morning medications. LPN D stated, R2's levothyroxine is not available. R2's levothyroxine was not administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 3:40 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, if medications should be administered per provider orders. DON B stated, yes. Surveyor shared with DON B that R2's levothyroxine was not adminstered on 12/3/24 due to the medication not being in stock. Surveyor asked DON B, should medications be in available to be administered per physician orders. DON B stated, yes. On 12/5/24 at approximately 4:00 PM, DON B (Director of Nursing) stated she followed up and found that levothyroxine was available in Omnicell contingency which could have been administered to R2. DON B stated, LPN D should have administered the medication from contingency. This resulted in an omission.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50698 Based on observation and interview, the facility did not ensure a sufficient number of trained staff worked in the facility's food service department in order to safely and effectively carry out the meal preparation and other food and nutrition services for 3 of 21 sampled residents (R42, R40, R2) and 3 of 6 supplemental residents (R19, R16, R70). R42 voiced concerns about meals being late. Surveyor observed meals to be 45 minutes or more late. R40, R19, R16, R70, and R2 voiced concerns that their meals were often served late. Evidenced by: Facility meal time schedule reads as follows: Meal Times and Locations Breakfast 0745 - 400 & 500 Wings 0800 - Main Dining Room 0815 - 600 Wing 0830 - Room Service Lunch 1145 - 400 & 500 Wings 1200 - Main Dining Room 1215 - 600 Wing 1230 - Room Service Dinner 1645 - 400 & 500 Wings 1700 - Main Dining Room 1715 - 600 Wing (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1730 - Room Service Example 1 R42 was admitted to the facility on [DATE] with diagnoses including: hyperlipidemia, vitamin D deficiency, deficiency of B group vitamins, hypercholesterolemia, heart disease, chronic kidney disease, gastro-esophageal reflux disease, depression, and vascular dementia. R42's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/20/24, indicates R42 has a Brief Interview for Mental Status (BIMS) score of 13 indicating R42 is cognitively intact. On 12/2/24 at 3:26 PM, Surveyor interviewed R42 about his care at the facility. R42 stated his meals are often late. R42 showed Surveyor a notebook and explained to Surveyor R42 wrote down days his meals were late and the time they were served. R42 started keeping track on 9/23/24. Surveyor observed the notebook and noted the following dates and times the meal was served: 9/23/24: breakfast served at 9:30am 9/24/24: breakfast at 10:00am 9/25/24: breakfast at 9:00am 9/26/24: breakfast at 10:30am 9/27/24: breakfast at 9:15am 9/28/24: breakfast at 9:30am 10/1/24: breakfast at 9:00am 10/3/24: breakfast at 10am 10/5/24: breakfast at 9am 10/6/24: breakfast at 9:30am 10/7/24: breakfast at 9:30am 10/11/24: breakfast at 8:45am 10/16/24: breakfast at 9:15am 11/3/24: breakfast at 9:30am 11/5/24: breakfast at 8:45am 11/8/24: breakfast at 8:45am (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/9/24: breakfast at 8:45am 11/10/24: breakfast at 9:00am 11/10/24: Lunch at 1:00pm 11/15/24: breakfast at 8:45am 11/30/24: breakfast at 9:00am 12/1/24: breakfast at 9:15am 12/2/24: breakfast at 9:15am 12/2/24: lunch at 12:40pm *It's important to note breakfast is scheduled for 7:45am on the 500 wing and lunch is scheduled for 11:45am on 500 wing (wing where R42 resides). On 12/2/24 at 12:06 PM, Surveyor observed the serving of lunch on the 500 wing. At 12:15 PM, the food arrived on the unit. Surveyor observed dietary staff leaving the serving area to go back to the kitchen to get wipes for food thermometer. At 12:30 PM, dietary staff was back on the unit and taking the temperature of the food. At 12:38 PM, residents started receiving food. It's important to note this is 53 minutes past the scheduled serving time. On 12/3/24 at 7:50 AM, Surveyor observed the serving of breakfast on the 500 wing. At 8:22 AM, a CNA was passing out muffins. At 8:25 AM, the food arrived on the unit. At 8:28 AM, staff were taking the temperature of the food. At 8:31 AM, resident food is starting to be served. At 8:40 AM, the last resident was served in dining room. It's important to note this is 55 minutes past the scheduled serving time. Example 2 On 12/3/24 at 2:00 PM, during Resident Council Task, R40, R19, R16, R70, and R2 indicated meals are often served late and residents are not offered snacks at bedtime. On 12/5/24 at 9:51 AM, Surveyor interviewed DM L (Dietary Manager) and RD M (Regional Director) about providing meals at the scheduled mealtimes. DM and RD both indicated staff should follow the listed times on the schedule and they look at returned meal tickets to make sure residents got food. DM stated they don't record when food gets delivered to the wings. On 12/5/24 at 4:43 PM, Surveyor interviewed NHA A about mealtimes. NHA A indicated she would expect dietary staff to follow the mealtime schedule and have food on the wings at their designated times.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 38882 Based on observation, interview, and record review, the facility did not ensure snacks were offered at bedtime daily when there are more than 14 hours between the evening meal and breakfast. This has the potential to affect 90 of 90 residents and 6 of 6 units. R40, R19, R16, R70, and R2 voiced concerns that residents were not consistently being offered a snack at bedtime. These residents reside on the following hallways: 200 hall, 600 hall, and 300 hall Staff on the following hallways reported to the Survey team that bedtime snacks were not being offered to all residents: 500 hall, 300 hall, 600 hall, 400 hall, 200 hall, and 100 hall. There were more than 14 hours between the evening meal and breakfast and the facility staff were not offering snacks to all residents. Evidenced by: Facility policy, titled Resident Food Service: Snacks, revised 1/24, includes: .All residents must be offered daily snack at bedtime unless otherwise specified in resident's plan of care. Nursing: Offer bedtime snacks to all residents. Facility's Posted Mealtimes and Locations are as follows: Breakfast 0745 - 400 &500 Wings 0800 - Main Dining Room 0815 - 600 Wing 0830 - Room Service Lunch 1145 - 400 & 500 Wings 1200 - Main Dining Room 1215 - 600 Wing 1230 - Room Service Dinner (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1645 - 400 & 500 Wings 1700 - Main Dining Room 1715 - 600 Wing 1730 - Room Service (It is important to note dinner and the following breakfast meal are scheduled 15 hours apart.) On 12/3/24 at 7:50 AM, Surveyor observed the serving of breakfast on the 500 wing. At 8:25 AM, the food arrived on the unit. At 8:31 AM, food was starting to be served. At 8:40 AM, the last resident was served in dining room. It's important to note this is 55 minutes past the scheduled serving time. On 12/3/24 at 2:00 PM, during Resident Council Task, R40, R19, R16, R70, and R2 indicated meals are often served late and residents are not offered snacks at bedtime. On 12/4/24 at 3:37 PM, CNA G (Certified Nursing Assistant) indicated she works on the 600 hall and staff get residents a snack between meals if they ask for one. CNA G indicated staff do not offer every resident a snack at bedtime. On 12/4/24 at 4:30 PM, CNA H indicated she works on different halls including the 100, 200, and 300 hall. CNA H indicated if there is a staff member available they offer a snack at the beginning of her shift, but not at bedtime. CNA H indicated the facility used to have a snack cart that went around but they do not anymore. On 12/4/24 at 4:35 PM, RN I (Registered Nurse) indicated he works on the 600 hall and they don't do snacks at night usually. RN I indicated staff do not go around and ask all residents if they want a snack at bedtime. On 12/4/24 at 4:41 PM, CNA J indicated she works on the 500 hall and staff do not offer snacks to all residents at bedtime or any time after supper. On 12/5/24 at 9:51 AM, DM L (Dietary Manager) indicated there are 15 hours between the supper meal and the next day's breakfast meal. DM L and Regional Food Service Director M indicated the nursing staff are to be offering all residents in house a snack at bedtime, but they are not consistently doing this. Surveyor shared Surveyors observations with DM L and Regional Food Service Director M of breakfast being served 55 minutes late during this survey. (Refer to F802 for additional information.) On 12/5/24 at 12:51 PM, CNA K indicated she works on the 400 hall and residents can have a snack outside of mealtime if they ask for it, but CNA K indicated a snack is not offered to all residents at bedtime. (continued on next page)

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	525630	A. Building B. Wing	12/05/2024

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/5/24 at 5:03 PM, Surveyor and NHA A (Nursing Home Administrator) reviewed the facility's scheduled mealtimes, noting 15 hours between supper and the following breakfast. NHA A and Surveyor reviewed the facility's snack policy, noting all residents are to be offered a snack at bedtime. Surveyor shared resident and staff interviews with NHA A. NHA A indicated staff are to be offering all residents in house a snack at bedtime. Residents are not being offered a snack at bedtime when there are 15 hours between the evening meal and breakfast meal.

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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 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. 38882 Based on observation and interview, the facility did not maintain a safe and sanitary environment in which food is prepared, stored and distributed. This has the potential to affect all 90 residents who reside in the facility. Surveyor observed multiple staff in food preparation areas, while food was being prepared, without donning hair restraints. Surveyor observed staff not allowing dishes to air dry completely before stacking them. Surveyor observed dented cans in circulation. Surveyor observed opened and undated food. Surveyor observed unclean stored equipment in facility's main kitchen. Evidenced by: Example 1 Facility policy, titled Uniform Dress Code, revised 1/24, includes: . Wear approved hair restraint when on duty regardless of length or presence of hair . On 12/2/24 at 10:11 AM, Surveyor observed DM L (Dietary Manager) in the facility's main kitchen, in the food preparation area without a hair restraint. Surveyor asked DM L about her hair restraint and DM L indicated she should have one on and she is sorry. On 12/5/24 at 8:20 AM, Surveyor observed CNA X (Certified Nursing Assistant) enter the kitchen, in the food preparation area while food was being prepared and served without a hair restraint. CNA X and Surveyor made eye contact and she left through the kitchen door. On 12/5/24 at 9:00 AM Surveyor observed DS Y (Dietary Supervisor) inside the facility's main kitchen, setting up a cart of beverages for residents' breakfast meal. DS Y did not have on a hair restraint. Surveyor asked DS Y about her hair restraint. DS Y indicated she should have on a hair restraint but she forgot. On 12/5/24 at 9:27 AM, Surveyor observed RDD M (Regional Dietary Director) walk into the food preparation area with a full beard and no hair restraint to cover it. Surveyor asked RDD M about his beard restraint. RDD M stated, I am just dropping something off quickly. I am sorry about that. Surveyor informed RDD M that he was the 4th staff member to enter the kitchen, in the food preparation area, while food was being prepared without donning a hair restraint. Example 2 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy, titled Storage of Pots, Dishes, Flatware, and Utensils, revised 1/23, includes: air dry all food surfaces . Do not stack or store when wet . On 12/5/24 at 9:40 AM, Surveyor observed Dining Room Attendant Z placing wet residents' coffee mugs and water pitchers upside down on plastic trays. Dining Room Attendant Z then took the tray of mugs and cups and placed them upside down onto a metal shelving unit in the dining room. Surveyor asked Dining Room Attendant Z to turn some of the mugs and cups over for observation. Surveyor observed mugs and cups to have a white film build up inside them or have condensation in them due to the seal being created when the cups and mugs are turned upside down. Example 3 Facility policy, titled Food and Supply Storage, revised 1/24, includes: . Maintain designated area for items that are damaged such as dented cans . On 12/2/24 at 10:11 AM, during initial tour of the kitchen, Surveyor observed 5 dented cans in circulation including a tomato heavy puree, a Concord grape jelly, and 3 cans of evaporated milk. Example 4 Facility policy, titled Food and Supply Storage, revised 1/24, includes: . cover, label, and date unused or opened packages . On 12/2/24 at 10:11 AM, Surveyor observed an opened gallon of white 2 percent milk with no open date. Surveyor also observed a package of whole grain brown rice to be opened and undated and veggie patties to be opened, removed from original packaging and undated. DM L indicated the milk should have an open date, the rice should have an open date, and the veggie patties should have a label on them and a use by date. Example 5 Facility policy, titled Equipment Cleaning, revised 1/24, includes: Director assigns daily cleaning responsibilities in each position workflow . Mixers, choppers, slicers, and peelers are disassembled when cleaned . On 12/2/24 at 10:11 AM, during initial tour of the kitchen Surveyor and DM L (Dietary Manager) observed a stored large mixer to have food particles on the undercarriage and to be covered in plastic, a stored small mixer to have food particles on the blades and cover, and a microwave to have food particles of two colors speckled on the inside roof. DM L indicated the food should be covered in the microwave, but staff do not always do this. DM L indicated both mixers should have been cleaned after they were used and before they were stored. On 12/5/24 at 9:51 AM, RDD M and DM L indicated opened foods should be sealed and have a date on it of when it was opened or when it should be used by. DM L and RDD M indicated dirty equipment should be cleaned before storing and the microwave should be cleaned after use if a mess was made. RDD M and DM L indicated all staff should have hair nets on when entering the food preparation area. DM L and RDD M indicated staff should all cups and mugs to air dry before turning them upside down on a surface. DM L and RDD M indicated dented cans should be removed from stock. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/5/24 at 5:02 PM, NHA A (Nursing Home Administrator) indicated dented cans should be removed from the shelf, equipment should be cleaned before stored, dishware should be allowed to air dry completely, hairnets should be donned by all staff who enter the food preparation area, and opened food should be sealed and dated.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 50698 Based on interview and record review, the facility did not maintain a Quality Assessment and Assurance Committee consisting of at a minimum, the Director of Nursing Services, the Medical Director, or his/her designee, at least three other members of the facility's staff at least one of whom must be the administrator, owner, a board member, or other individual in a leadership role, and the Infection Preventionist, which met at least quarterly. This has the potential to affect all 90 residents residing within the facility. Quality Assurance and Performance Improvement (QAPI) meetings did not consist of the required attendees/members for the months of February and June, 2024. This is evidenced by: The facility QAPI plan, titled (Facility Name) QAPI Plan, undated, states in part: .(Facility Name) will establish a quality management committee that consists of the following members: Administrator/Executive Director, Director of Nursing/Director of Quality Improvement and Education, Medical Director of designee, Consulting Pharmacist, three general staff members representing disciplines directly involved in resident care . Of note, the plan does not list the Infection Preventionist as being a member of the committee. The facility policy, titled QAPI Policy and Procedure, dated 2/23/23, states, in part: . Policy Explanation and Guidelines: . 2. The QAA (Quality Assessment and Assurance) Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services ii. The Medical Director or his/her designee. iii. At least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member, or other Individual in a leadership role; and iv. The Infection Preventionist . On 12/5/24 at 9:10 AM, Surveyor reviewed the facility's QAA committee meeting sign in sheets and noted the following: The QAPI sign in sheet dated 2/19/24 (Quarter 1), did not include Director of Nursing (DON) or Infection Preventionist (IP). (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The QAPI sign in sheet dated 6/19/24 (Quarter 2), did not include the DON or IP. The QAPI sign in sheets dated 8/14/24 (Quarter 3) and 11/13/24 (Quarter 4), had all required members. On 12/5/24 at 5:53 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked who should be on the QA committee. NHA A stated, The members should be listed on the QAPI plan. NHA A told Surveyor who regularly attends the meetings and stated the following: DON, Executive Director, Maintenance, NHA, Medical Director, Pharmacist, unit managers, Activities. Of note, NHA A did not mention the Infection Preventionist. Surveyor showed NHA A the attendance from the two meetings where the DON and IP were not present. NHA A confirmed the sign in sheets would have been accurate for who was in attendance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview, and record review, the facility did not establish and maintain an Infection Control Program designed to provide a safe environment to help prevent the development and transmission of disease and infection (such as Legionella). This has the potential to affect all 90 residents who reside in the facility. The facility did not maintain a water management program to prevent the spread of Legionella. The facility did not ensure laundry services were being conducted according to current standards of practice to prevent the transmission of communicable diseases between residents. One resident was not added to the line list after showing signs and symptoms of an infection according to facility policy and procedure. This is evidenced by: Example 1: The facility policy titled, Infection Prevention and Control Program Policy, dated 2/13/23, states in part: . Water Management: a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program . The facility policy titled, Water Management Program Policy, undated, states in part: Policy Statement: It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens . in the facility's water systems based on nationally accepted standards . Procedure: 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing . 2. The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder. 3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The risk assessment will consider the following elements: A. Premise plumbing . b. Clinical equipment .c. At-risk population - The facility's entire population is at risk. High risk areas shall be identified through the risk assessment process. Supporting documentation of any areas or resident population that exhibit greater risk than the general population shall be kept in the water management program binder . 5. Based on the risk assessment control points will be identified. The list of identified points shall be kept in the water management program binder. 6. Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management action plan . 8. The water management team shall regularly verify the water management program is being implemented as designed . 9. The effectiveness of the water management program shall be evaluated no less than annually . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled, Legionella Surveillance Policy, undated, states in part: Policy Statement: It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections . Procedure: 1. Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems . 5. Primary prevention strategies: . c. Physical controls: i. Cooling towers and portable water systems shall be routinely maintained. ii. At-risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations. iii. Non-portable water systems shall be routinely cleaned and disinfected. iv. Nebulization devices shall be filled only with sterile fluid . d. Temperature controls: i. Cold water shall be stored and distributed below 68F (Fahrenheit). ii. Hot water shall be stored above 140F and circulated at a minimum return temperature of 124F . Surveyor requested to review the facility's water management program. Upon request, Surveyor was provided with the policies detailed above along with a document titled, Legionella Test Results Summary Log, dated 8/21/24. The test log indicates all 10 locations tested , that include three resident rooms, four resident showers, a laundry room, and two ice machines; all tests were negative for the presence of Legionella. On 12/5/24 at 9:13 AM, Surveyor interviewed MD N (Maintenance Director). Surveyor asked MD N if he had the actual water management program, including the binder detailed in the facility policy, flush logs, temperature logs, or any other components that are supposed to be included in the water management program. MD N stated the facility does not have a water management program, and the binder was thrown out by the previous Maintenance Director that is no longer employed by the facility. Surveyor asked MD N who is included in water management team meetings. MD N described an outside company that comes in to do testing, however, indicated that there is no active water management team within the facility. On 12/5/24 at 3:13 PM, Surveyor interviewed IP T (Infection Preventionist). Surveyor asked IP T if she participates in the facility's water management team. IP T indicated she works with MD N and an outside company to complete testing, however, did not indicate the facility conducts routine meetings to discuss water management and infection control risks. Example 2: The facility policy titled, Infection Prevention and Control Program Policy, dated 2/13/23, states in part: . Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. b. Clean linen shall be separated from soiled linen at all times. c. Clean linen shall be separated from soiled linen at all times. d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets . On 12/2/24 at 11:10 AM, Surveyor observed the laundry cart being transported uncovered by HK U (Housekeeping) in an elevator, then through the resident common area, and towards the 400 hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/2/24 at 11:55 PM, Surveyor conducted the laundry tour with HK U. Surveyor noted a single door entering the laundry room. Surveyor asked HK U if both dirty and clean clothes go through the same door. HK U indicates that they do. Surveyor asked HK U what personal protective equipment she utilizes when handling dirty laundry. HK U stated she only wears gloves because she does not have aprons or gowns available for her to use. Surveyor observed a single laundry room with a small storage area adjacent to the left of the laundry room. A clothes rack with clean clothes hanging and stacked on shelves is uncovered and located in between the washers and dryers, with only a few feet between the shelves and either appliance. Surveyor asked HK U if she covers clean laundry when she delivers it to the residents. HK U stated that in all the years she has been there she has never covered the clean laundry. On 12/2/24 at 12:04 PM, Surveyor observed HK U exit the laundry room, with clean laundry hanging from the back of a grocery cart, uncovered, and within close proximity to her work uniform. On 12/5/24 at 9:36 AM, Surveyor observed HK U delivering clean laundry to the 400 hallway in the same manner. The clothing was uncovered and hanging from an old grocery cart, in close proximity to her work uniform. On 12/5/24 at 3:13 PM, Surveyor advised IP T of her observations and asked what the expectation was for delivering laundry. IP T indicated it should be covered. Survey asked IP T if gowns or aprons were available for laundry staff to use while handling dirty linens. IP T indicated staff should have gowns available to use, and they should be using them. Example 3: R38 admitted to the facility on [DATE]. R38's Nurses Note, dated 11/15/2024, includes: Note Text: Resident noted with undigested emesis on clothes. VSS (Vital Signs Stable) low grade temp at 99.9 (F) assisted back into bed and cleaned up. Call to (Named) Hospice sent to report and for orders if any. (It is important to note R38 was not included on the facility's infection control line list even though he presented with a low grade temperature and an emesis.) On 12/5/24 at 3:13 PM, Surveyor interviewed IP T. IP T indicated staff did not make her aware of R38's symptoms to add to the line list, but any resident with symptoms should be included.