STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525642	A. Building B. Wing	05/01/2025

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Hope Health and Rehab	438 Ashford Ave Lomira, WI 53048

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not immediately notify and consult with a resident's physician when there was a significant change in condition. This occurred for 1 of 16 residents (R8) reviewed for notification of change in condition. R8 had blood sugars below ordered parameter of 70 without notification of physician. Evidenced by: The facility's Physician Notification policy, dated 4/12/17, states, in part: Purpose: To provide guidance to licensed nurse as to when and how to notify a physician/practitioner of changes in resident status.Procedure: .Take into consideration: immediate notification includes any symptom, sign, or apparent discomfort that is acute or sudden in onset, and a marked changed in relation to usual symptoms and signs . Surveyor requested a blood sugar parameter policy. No policy was provided. On 4/21/25 at 10:07 AM, Surveyor interviewed R8 during resident screening. R8 stated that R8 had recently been having low blood sugars in the morning; I think it was 48 this morning. R8 admitted to the facility on [DATE] and has diagnoses that include: type 2 diabetes mellitus (a disorder which affects the body's ability to produce enough insulin or to effectively use the insulin it produces which can raise blood sugar levels); long term (current) use of insulin (a medication administered to lower blood sugar levels). R8's progress notes show a Brief Interview for Mental Status (BIMS) evaluation, dated 3/12/25, with score of 11, indicating R8 has moderate cognitive impairment. R8's physician orders include: *Insulin Lispro Injection Solution 100 unit/ml (milliliters) Inject as per sliding scale: If 0-69=0 units Notify MD/NP; .subcutaneously (under the skin) with meals for type 2 diabetes. Start date 3/6/25 (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Blood glucose monitoring as needed for signs/symptoms of hypo/hyperglycemia (low or high blood sugar levels) Notify MD if less than 70 or greater than 450. Start date 3/6/25 R8's April 2025 Medication Administration Record (MAR) shows documentation of blood sugars below ordered parameter of 70 as follows: *4/10/25 8:00 AM blood sugar 62 *4/12/25 8:00 AM blood sugar 50 *4/13/25 8:00 AM blood sugar 67 *4/14/25 8:00 AM blood sugar 55 *4/15/25 8:00 AM blood sugar 49 *4/20/25 8:00 AM blood sugar 49 *4/21/25 8:00 AM blood sugar 48 R8's progress notes indicate the following: *4/10/25 9:06 AM .Provided resident with juice at 8:02 AM for a blood sugar of 47. His nurse was to follow up. Important to note: there is no progress note regarding 8:00 AM blood sugar level on 4/12/25 or 4/13/25. *4/14/25 9:05 AM .resident blood glucose this AM 55.Did call hospice as lower blood sugars are trending lately and may also need lantus adjustment. RN updated and will update doc . *4/15/25 8:02 AM .resident blood sugar this AM 49 .Hospice updated this AM, as they were yesterday. Triage nurse says she will pass on note. *4/20/25 and 4/21/25 indicate NP (Nurse Practitioner) update On 4/22/25 at 3:07 PM, Surveyor interviewed LPN J (Licensed Practical Nurse) and asked about diabetic protocols. LPN J stated blood sugars are checked, correct diet is given, monitor for high or low blood sugars, offer a snack at night, and complete foot checks daily. Surveyor asked about parameters for notification with blood sugars. LPN J stated need to report if below 70 or above 400. Surveyor asked if there is any difference in reporting if the resident is receiving hospice care. LPN J stated no, still need to notify the physician or NP and also notify hospice. On 4/22/25 at 3:58 PM, Surveyor interviewed DON B (Director of Nursing) and asked about parameters for notification of low blood sugars. DON B stated staff is expected to notify NP or physician if blood sugar is less than 70. Surveyor asked if an NP or physician was notified of each incidence of low blood sugar for R8 (4/10/25, 4/12/25, 4/13/25, 4/14/25, 4/15/25). DON B indicated that physician/NP was not updated and should have been.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50698 Based on observation, interview, and record review, the facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This affects 1 sampled resident (R6) and 5 supplemental residents (R5, R15, R17, R23, R25) reviewed for activities. R5, R6, R15, R17, R23, and R25, voiced concerns during Resident Council of the facility's activity program regarding evenings and weekends. Evidenced by: The facility does not have a policy for activity programming. Example 1 On 4/22/25 at 3:00 PM, Surveyor reviewed the activity calendars from December 2024 through March 2025. The facility activity calendar for December 2024 states, in part: Fridays: handwritten on provided calendar states AA (Activity Assistant name) 4-7pm with a line through all Fridays *It's important to note calendar does not specify what AA is doing during this time. Saturdays: no activities listed Sundays: no activities listed The facility activity calendar for January 2025 states, in part: Mondays, Wednesdays, Fridays 4:00PM 1:1 visits with AA (Activity Assistant name) Saturdays: no activities listed Sundays: no group activities listed 1/5/25: 1:1 visits with AA, cards 1:30pm 1/12/25:1:1 visits with AA, Bible readings, no time written 1/19/25: 1:1 visits with AA, cards, no time written 1/26/25: 1:1 visits with AA, Bible readings, no time written (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility activity calendar for February 2025 states, in part: Saturdays: no activities listed Sundays: no activities listed No evening activities for the month were listed Facility activity calendar for March 2025 states, in part: Saturdays: no activities listed Sundays: no activities listed 3/3/25: 4:00 1:1 visits with AA 3/5/25: 4:00 1:1 visits with AA 3/7/25: 4:00 1:1 visits with AA Example 2 R5 was admitted to the facility on [DATE]. The most recent Minimum Data Set (MDS) with target date of 2/1/25 indicates a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R5 is cognitively intact. On 4/22/25 at 10:00 AM, during the Resident Council Meeting with Surveyors, R5 indicated the facility does not offer activities on the evenings or weekends. R5 stated, It's dead around here on the weekends, makes our days long. R5's activity attendance shows no activity involvement on the following dates: 3/29/25 Saturday 4/5/25 Saturday 4/6/25 Sunday 4/12/25 Saturday 4/13/25 Sunday 4/19/25 Saturday 4/20/25 Sunday Example 3 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6 was admitted to the facility on [DATE]. The most recent MDS with target date of 4/2/25 indicates a BIMS score of 13 out of 15, indicating R6 is cognitively intact. On 4/22/25 at 10:00 AM, during the Resident Council Meeting with Surveyors, R6 indicated the facility does not offer activities on the evenings or weekends. R6's activity attendance shows no activity involvement on the following dates: 3/29/25 Saturday 4/5/25 Saturday 4/6/25 Sunday 4/12/25 Saturday 4/13/25 Sunday 4/19/25 Saturday 4/20/25 Sunday Example 4 R15 was admitted to the facility on [DATE]. The most recent MDS with a target date of 3/8/25 indicates a BIMS score of 13 out of 15, indicating R15 is cognitively intact. On 4/22/25 at 10:00 AM during the Resident Council Meeting with Surveyors, R15 indicated the facility does not offer activities on the evenings or weekends. R15's activity attendance shows no activity involvement on the following dates: 3/29/25 Saturday 4/5/25 Saturday 4/12/25 Saturday 4/13/25 Sunday 4/19/25 Saturday 4/20/25 Sunday Example 5 R17 was admitted to the facility on [DATE]. The most recent MDS with a target date of 1/24/25 indicates a BIMS score of 7 out of 15, indicating R17's cognition is severely impaired. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/25 at 10:00 AM during the Resident Council Meeting with Surveyors, R17 indicated the facility does not offer activities on the evenings or weekends. R17's activity attendance shows no activity involvement on the following dates: 3/29/25 Saturday 4/5/25 Saturday 4/12/25 Saturday 4/13/25 Sunday 4/19/25 Saturday 4/20/25 Sunday Example 6 R23 was admitted to the facility on [DATE]. The most recent MDS with a target date of 1/29/25 indicates a BIMS score of 6 out of 15, indicating R23's cognition is severely impaired. On 4/22/25 at 10:00 AM, during the Resident Council Meeting with Surveyors, R23 indicated the facility does not offer activities on the evenings or weekends. R23's activity attendance shows no activity involvement on the following dates: 3/29/25 Saturday 4/5/25 Saturday 4/12/25 Saturday 4/13/25 Sunday 4/19/25 Saturday 4/20/25 Sunday Example 7 R25 was admitted to the facility on [DATE]. The most recent MDS with a target date of 2/15/25 indicates a BIMS score of 15 out of 15, indicating R25 is cognitively intact. On 4/22/25 at 10:00 AM, during the Resident Council Meeting with Surveyors, R25 indicated the facility does not offer activities on the evenings or weekends. R25's activity attendance shows no activity involvement on the following dates: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/29/25 Saturday 4/5/25 Saturday 4/6/25 Sunday 4/12/25 Saturday 4/13/25 Sunday 4/19/25 Saturday 4/20/25 Sunday On 4/23/25 at 8:58 AM, Surveyor interviewed AD H (Activity Director) regarding activities on the weekends and evenings. AD H indicated there has not been much for activities on weekends or evenings, but she plans to try to get some music shows scheduled in the future again. AD H stated she has a part time aide that does some evening and Sunday activities. On 4/22/25 at 10:00 AM, Surveyors conducted a Resident Council Meeting. R5, R6, R15, R17, R23, and R25 voiced concerns with the lack of weekend and evening activities. Surveyor asked what residents would like to do for activities on Saturdays and Sundays. R5, R15, R17, R23, and R25, indicated they used to wake up Sunday mornings and attend a church service with their family; they would like to have a church service on Sunday at the facility. R5, R15, R17, R23, and R25, indicated they would like to have music programs on Saturdays. R5 suggested a community play on a Saturday. On 4/23/25 at 8:58 PM, AD H indicated on the weekends there are no activities on Saturdays, stated she doesn't work on weekends, and there are one or two activities scheduled on Sunday afternoon when her part time aide can come in; these are usually one on one activities, sometimes a group. AD H indicated the evening activities with the part time aide are usually one on one activities, occasionally a group. AD H indicated music programs should be starting up again when more performers come back from going to a warmer area for the winter. On 4/23/25 around 4:00 PM, during an interview ANHA F (Assistant Nursing Home Administrator) indicated activity staff should be offering activities for residents in the evenings and on the weekends if this is what they are asking for.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 of 3 residents identified in closed records review (R31). R31 presented with a change in condition (COC) on [DATE]. Facility staff did not document all R31's symptoms in R31's medical record and did not complete a thorough and ongoing RN (Registered Nurse) assessment related to the COC. R31's condition continued to decline. R31's vital signs warranted immediate MD (Medical Doctor) notification/consultation and the facility did not notify the MD. R31 continued to deteriorate and was sent to the hospital where R31 became pulseless and nonbreathing (PNB) and expired due to a critical potassium level. The facility's failure to provide care consistent with standards of practice for R31 by not documenting signs and symptoms of a change of condition in R31's medical record, not completing an RN assessment with a change of condition, not providing continued monitoring with a known change in condition, and not notifying the Physician of vital signs timely created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the immediate jeopardy on [DATE] at 12:30 PM. The immediate jeopardy was removed and corrected on [DATE] when the facility began to implement its action plan. Evidenced by: The facility's policy titled Change in Condition, undated, includes: What is considered a change in condition? The definition of a change in condition is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death . Facility staff should be able to promptly identify changes that may indicate a change in health status. Once identified staff should demonstrate effective actions to address a change in condition . an RN (Registered Nurse) who is informed of a change in condition . conduct an in-depth assessment, and then call the attending practitioner . Licensed nurses: Immediately upon notification of a change in condition, no matter how minor you feel the change may be, an in-depth evaluation must be performed on the resident. The evaluation should include a physical assessment of the resident with special focus on body systems associated with the change in condition, a full set of vital signs (including blood sugar for diabetics), a review of the resident's diagnoses list/past vitals/weights/ and medications, and a review of nurse notes for the last week to see if the change has already been noted and addressed. According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data . Interventions to Reduce Acute Care Transfers (INTERACT) standard of practice for notice of change, indicates immediate notification to the Physician if Systolic Blood pressure (BP) > 210 mmHg, < 90 mmHg; Diastolic BP >115 mmHg; Resting pulse > 130 bpm, < 55 bpm, or >110 bpm and patient has dyspnea or palpitations. American Medical Directors Association (AMDA) Acute Change of Condition (ACOC) in the long-term care setting guidelines indicate the following: an acute change of condition (ACOC) is a sudden, clinically important deviation from a patients baseline in physical, cognitive, behavioral or functional domains. Clinically important, means a deviation that, without intervention, may result in complications or death.Blood pressure, as soon as possible after admission, establish the patients usual blood pressure (BP) range. (Normal range is approximately 100 -140mmhg (millimeters of mercury) diastolic ,d+[DATE] mmHg. A change in BP is more often a symptom than a cause of an ACOC (acute change of condition) isolated BP elevations generally are not significant. Sustained elevation in systolic pressure should trigger further assessment. A BP change alone should not trigger a call to the practitioner without additional signs or symptoms (e.g., sustained elevation, new neurological symptoms.) . R31 admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, morbid obesity, polyneuropathy (nerve disorder that affects many nerves), hypotension (low blood pressure), Chronic Obstructive Pulmonary Disease (COPD; lung condition that causes breathing difficulty), and sleep apnea (sleep disorder where breathing stops). R31's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] indicates R31 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. R31's MDS also indicates R31 requires staff assistance to meet his needs in toileting, showering, dressing, transferring, going from lying to sitting or sitting to lying, and rolling side to side. R31's Comprehensive Care Plan, initiated [DATE], indicates R31 transfers with two staff assisting and with a Hoyer lift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R31's Medical Record includes the following: Nurse Note and Medication Administration Record (MAR), dated [DATE] at 2:43 AM, includes simethicone given for Gi upset. (It is important to note the facility did not perform a thorough RN assessment at this time, including an abdominal assessment such as listening for bowel sounds, palpating R31's abdomen, or collecting a full set of vitals.) R31's MAR for February 2025, includes: [DATE] at 4:46 AM Simethicone given . Nurse Note, dated [DATE] at 5:00 AM, includes: Approximately 3:00 AM resident stated, I just want to take a knife to my stomach to release the gas. This was after writer had given him simethicone due to resident request for feeling gassy. Will continue to monitor. Physician Communication Form, undated, includes: Nausea - no appetite. Severe pain. Possible appendicitis? Request - Please see R31. He is in severe pain on right side . Medical Doctor Signature - (blank) (It is important to note the facility did not perform an RN assessment at this time including palpating R31's abdomen, listening for bowel sounds, collecting a full set of vitals, or evaluating R31's pain level.) R31's MAR for February 2025 includes, [DATE] at 7:45 AM Calcium Carbonate given. Nurse Note, dated [DATE] at 9:50 AM, indicates R31 has improved but still symptomatic. (It is important to note this note does not specify what symptoms R31 was experiencing and no RN assessment is documented.) Lab Report, dated [DATE], includes: Metabolic Panel: collected- [DATE] at 11:48 AM, received- [DATE] at 12:53 PM, verified [DATE] at 1:22 PM . Potassium- 5.9 mEq/L . High (normal range reference- 3XXX, d+[DATE].9) . Carbon Dioxide- 21 mEq/L . low (normal range reference-,d+[DATE]) . BUN-39 mg/dL . High (normal range reference-,d+[DATE]) . Creatinine- 1.51 mg/dL .High (normal range reference- 0XXX, d+[DATE].27) . BUN/Creatinine Ratio- 26 High (normal range reference- ,d+[DATE]) . (Of note: Hyperkalemia (high potassium) signs and symptoms include abdominal pain, diarrhea, nausea, and vomiting.) Physician Communication Form, dated [DATE], includes: Time - (blank) . Situation- Potassium Chloride increase to 60 mEq in morning and 40 mEq in evening on [DATE]. Was on 40 mEq two times a day prior. Held Potassium Chloride on [DATE] evening and [DATE] morning per Medical Doctor. Rechecking BMP on [DATE] . Signed by Medical Doctor on [DATE]. Nurse Note, dated [DATE] at 1:45 PM, lab results showed high potassium, MD notified and gave orders to hold potassium supplement . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R31's MAR for February 2025 includes: [DATE] at 4:46 AM Simethicone was given. R31's MAR for February 2025 includes: [DATE] at 4:58 AM Oxycodone was given. EMS Report, dated [DATE], includes: unit notified at 5:29 AM, arrived at 6:23 AM . Narrative- Emergency Services (EMS) and First Responders paged to facility for male who was in and out of consciousness but breathing. When EMS arrived on scene charge nurse stated she believed she witnessed some seizure activity, his oxygen saturation was up and down and intermittent consciousness. They had placed him on oxygen mask at 2 liters per minute prior to EMS arrival. Patient found in bed pale and cool/diaphoretic 2 touch. Gazes straight ahead with eyes, pupils 5 to 6mm (millimeters). Does blink when hand is close to face, retracts to pain but otherwise nonverbal at this time. Nursing home staff stated that abdomen especially extended ever since beginning of shift. Due to weight, Hoyer machine used to place patient on stretcher. Once inside of ambulance vital signs obtained. During transport, oxygen saturation fluctuates up and down, those circulation appears to be poor, fingers and ears cold to touch. Patient does not answer questions, makes inaudible noises occasionally but does not communicate. Due to size of patient at one point in transport, writer had to free arm for vitals and unbuckle one strap to gain access to arm. Patient then partially on writers lab and if writer would have moved, potential for falling off stretcher. Breathing rates and pulses varied throughout transport. When writer called in report to hospital, all above observations were relayed to ER (emergency room) staff. ER staff questioned why vitals were so all over the place and writer stated she was unaware of why this was. When pulling into garage for ER/hospital, it was noted resident started to decline. Wheeled quickly into ER, and agonal breathing started. Once on hospital bed CPR was begun by staff . chief complaint - patient nonverbal. Nursing homes states in and out of consciousness, believe some seizure like activity . dispatched two nursing home for . male . complaining of altered mental status . [DATE] at 6:08 AM Blood pressure - ,d+[DATE] right arm . opens eyes to painful stimulation . inconsistently consolable, moaning . (It is important to note the facility provided no evidence they reported to EMS the symptoms that R31 was experiencing throughout the last 24 hours including high blood pressure readings, nausea, gas pain, extended and firm abdomen, tracheal congestion, or shortness of breath. It is also important to note the facility did not provide evidence of reporting R31's received lab results being positive for prominent loops of air filled bowel throughout abdomen and pelvis suggestive of ileus or constipation . distal large bowel obstruction cannot be excluded . and the EMS Report does not capture this information in R31's history or chief complaint.) emergency room Intake Note, dated [DATE], includes: date and time of service- [DATE] at 5:42 AM . Patient coming from facility. Staff called and stated that last night patient began having labored breathing. States she gave nebulizer and patient seemed to improve. States that as the night progressed he became more restless and short of breath. States oxygen saturations were in 70's. Staff gave another nebulizer and put patient on 2 liters of oxygen per minute via nasal canula. States started to become agitated and complaining of abdominal pain. Staff gave pain medication with no relief. Patient had abdomen ultrasound yesterday suggestive of an ileus. Staff stated patient abdomen is much more distended than normal. Patient is a hoyer lift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	emergency room Note, dated [DATE], includes: date and time of service- [DATE] at 6:22 AM . Patient is a . male with history of hypertension (high blood pressure), hyperlipidemia (high level of fats in the blood) , type 2 Diabetes Mellitus, chronic obstructive pulmonary disease, obstructive sleep apnea, . presenting EMS for hypoxia and found to be pulseless and nonbreathing . Patient comes from facility where staff report he began having labored breathing last night that seemed to improve with a nebulizer treatment. States he became more short of breath and restless throughout the night with oxygen saturations in the 70s. Staff then gave another nebulizer treatment and put him on 2 liters of oxygen. He subsequently became agitated and complained of abdominal pain that was not improved with pain medication (ultrasound was done suggestive of ileus yesterday), and EMS was called. Patient continued to decompensate en route per EMS and became unresponsive with fixed gaze. As patient was wheeled into our Emergency Department, I noted the patient to be apneic and he did not have a pulse. So I started CPR (Cardiopulmonary Resuscitation) and CODE HEART was called . I was the one who discovered the patient to be in cardiac arrest. I started chest compressions myself and called a CODE HEART. Patient was difficult to bag and due to not having enough staff present for safe intubation, I inserted a #5 IGEL and patient was bagged until respiratory therapist was available to assist while continuous chest compressions were ongoing. Patient was too large . and so continuous high quality CPR was carried out throughout the code. Patient did not have IV access, IV was very difficult to obtain and so I placed the left tibial IO (intraosseous (injecting Intravenous medications directly into the bone marrow)), original IO attempt on the right was unsuccessful. Patience rhythm was PEA ((pulseless electrical activity) a form of cardiac arrest where the heart shows electrical activity but does not provide a pulse) throughout the arrest. He was noted to be [NAME] cardiac wide complex PEA. Patient ended up receiving 3 A of sodium bicarbonate, 2 A calcium chloride and a gram of magnesium . in addition to 7 mg of epinephrine throughout the code. Utilization of bedside ultrasound showed cardiac contractility midway through the code and ROSC (return of spontaneous circulation, which is the return of a pulse and blood pressure) was achieved but patient subsequently [NAME] cardiac down and had subsequent cardiac arrest shortly thereafter prompting repeat CPR and more rounds of epinephrine. We attempted pacing with some capture for a brief period however patients cardiac contractility was not sufficient enough to sustain life as so pacing was stopped and CPR was continued. VBG (Venous blood gas) noted potassium of 7.1 with very low pH . unclear whether this was a hemolyzed sample or not but given the [NAME] cardiac PEA with wide complex, my suspicion was true hyperkalemia and we treated with multiple amps of bicarbonate/calcium and magnesium . Labs were obtained showing hyperkalemia and very high white blood cell count. Given recent history of ileus, this may be severe dehydration leading to AKI (acute kidney injury) with hyperkalemia and/or sepsis however despite resuscitation, patient was without a pulse a prolonged period of time in our ED. It was deemed medically futile to attempt continued resuscitation and therefore the patient was pronounced deceased at 7:06 AM. He did not have a pulse, was not breathing. His final rhythm was bradycardiac PEA rate of 22 (agonal) . Timestamps: 6:26 AM manual compressions began . 6:27 AM code heart called overhead . 6:31 AM 1 mg epi given . 6:31 AM pause, pulse check-PEA on monitor, compressions resumed . 6:34 AM 1 mg epi given . 6:35 AM intubated . 6:36 AM pause, pulse check- PEA on monitor, compressions resumed . 6:37 AM sodium bicarb given . 6:38 AM 1 mg epi given . 6:41 AM 1 mg epi given . 6:42 AM pause, pulse check- PEA on monitor, compressions resume . 6:44 AM 1 mg epi given . 6:46 AM pause, pulse check via bedside ultrasound- ROSC obtained . 6:49 AM sodium bicarb given . 6:50 AM 1 g calcium chloride given . 6:52 AM 1 mg epi given . 6:55 AM pause, pulse check via bedside ultrasound- cardiac activity, bradycardiac, compressions resumed . 6:56 AM 1 g calcium chloride given . 6:57 AM sodium bicarb given . 6:58 AM pause, pulse check- bradycardiac agonal, compressions resumed . 7:00 AM 1 g magnesium sulfate given . 7:01 AM 1 mg epi given . 7:02 AM pause, pulse check- agonal PEA wide complex. Compressions resumed . 7:05 AM pause, pulse check- final rhythm: bradycardia PEA, agonal wide complex . 7:06 AM time of death . Diagnoses: Cardiac arrest, hyperkalemia . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse Note, dated [DATE] at 6:48 AM, includes: Resident was banging his hands on the wall at about 4:00 AM and was calling out Help multiple times. When writer and CNAs (Certified Nursing Assistants) arrived at his room he continued to call out for help and was incoherent. He took off his CPAP and could only answer to his name. Resident's abdomen was distended and tender on palpation and he complained of pain in his shoulders and neck. Simethicone and oxycodone was administered. Oxygen saturation dropped to 71%, 2 Liters oxygen was applied via nasal canula. 911 was then called and DON (Director of Nursing) notified. Oxygen saturation rose to 88% after oxygen was administered. EMS (Emergency Services) left with resident at 6:10 AM . Facility Timeline indicated in their action plan, dated [DATE], includes: On [DATE] at 11:00 AM CNA (Certified Nursing Assistant) attended to R31 to give him a bed bath. CNA noted that resident exclaimed in pain when she attempted to wash resident's lower right stomach area. Due to this pain, CNA opted not to wash resident's back until nurse was available for skin check so as to only roll resident once in bed. At this interaction R31 also refused lunch due to stomach pain. CNA noted this to be unusual for R31 and reported both pain and lunch refusal to nurse. (It is important to note R31's Medical Record did not contain this information. This information was collected after R31 passed (on [DATE]) while the QAPI team investigated and started a plan of correction related to R31's care.) Nurse Note, dated [DATE] at 9:15 AM, includes: Late entry for [DATE] . Writer notified of resident's complaints of abdominal pain/nausea and refusal of breakfast and lunch. Writer in to assess resident at 1:00 PM . resident verbalized generalized discomfort in abdomen. Writer auscultated bowel sounds and bowel sounds were noted to be hypoactive in all quadrants . Resident reported pain with palpation of right upper quadrant where old scar tissue is, as well as acute pain with palpation in left lower quadrant. Abdomen distended and more firm than usual for resident. Doctor updated and order for abdominal X-rays obtained. Writer also received resident's BMP (Basic metabolic panel) results at that time, and potassium was noted to be elevated at 5.9, and kidney function markedly decreased from previous labs. Doctor updated on lab results and orders received to hold potassium on [DATE] PM (med pass) and [DATE] PM (med pass), recheck BMP on [DATE], and that doctor would be in to see resident on the morning of [DATE]. Resident updated with plan and in agreement. [company name] in and X-ray completed. Results were received later in the day and showed constipation or ileus, or large bowel obstruction. Resident had change in condition overnight including restlessness vital signs all over the place . and requesting resident transfer to hospital. Writer was in agreement and resident was transferred out [DATE] early morning. Writer received notice shortly after that resident had coated and expired in the hospital. Administrator and doctor made aware. (It is important to note R31's medical record did not contain this RN assessment ([DATE] at 1:00 PM) until after his passing when a late entry was added.) Nurse Note, dated [DATE] at 9:21 AM, includes: resident was not feeling well, had bloated abdomen, pain, and nausea. Resident refused breakfast and lunch. Abdominal x-ray series ordered and performed. Resident slept on and off most of the day . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:24 PM during interview with Surveyor, ADON P (Assistant Director of Nursing) indicated a full set of vitals includes a temperature reading, pulse reading, oxygen level reading, blood pressure reading, blood sugar reading if resident is diabetic, and respiration reading. ADON P indicated an abdominal assessment should include palpating for pain and firmness, listening for bowel sounds, and a full set of vitals. ADON P indicated if a resident reports pain, the nurse should ask location of pain and intensity using the pain scale 0 to 10. ADON P indicated it is important to document findings in resident's medical record. On [DATE] at 5:17 PM during interview with Surveyor, DON B (Director of Nursing) indicated when R31 reported abdominal pain she expected the nurse to gather information about this including where the pain was located, what the intensity of the pain was, and DON B indicated she expects the nurse to record her findings in R31's medical record. DON B indicated a thorough abdominal assessment would include palpating for pain, listening to the four quadrants for bowel sounds, a full set of vitals, and a blood sugar check. DON B indicated a pain assessment would include gathering information related to where the pain is located and a pain rating. DON B indicated when R31 stated he just wanted to take a knife to his stomach to release the gas, she expected the nurse to perform an abdominal assessment and a pain assessment but this did not occur. DON B indicated the nurse that was working was let go and is no longer employed by the facility. DON B indicated she performed an RN assessment on [DATE] at 1:00 PM, but the nurse on the floor never documented this in R31's medical record and should have. DON B indicated all signs and symptoms of a change in condition should be captured in a resident's medical record, including missed or refused medications, missed or refused meals, nausea, seizure activity, firmness in abdomen, bloating, pain, abdominal distension, abnormal lab values, shortness of breath, congestion, and more. DON B indicated a blood pressure reading of ,d+[DATE] or ,d+[DATE] would be alarming and she would expect the nurse to recheck the blood pressure and if it has not changed, notify the MD. DON B indicated upon notice of R31's death the facility called together an emergency QAPI (Quality Assurance Performance Improvement) meeting where they identified deficient practice and began to put together a plan of correction. On [DATE] at 11:37 AM during interview with Surveyor, RN Q indicated she was the nurse on the floor when R31 said I just want to take a knife to my stomach to release the gas. RN Q stated she gave R31 another one of his simethicone for gas and bloating. RN Q stated, I noticed he was bloated. It was not hard. Could tell he was uncomfortable and this was not his normal. I palpated and felt he was distended and gassy, but not hard. RN Q indicated she did not remember if she took R31's vitals at this time. RN Q indicated she did notify R31's MD about a hard mass that was found on [DATE] and she did not think to notify his MD about his abdominal pain as she assumed it was all related. When asked, RN Q stated, I did not perform a full RN assessment. I received education on change in condition since this incident. I should have done an assessment and called MD N. On [DATE] at 12:23 PM during interview with Surveyor, LPN R (Licensed Practical Nurse) indicated she no longer works for the facility and she does not remember this resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:36 PM during interview with Surveyor, MD N (Medical Doctor/Medical Director) indicated the facility identified some concerns when they performed a look back at R31's last 48 hours, including the nurse on the floor did not perform thorough assessments until DON B performed one on [DATE], but even then it was not recorded in R31's medical record. MD N indicated the facility did not perform ongoing close monitoring as she would have expected. MD N indicated the facility did not notify her of R31's change in condition every time he developed new symptoms. MD N indicated if the facility had notified her sooner, R31 may have been sent out to the emergency room sooner, but she did not believe the outcome would have changed. MD N indicates she expects the facility to document signs and symptoms of a change in condition in R31's medical record, including missed/refused meals, missed or refused medications, pain, abdominal bloating, nausea, abdominal distention, firmness of the abdomen, seizure activity, and more. MD N indicated a full set of vitals includes a temperature. MD N indicated the facility realized they were out of compliance and began to make a plan of correction immediately. MD N indicated if a resident states he wants to take a knife to his stomach to release the gas, her expectation is the staff would perform a pain assessment to gather pain level/location/intensity and an abdominal assessment that includes palpating for pain/tenderness/firmness, listening for bowel sounds, a full set of vitals. On [DATE] at 1:07 PM during interview with Surveyor, NP O (Nurse Practitioner) indicated the week of [DATE] she was out of work status and did not take any calls regarding R31. NP O indicated when a resident presents reporting pain in the abdomen it is her expectation that the facility will perform an RN assessment, including a full set of vitals, bowel sounds, palpating the abdomen for distention and/or firmness. NP O also indicated the facility should call her or the MD with the gathered information. NP O indicated a blood pressure of ,d+[DATE] and ,d+[DATE] could be critical especially associated with other symptoms. NP O indicated it is her expectations that staff would document all signs and symptoms of a change in condition in the resident's medical record, including missed/refused medications, missed or refused meals, nausea, pain, seizure activity, mental status changes, distention, bloating, and more. NP O indicated R31 could have been sent out to the emergency room sooner and maybe the outcome could have changed, but maybe it wouldn't have because NP O stated R31 was a very unwell man. The facility's failure to assess R31 when he was experiencing a significant change in condition and failure to take appropriate action in response to the change in condition, such as documenting signs and symptoms, consulting with a physician, and providing continued monitoring created a reasonable likelihood that serious harm or death could occur and led to a finding of immediate jeopardy. The Immediate Jeopardy was removed and corrected on [DATE] when the facility completed the following: - LPN R's employment was terminated. - Vitals were taken on all residents to ensure no change in condition/need for additional assessment - Educational in-services on change in condition were provided for all clinical staff to be completed by the end of their shift for those present and prior to starting next shift for those not present - Interviewed all residents and [NAME] of Attorney regarding comfort with cares, facility responsiveness to clinical needs to ensure the facility continues to meet the resident needs to their satisfaction (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- DON B performed 72 hour chart review for all residents to ensure all changes in condition noted were accompanied by follow-up assessments and proper notification. - DON B organized a skills fair for nursing to ensure competence in assessments, evaluations, nursing skills, and clinical judgement - Management team revamped morning meeting process with additional audits and accountability on 24 hour board - Continue audits/education on Stop and Watch program for entire staff. DON B will continue to provide weekly scenarios [TRUNCATED]

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure that residents are provided foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) for 1 of 3 residents (R8) reviewed for diabetic foot checks. R8 was not provided routine diabetic foot checks. Evidenced by: The facility did not provide a policy for diabetic foot checks. R8 admitted to the facility on [DATE] and has diagnoses that include: acute osteomyelitis, left ankle and foot (infection in the bone); type 2 diabetes mellitus (a disorder which affects the body's ability to produce enough insulin or to effectively use the insulin it produces which can raise blood sugar levels); peripheral vascular disease (a condition where blood flow to the extremities, primarily legs and feet, is restricted due to narrowed or blocked blood vessels, which can lead to slowed healing of wounds). R8's progress notes show a Brief Interview for Mental Status (BIMS) evaluation, dated 3/12/25, with score of 11, indicating R8 has moderate cognitive impairment. R8's Minimum Data Set (MDS) dated [DATE], Section GG indicates R8's lower extremity is Impaired on one side. R8 is dependent for toileting hygiene, transfers, lower body dressing and putting on/taking off footwear. R8's physician orders include: Diabetic foot checks one time a day. Start date 4/22/25. *Important to note that foot checks are not on the physician orders prior to 4/22/25 and R8 was admitted on [DATE]. R8's Care Plan states, in part: Focus-the resident has type 2 diabetes mellitus and uses insulin .Interventions .Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Date initiated 4/21/25. *Important to note that inspection of feet is not on the care plan prior to 4/21/25. On 4/22/25 at 3:07 PM, Surveyor interviewed LPN J (Licensed Practical Nurse) and asked about protocols for diabetic residents. LPN J indicated to complete nightly foot checks. Surveyor asked if nightly foot checks are documented. LPN J stated yes, by the nurse in the TAR (treatment administration record). Surveyor asked if foot checks are not listed on the TAR, would they be done. LPN J indicated LPN J cannot say for sure. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 3:58 PM, Surveyor interviewed DON B (Director of Nursing) and asked if diabetic residents receive nightly foot checks. DON B stated yes, they are documented on the TAR. Surveyor asked if R8 had foot checks nightly. DON B checked the TAR and stated that foot checks were not on R8's TAR. Surveyor asked if foot checks were completed if they are not documented. DON B stated no. Surveyor asked if R8 should have foot checks completed nightly. DON B stated yes.

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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** 39849 Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision to prevent accidents for 1 of 1 residents (R334) reviewed. R334 was observed smoking in the street, not disposing of cigarette materials properly, and not returning materials to staff after returning from smoking. Evidenced by: The facility policy, Smoking Policy, effective date 11/27/2024, included, in part: Policy: It is the policy .to not allow smoking, including e-cigarettes, vapes, cigars etc. on .property. Procedure: *No residents are permitted to smoke in the facility or on the facility property, including the facility side walk [sic], courtyard or other green spaces, driveway, parking lot, or entrances to the parking lot. *Staff will not assist residents to smoke, but will review resident safety to determine whether resident is competent to smoke independently. Residents who wish to smoke will need to be assisted by a family member, resident representative, or other loved one if deemed unable to safely smoke independently. Activated residents are not allowed to go outside alone to smoke, due to risk of moving vehicles . *Cigarettes and other smoking products will not be permitted in resident rooms and will not be kept by staff in medication carts for the resident. If a resident is discovered with smoking products they will be held by staff until a family member, resident representative, or other loved one can take them off .property. If this is not possible, the smoking products will be held by the facility if the resident is anticipated to discharge within 30 days . *When a resident wishes to go off the premise [sic] to smoke, the resident must sign out of the building . *Residents and family are required to sign out and leave the premise [sic] if they wish to smoke. There will be no smoking in the parking lot, facility side walk [sic], courtyard or other green spaces, driveway, entrances to the parking lot, or in the road. Residents and families must find a safe location to smoke that is not on the facility premise [sic] and is not in the way of traffic. R334 was admitted to the facility on [DATE] with diagnoses that include, in part: Sepsis (a life-threatening medical emergency caused by the body's extreme response to an infection); Acute embolism and thrombosis of unspecified deep veins of left lower extremity (blood clots); Other specified forms of tremor; Alcohol dependence with withdrawal . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R334's most recent Minimum Data Set (MDS), target date 4/22/25, indicates a Brief Interview of Mental Status (BIMS) of 10. Indicating that R334's cognition is moderately impaired. R334's Smoking Safety Evaluation in the Electronic Health Record (EHR) with an effective Date of 4/18/25, indicates, in part: Score: N/A Evaluation: Poor Vision or blindness and Balance problems while sitting or standing are marked Yes. All other areas are marked No. Concerns: 10. Unable to light a cigarette safely; 11. Unable to hold a cigarette safely; 12. Unable to extinguish a cigarette safely; 13. Unable to use ashtray to extinguish a cigarette. All Questions listed are marked as No. The form is signed by SW C (Social Worker). On 4/22/25 at 12:55 PM, surveyors observed R334 going outside the building. R334 was in his wheelchair, was wearing gripper socks, and proceeded down the exterior sidewalk incline (the one without rails) stopped at the bottom by the road as a [UPS] truck was coming from R334's left. R334 waited for the [UPS] truck to go by and began to cross the street. R334 was part way into street when he stopped due to pick-up truck coming from the right. R334 waited for the pick-up truck to pass and then proceeded across the street. R334 stopped in the street near the curb and turned his wheelchair around and stayed in the street to smoke. R334 was approximately 3 feet from the curb on the opposite side of the street from the facility. R334 indicated he didn't feel he was in the street as the area he was in is where cars would be parked. (Of note, there are signs that indicate no parking on this part of the side of the street.) When R334 completed his first cigarette he used his fingers to put the cigarette out and then pull off the end of the cigarette butt, dropped it on the ground, and then put the remaining portion of the cigarette butt into his jacket pocket. R334 indicated this his normal process and stated, believe me there are no burns. R334 pulled out another cigarette from pack and lit it and started smoking it. R334 was observed to flick ashes on the ground and disposed of the cigarette in the same manner as his first and put the remaining portion of the cigarette butt from the second cigarette in his pocket as well. During the observation between 1:08 PM and 1:13 PM, three vehicles were observed on the road in the opposite lane of traffic from where R334 was sitting in his wheelchair. During the observation, R334 indicated that he takes his cigarette butts back in the facility with him and flushes them down the toilet. R334 indicated the facility did not give him guidance on what to do and just told him to go across the street. R334 did indicate the first several times he came out to smoke staff came with him and he smoked in this spot then as well. Surveyor asked R334 if he gives his lighter to nurse when he gets back in the facility. R334 indicated he does return it sometimes but that there is never anyone there for me to give it to and that he is not going to wait an hour. R334 also indicated he takes as many cigarettes as he wants from the nurse and doesn't always return the ones he has left. Surveyor asked R334 if that means he has cigarettes and a lighter in his room and R334 indicated, yes. When R334 was finished he wheeled himself back across the street and back into the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 1:21 PM, CNA D (Certified Nursing Assistant) was at the nurse's station when R334 was coming back into the building from smoking. CNA D spoke to R334 about his lunch. R334 did not offer to give CNA D his smoking materials nor ask CNA D where the nurse was to return them to. R334 then wheeled himself back to his room without returning cigarette materials to a staff member. On 4/22/25 at 2:08 PM, Surveyor interviewed CNA D and asked what her role is as a CNA if she is caring for a resident that smokes. CNA D indicated the cigarettes are kept in the cart and if they are able to be independent, they can get the cigarettes from the nurse and go out. Surveyor asked CNA D if residents can return their smoking materials to a CNA if the nurse is not available. CNA D indicated yes. Surveyor asked CNA D if she has been given any training to ask a resident who have come back in from smoking if they returned their supplies. CNA D indicated, no. On 4/22/25 at 1:25 PM, Surveyor interviewed SW C and informed SW C of surveyors observation of R334 putting the cigarette butts in his pocket. SW C went to R334's room and on return to her office indicated she did retrieve the cigarette butts. Surveyor proceeded to interview SW C who indicated that R334's smoking assessment was the first one she had ever completed. SW C indicated she had not received any training on performing a smoking assessment and that she felt the assessment in the facility electronic health record was pretty clear. SW C also indicated that she went out with R334 once and made the observation. Surveyor requested SW C to walk through the observation outside. SW C and surveyor went outside. SW C indicated that R334 went down the ramp (at that time he used the one with the rails) and went across the street. SW C indicated she informed him the options were to go across the street or to stay on this side of the street and go up the sidewalk past the facility driveway. SW C indicated R334 stated that it was too far to go to stay on the same side and go up the sidewalk. SW C indicated that R334 could not get up the lip of the sidewalk when he crossed the street and so stayed between the curb and the where the blacktop road starts on the small strip of cement. Surveyor showed SW C where R334 was observed smoking today and SW C indicated R334 would be considered in the street, and that this was not considered safe. Surveyor reviewed other parts of the observation and SW C indicated that it was not safe for R334 to put his cigarettes out with his hand. SW C indicated when she made her observation he put the cigarette out on the ground with his foot and was wearing shoes at that time. Surveyor asked SW C if it was safe for R334 to dispose of cigarettes in the street or if she was given guidance on this. SW C indicated no and that there was nothing in the facility electronic health record about that. Surveyor asked SW C if she informed the nurse that she had never performed a smoking assessment before. SW C indicated no and that she was just trying to help out the team. Surveyor asked SW C if she felt it was safe for R334 to put his cigarette butts in his pocket and SW C indicated, no. SW C indicated that R334 is supposed to give the lighter and cigarettes to the nurse when he comes back in. Surveyor asked SW C if she feels it is safe for R334 to have his lighter and cigarettes in his room. SW C indicated I do, knowing him, I'm not concerned, but that's our policy. Surveyor asked SW C if it would be concerning if R334 left his lighter and cigarettes laying out in the open and another resident came in and took them. SW C indicated, yes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 1:49 PM Surveyor interviewed RN E (Registered Nurse) who indicated she has not had to complete a smoking assessment. RN E indicated she knows residents have to be assessed to be able to safely get off the premises as they are not allowed to smoke on the premises. Surveyor asked RN E if she has been given any training on how to complete a smoking assessment or how to determine if someone is safe to smoke independently. RN E indicated she knows they have to be safe to hold the cigarette, light it themselves, get off premises, and that they like them to go across the street. Surveyor asked RN E if she has been given any guidance on how residents should dispose of their cigarette since they are going off premises and don't provide a receptacle. RN E indicated she would have to get back to surveyor regarding that. Surveyor asked RN E what the process is when R334 goes out to smoke. RN E indicated R334 has to come to the nurse to get his lighter and cigarettes from the med cart. RN E indicated R334 should give them back when he comes back in but that she didn't know if they got them back from him this last time because she was on break so she has to get them from him. Surveyor asked RN what R334 should do if she is on break and if he could give his materials to another staff member. RN E indicated R334 can give them to another staff member. Surveyor asked RN E if she knows how many times R334 has not returned his smoking supplies today. RN E indicated she didn't know. Surveyor asked RN E when R334 had just went out did he come to her and get his smoking materials. RN E indicated, no, he must have had them on him because I was on break when he came back. Surveyor asked RN E how often residents should be assessed to see if they are safe to smoke independently. RN E indicates she would have to get back to surveyor on that answer. Surveyor asked RN E if R334 had ever mentioned to her that he brought his cigarette butts back into the building. RN E indicated he did not mention anything and she has not seen anything like that. Surveyor asked RN E if she would assess someone to be safe to smoke independently if they were smoking in the street, putting cigarettes out with their hand, putting butts back into their pocket and bringing them back into the building, and not returning smoking materials after. RN E indicated these would not be considered safe. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 2:28 PM, Surveyor interviewed DON B (Director of Nursing) and asked what the process is when a resident is admitted who wants to smoke? DON B indicated if they are responsible for themselves and not activated, they have that right. If they have supplies, we ask that they keep them in our med cart for safety. When they want to go out to smoke, we observe them the first time for safety to see if they can use the equipment properly, use lighter safely, extinguish safely, ash safely, and educate that they have to go off grounds, either across the street or down the sidewalk past the driveway where the employees pull in to park. As long as they are safe, they are able to go out. They need to notify us they are going out and they usually do this because they get their supplies from the nurse. DON B indicated she believes the smoking assessments are completed quarterly and with a change in condition. DON B indicated that it was her understanding R334 was observed putting his cigarette out with his hand and that is not considered safe, so she asked staff to observe him when he goes out the next time to re-do the assessment. DON B indicated she was also made aware that R334 was not going completely up on the sidewalk and so they reeducated R334 that he needs to be up on the sidewalk and not in the street. Surveyor asked DON B who should be completing the smoking assessments. DON B indicated, really anybody can do it, generally it is usually the nurse, SW C is perfectly capable, ANHA F (Assistant Nursing Home Administrator) could even do it. Doesn't have to be a licensed person. Surveyor asked DON B if the person performing the assessment should be trained. DON B indicated that she doesn't know that there is really training that needs to be done to know if someone is safe lighting a cigarette and not burning themselves. Surveyor asked if someone should assess safety in getting up and down the sidewalk, across the street and up to the sidewalk. DON B indicated she would have to defer to therapy. Surveyor asked DON B if therapy is involved in the smoking assessment. DON B indicated not specifically the smoking assessment. Surveyor asked DON B where residents dispose of their cigarettes. DON B indicated they were just discussing putting a receptacle down by the end of the building by the driveway so it's accessible to people. Surveyor and DON B went outside to review observation that was completed with R334. DON B indicated it would not be considered safe where R334 was smoking in the street, putting cigarettes out with his hands, putting butts in his pocket and bringing them back into the facility, and not returning smoking supplies. DON B indicated at this time there is no receptacle provided by the facility for smokers to dispose of cigarettes in.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not provide a suitable, nourishing snack to residents who want to eat outside of scheduled meal service times for 1 of 1 resident (R8) reviewed for nightly snacks. R8 had blood sugars below ordered parameter of 70 and was not receiving a routine nightly snack. Evidenced by: The facility's Resident Diet policy, dated 1/14/25, states, in part: Purpose: To outline how the dietary department provides each member a nourishing, palatable, well-balanced diet that meets daily nutritional and special dietary needs.dining program for residents includes service of three meals per day , and a snack program. Snacks If not prohibited by the resident's diet, condition or physician order, bedtime snacks are offered routinely to all residents.Snacks will conform to the residents' therapeutic or texture modified diet. On 4/21/25 at 10:07 AM, Surveyor interviewed R8 during resident screening. R8 stated that R8 had recently been having low blood sugars in the morning; I think it was 48 this morning. R8 stated he was unsure if he was getting a snack at bedtime. R8 admitted to the facility on [DATE] and has diagnoses that include: type 2 diabetes mellitus (a disorder which affects the body's ability to produce enough insulin or to effectively use the insulin it produces which can raise blood sugar levels); long term (current) use of insulin (a medication administered to lower blood sugar levels). R8's progress notes show a Brief Interview for Mental Status (BIMS) evaluation, dated 3/12/25, with score of 11, indicating R8 has moderate cognitive impairment. R8's physician orders include: *Controlled carb diet (a diet plan which involves eating a consistent amount of carbohydrates at each meal and snack throughout the day to help stabilize blood sugar levels). Start date 3/6/25 *Insulin Glargine Solution (a long-acting insulin medication) 100 units/ml (milliliters) Inject 20 units subcutaneously (under the skin) every morning and at bedtime for diabetes. Start date 4/22/25 *Insulin Lispro Injection Solution 100 unit/ml Inject as per sliding scale: If 0-69=0 units Notify MD/NP; 70-149 units .subcutaneously with meals for type 2 diabetes. Start date 3/6/25 *Blood glucose monitoring as needed for signs/symptoms of hypo/hyperglycemia (low or high blood sugar levels) Notify MD if less than 70 or greater than 450. Start date 3/6/25 (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's April 2025 Medication Administration Record (MAR) shows documentation of blood sugars below ordered parameter of 70 as follows: *4/10/25 8:00 AM blood sugar 62 *4/12/25 8:00 AM blood sugar 50 *4/13/25 8:00 AM blood sugar 67 *4/14/25 8:00 AM blood sugar 55 *4/15/25 8:00 AM blood sugar 49 *4/20/25 8:00 AM blood sugar 49 *4/21/25 8:00 AM blood sugar 48 R8's Tasks-Nutrition Snacks shows documentation as follows for the question Did Resident take snack? *4/10/25 yes *4/18/25 yes *4/19/25 yes *4/20/25 no Important to note: in the 28 day look back for this documentation, there are no other days with documentation about a snack. On 4/22/25 at 1:23 PM, Surveyor interviewed RN E (Registered Nurse) and asked about protocols for diabetic residents. RN E stated verify orders, check blood sugars, administer insulin, monitor for low blood sugars, update provider, offer correct diet type, complete diabetic foot checks and give a nightly snack. RN E stated that snacks are documented by the CNA (Certified Nursing Assistant). On 4/22/25 at 2:58 PM, Surveyor interviewed CNA L and asked about CNA responsibilities for residents with diabetes. CNA L stated check blood sugars as directed by nurse, give diet soda rather than regular, check with the nurse prior to giving snacks, give a snack around 7:00 PM. Surveyor asked if snacks are documented. CNA L stated snacks are documented in the resident chart. On 4/22/25 at 3:58 PM, Surveyor interviewed DON B (Director of Nursing) and asked about diabetic protocols. DON B stated blood sugar checks and insulin per orders, update if blood sugars under 70 or over 400, nightly diabetic foot checks, controlled carb diet, encourage snacks that are low in sugar, offer bedtime snack that is substantial in protein for [sic] hold over of blood sugar level. Surveyor asked if R8 receives a bedtime snack nightly. DON B stated it should be offered, not sure if he accepts. Reviewed documentation of snacks. DON B confirmed there is no documentation of resident refusal of snack and stated that R8 should have a nightly snack.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50698 Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect 26 of 27 residents. Surveyor observed dust in the facility's stove hood, over open food being prepared for resident meals. Surveyor observed food to have been removed from the original packaging and not sealed or dated with an expiration date, an open date, or a use by date. Surveyor observed a box of potatoes on the floor in the dry food storage area. Evidenced by: Example 1 Facility's Cooks Weekly Cleaning Tasks sheet, undated, states in part: Sunday, Hood cleaning above stove, AM cook, take vent down run thru dishwasher. Clean all nozzles free of dust or dirt . On 4/21/25 around 9:30 AM, Surveyor and DM G (Dietary Manager) observed facility stove hood. Surveyor and DM G observed a layer of dust to be on the sprinkler pipes and the grease trap directly above the burners/food preparation area. DM G indicated there is potential for the dust to dislodge and fall into the open food and she would have staff wipe these down again. Example 2 Facility policy, entitled Food Receiving and Storage, undated, includes: all food will be dated upon stocking if taken out of its original packaging . If not in the original packaging, all food items must be labeled with the name of the contained food . On 4/21/25 around 9:20 AM, Surveyor and DM G observed an opened bag of vanilla wafers in the dry food storage area which was not labeled. This bag had been removed from the original manufacturer's box, was not sealed, and did not contain a use by or an opened date. DM G indicated she was not sure when these were opened, threw them away, and stated they should have been placed in an airtight container and labeled with an opened date or use by date. Example 3 Facility policy, entitled Food Receiving and Storage, undated, states in part: .Keep food off the floor .All food will be stored in areas protected from contamination by condensation, leakage, drainage, rodents or vermin . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/21/25 around 9:15 AM, during initial walk through of the facility's kitchen, Surveyor and DM G observed a box of potatoes sitting directly on the floor in the dry food storage area. DM G indicated the potatoes should not be on the floor, picked them up, and placed them on a crate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50228 Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 1 residents (R8) reviewed for infection control with personal cares. CNA K (Certified Nursing Assistant) had a breach in infection control when performing pericare (cleansing of the genital area). Evidenced by: The facility's Standard Precautions policy, dated 4/10/24, states, in part: Purpose: The objectives of this policy is to communicate the requirements and expectations regarding the use of standard precautions to prevent the transmission of infection throughout the facility. Standard: Standard precautions are a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. Standard precautions will be used when providing care to all residents, whether they appear infectious or symptomatic or not. Standard precautions apply at all times. The components of standard precautions include hand hygiene, use of PPE (Personal Protective Equipment), Hand Hygiene refers to cleaning your hands, either by washing with soap and water, or using alcohol-based hand rub. Hand hygiene will be performed: before and after contact with a resident; immediately after touching blood, body fluids, non-intact skin, mucous membranes, or contaminated items (even when gloves are worn during contact); immediately after removing gloves; . On 4/24/25 at 8:39 AM, Surveyor observed CNA K performing pericare for R8. CNA K had set up a wash basin at bedside that contained water and two wash clothes. CNA K took one wash cloth and performed frontal pericare for R8. CNA K placed the used wash cloth into the basin and took the second wash cloth to rinse the soap from the resident. CNA K placed the second wash cloth into the basin, grabbed a hand towel and dried the resident. Without removal of gloves and hand hygiene, CNA K opened the bedside cabinet drawer, removed a bottle of powder, closed the drawer, and applied powder to R8's groin. CNA K again opened the drawer and returned the powder to the drawer. Surveyor asked CNA K if a wash cloth is contaminated after performing pericare. CNA K stated yes. Surveyor asked if a contaminated wash cloth should be placed into a wash basin. CNA K stated no. Surveyor asked if gloves are contaminated after performing pericare. CNA K stated yes. Surveyor asked if the bedside cabinet drawer and powder should be touched with contaminated gloves. CNA K stated no. On 4/24/25 at 9:00 AM, Surveyor interviewed DON B and asked about infection control with pericare. DON B stated that the wash cloth is contaminated after performing frontal pericare and should not be placed into the basin. DON B stated that gloves should be removed and hand hygiene performed after pericare prior to touching other items.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized for 1 of 5 residents (R7) reviewed for immunizations. R7 was not offered the pneumococcal vaccination. Evidenced by: The facility's Pneumococcal Conjugate Immunization policy, dated 4/9/24, states, in part: It is the goal of facility to reduce morbidity and mortality related to pneumonia through various measures, including by educating all residents on pneumococcal conjugate vaccination and offering the opportunity for vaccination in accordance with current Centers for Disease Control and Prevention (CDC) recommendations and CMS regulatory requirements . All residents of the facility will be educated on current CDC recommendations for pneumococcal conjugate vaccination, upon admission and annually, and will be offered the opportunity to receive immunization if they are not currently up-to-date (as determined using the Pneumococcal Vaccine Timing for Adults guidelines from the CDC), unless otherwise contraindicated . The resident or their legal representative must give consent or declination for the pneumococcal conjugate vaccination, which will be documented in the resident's record . R7 admitted to the facility on [DATE]. R7 had pneumococcal vaccinations as follows: *Prevnar 13 on 4/29/16. *Pneumovax 23 on 5/1/17. Per Pneumo Recs Vax Advisor, the recommendation for R7's age group is to give 1 dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. There is no documentation that R7 was offered a dose of PCV20 or PCV21. On 4/23/25 at 2:40 PM, Surveyor interviewed IP I (Infection Preventionist) and DON B (Director of Nursing) and asked if R7 was up to date with pneumococcal vaccinations. DON B stated no. Surveyor asked if R7 had been offered a dose of PCV20 or PCV21. IP I and DON B stated no. DON B stated vaccination should have been offered based on guidance.