STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525654	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Lakeside	1016 Lakeshore Dr Rice Lake, WI 54868

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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** 47807 Based on interview and record review, the facility did not promptly notify and consult with a resident's physician when there was deterioration in a resident's clinical condition. R12 presented with symptoms of low blood pressure. R12's physician was not notified for all low blood pressure occurrences as was instructed by orders. This occurred for 1 of 4 residents (R12), reviewed for change in condition. Findings include: The facility policy, entitled Blood Pressure, Measuring revision date September 2010, states: 6. Hypotension is defined as blood pressure less than 100/60 mm/hg . 9. Hypotension should be reported to the physician. Staff should record several readings throughout the day, including before and after meals. R12 was admitted to the facility on [DATE] with diagnoses that included in part, cellulitis of right lower limb, morbid obesity, muscle weakness, (primary) hypertension, persistent atrial fibrillation, acute on chronic systolic (congestive) heart failure, type 2 diabetes mellitus with diabetic neuropathy, unspecified, atherosclerotic heart disease of native coronary artery without angina pectoris, localized edema. Record Review of R12's orders stated to: Monitor for any signs of bleeding. Monitor BP every shift, PLEASE COLLECT MANUAL BP. Update MD with any concerns. every shift for monitoring - low Hgb enter progress note each shift on resident's condition. Start Date of 08/01/24, discontinued on 09/17/24. On 09/18/24 at 10:15 AM, Surveyor analyzed R12's record for low blood pressure reading and found blood pressures below 100/60 mm/hg on the dates of: 09/12/24 at 7:34 AM, 09/11/24 at 7:55 AM, 09/10/24 at 7:36 AM, 09/09/24 at 8:11 AM, 09/07/24 at 8:02 AM, 09/07/24 at 7:28 AM, 09/07/24 at 3:27 AM, 09/06/24 at 2:48 AM, 09/05/24 at 6:29 AM, 09/04/24 at 2:45 PM, 09/04/24 at 7:50 AM, 09/03/24 at 10:27 AM, 09/03/24 at 7:27AM, 09/01/24 at 9:08 AM. There were 14 instances of low blood pressure monitoring. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 10:20 AM, Surveyor analyzed R12's records for physician notification after low blood pressures were recorded. The only recorded dates of physician notification were: 09/12/24 at 7:34 AM and 9/3/2024 at 8:09 AM. This indicated that 12 opportunities to contact physician were not taken. On 09/18/24 at 3:45 PM, Surveyor interviewed Director of Nursing (DON) B regarding where notification of physician documentation could be found and notifications expectations. Notifications should be located in the progress notes, and DON B would expect that staff be following the facility's policy on notification for blood pressures. On 09/19/24 at 8:35 AM, Surveyor interviewed Medical Doctor (MD) P and asked when MD P would expect staff to notify MD P when a resident's Blood Pressure (B/P) parameters fall below 100 systolic. MD P indicated that staff should follow protocols set in place. MD P indicated that MD P sets parameters for B/P for certain residents and whatever those set parameters are, that is what staff should follow for individual basis. MD P indicated overall if MD P did not set parameters, then MD P expects staff to continue to give the B/P medication and follow the facility protocol. MD P indicated the staff is expected to notify MD P right away with B/P irregularities.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure 1 (R1) of 13 residents was provided privacy during personal cares. *Surveyor observed staff leave the window drapes and privacy curtain open while providing cares to R1. *Surveyor observed R1's breasts exposed from hallway. Findings include: R1 was readmitted to the facility on [DATE] with diagnoses which included in part: Alzheimer's disease, atrial fibrillation, nonrheumatic mitral valve insufficiency, and atherosclerotic heart disease. R1's Minimum Data Set (MDS) assessment, dated 07/23/24, identified R1 scored 3 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was independent with eating, supervision for oral hygiene, partial assistance rolling from left to right in bed, and dependent on toileting, upper/lower body dressing, and personal hygiene. MDS dated [DATE] indicated significant change in status, and MDS was not completed to show R1's current physical functionality. Surveyor observed resident functionality as totally dependent on staff for all cares. Surveyor reviewed R1's care plan. Surveyor observed no updated care plan since 2021. On 09/17/24 at 7:55 AM, Surveyor observed R1's room door open. R1 was lying on bed in supine position. Surveyor observed R1's left breast exposed while R1 was lying in bed. Surveyor did not observe privacy curtain pulled and Surveyor could see R1's left breast from the hallway outside R1's room. On 09/17/24 at 8:40 AM, Surveyor interviewed Family Member (FM) R and asked how FM R would think R1 would feel that R1's left breast was exposed to the facility hallway. FM R indicated to Surveyor that FM R was very mad that R1's left breast was exposed for all the facility to see as the staff and visitors walk by R1's room. FM R indicated to Surveyor that R1 would not want R1's breast to be exposed. Surveyor observed FM R pull R1's gown up and cover left breast. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/24 at 9:16 AM, Surveyor observed Certified Nurse Assistant (CNA) I and CNA N enter R1's room. CNA I and CNA N took covers off R1. Surveyor observed blinds to window wide open when CNA I and CNA N started undressing R1. CNA I and CNA N took R1's gown off exposing R1's breasts. CNA I and CNA N then took R1's brief off exposing R1's genital area. Surveyor did not observe CNA I and CNA N cover R1's top half while R1's breasts were being exposed during peri cares. CNA I assisted CNA N with rolling R1 back and forth fully exposed. CNA I rolled R1 back to the right side facing the window and Surveyor observed another staff member knock and open R1's door wide open, exposing R1's naked bottom to the hallway. Surveyor did not observe CNA I and CNA N try to cover R1 from being exposed or pull the privacy curtain to prevent exposure. On 09/17/24 at 1:07 PM, Surveyor observed R1's gown pulled down below R1's chest exposing R1's left breast and nipple to the hallway. On 09/17/24 at 1:20 PM, Surveyor brought Licensed Practical Nurse (LPN) D into R1's room to discuss R1's left heel. Upon entering R1's room, LPN D noticed R1's left breast exposed. LPN D pulled R1's gown up and covered R1's left breast. LPN D indicated out loud that R1's left breast exposed was not appropriate and staff should have the privacy curtain pulled a little way to provide privacy for R1. On 09/17/24 at 3:17 PM, Surveyor observed from the hallway R1 uncovered with left breast and nipple exposed with door wide open. Surveyor did not observe privacy curtain pulled for privacy. On 09/18/24 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked about privacy measures when providing cares for R1. DON B indicated that for all residents expectation for privacy would be to shut window blinds and pull privacy curtain during cares.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, record review and interviews, the facility did not ensure that 1 of 7 sampled residents (R) who are unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene. (R1) Findings include: R1 was readmitted to the facility on [DATE] with diagnoses which included in part: Alzheimer's disease, atrial fibrillation, nonrheumatic mitral valve insufficiency, and atherosclerotic heart disease. R1's Minimum Data Set (MDS) assessment, dated 07/23/24, identified R1 scored 3 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was independent with eating, supervision for oral hygiene, partial assistance rolling from left to right in bed, and dependent on toileting, upper/lower body dressing, and personal hygiene. MDS dated [DATE] indicated significant change in status, and MDS was not completed to show R1's current physical funcationality. Surveyor observed resident functionality as totally dependent on staff for all cares. Surveyor reviewed R1's care plan. Surveyor observed no updated care plan since 2021. On 09/16/24 at 10:33 AM, Surveyor observed R1 lying in bed supine. Surveyor observed R1's hair disheveled and dried substance down R1's face. Surveyor could smell heavy urine within R1's room. Surveyor observed R1's catheter bag lying on the floor. On 09/16/24 at 12:20 PM, Surveyor observed R1 in same position lying supine, sleeping in bed. Surveyor observed R1's hair disheveled and dried substance down R1's face. Surveyor could smell heavy urine within R1's room. Surveyor observed R1's catheter bag lying on the floor. On 09/16/24 at 12:29 PM, Surveyor observed Licensed Practical Nurse (LPN) C enter R1's room and applied nebulizer mask. Surveyor did not observe LPN C provide any other cares. On 09/16/24 at 12:41 PM, Surveyor observed LPN C and Certified Nurse Assistant (CNA) I reposition R1. Surveyor did not observe LPN C and CNA I perform any other cares for R1. On 09/17/24 at 7:32 AM, Surveyor observed R1 lying in bed supine. Surveyor observed the fitted sheet to be bunched up to R1's bottom/back and not under R1's lower extremities. Surveyor could smell heavy urine within R1's room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/24 at 8:40 AM, Surveyor interviewed Family Member (FM) R and asked FM R about R1's condition when FM R comes to visit R1. FM R indicated that every time FM R comes into visit that R1 looks like R1 does right now which is a mess. FM R indicated that R1 is always lying in bed with no clothes on. R1 is always in a hospital gown and not R1's regular clothes. R1 has sheets underneath R1 that are always bunched up and creases that R1 must lie on. R1 always has a urine smell to R1, and this upsets FM R. On 09/17/24 at 9:12 AM, Surveyor observed FM R upset and request CNA I and CNA N come in and reposition and provide cares to R1. On 09/17/24 at 9:16 AM, Surveyor observed CNA I and CNA N enter R1's room. CNA I and CNA N took R1's gown off and CNA N applied powder under R1's breasts. Surveyor did not observe CNA I and CNA N provide facial care, oral care, or under arm hygiene. CNA I and CNA N then took R1's brief off and started wiping R1's genital area. Surveyor observed fitted sheet soaked through with dark brown liquid and a dry circle around the whole wet spot on bed. CNA I assisted CNA N with rolling R1 back and forth and CNA N untucked the contaminated soiled fitted sheet and threw contaminated linens on the floor. CNA I and CNA N placed a new fitted sheet underneath R1 and rolled R1 back and forth to tuck new fitted sheet. CNA I and CNA N placed clean brief under R1 and repositioned R1 up into bed. Surveyor did not observe any other cares being performed for R1. On 09/17/24 at 2:00 PM, Surveyor observed CNA N enter R1's room to empty catheter bag. Surveyor did not observe any other cares performed for R1. On 09/17/24 at 2:05 PM, Surveyor interviewed CNA N and asked expectation for providing personal hygiene cares such as oral care for R1. CNA N indicated that R1 should be offered a mouth swab to moisten lips. Surveyor asked if CNA N performed this today and CNA N indicated no CNA N did not offer this today. On 09/18/24 at 7:45 AM, Surveyor observed R1 lying in bed supine with podus boots up to knees, hair messy with hospital gown on. Surveyor could smell heavy urine within R1's room. On 09/18/24 at 9:00 AM, Surveyor observed FM R in room with R1 visiting. Surveyor observed podus boots to be up to knees and R1 still lying supine in bed. Surveyor could smell heavy urine within R1's room. On 09/18/24 at 12:35 PM, Surveyor observed FM R in room with R1 visiting. Surveyor observed R1 still lying supine in bed. Surveyor interviewed FM R and asked if staff have been in to provide cares or reposition R1. FM R indicated that R1 has not had cares performed or been repositioned, but FM R requested to staff that staff assist in hygiene cares and repositioning for R1. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 1:30 PM, Surveyor interviewed CNA U who was on R1's hall. CNA U indicated that CNA U and the other CNA have not been in R1's room since earlier this morning around 7:30 AM. CNA U did not reposition or provide cares since this morning. CNA U asked Surveyor isn't R1's family in R1's room. Surveyor asked CNA U does that mean that family provides cares. CNA U indicated well sometimes they help but that CNA U should have probably been in R1's room earlier to reposition and at least provide oral care by offering mouth swabs to keep lips moistened. Surveyor asked CNA U if R1's catheter is leaking or when they changed R1 did they observe the sheets to be wet as Surveyor could smell a heavy odor of urine. CNA U indicated yes in fact R1 was an entire bed change, but that CNA U didn't know to think the catheter may be kinked or not working. On 09/18/24 at 1:44 PM, Surveyor observed family reposition R1 onto left side and placed podus boots on R1's feet to off-load R1's heels and provide grooming and oral cares. Surveyor interviewed FM R and asked if staff came in to reposition R1 earlier and FM R stated, No, my daughter and I had to reposition mom and provide oral cares just now. FM R indicated that FM R brushed R1's hair and got R1 comfortable. On 09/18/24 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked about R1's personal cares and expectation that staff assist R1 with cares. DON B indicated that staff are supposed to offer mouth swabs frequently and provide all personal cares to R1 as R1 is totally dependent on staff.

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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 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** 48793 Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice (N6 Wisconsin Nurse Practice Act), the comprehensive person-centered care plan, and the resident's choice for 1 of 13 sampled residents (R1). R1 had a change in condition; staff did not complete comprehensive neurological assessments or have a Registered Nurse assess R1 as the change of condition continued. R1 was sent to the emergency room several hours later and had suffered a stroke, and as a result was put on hospice services. The facility's failure to assess R1 and provide appropriate treatment for stroke symptoms created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator of the immediate jeopardy on [DATE] at 11:55 a.m. The immediate jeopardy was removed on [DATE]; however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: Facility policy titled, Neurological assessment dated ,d+[DATE], states in part, - .General guidelines: -1. Neurological assessments are indicated: d. When indicated by resident's condition. -2. When assessing neurological status, always include frequent vital signs. -3. Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately. -Steps in the Procedure: -4. Determine residents' orientation to time, place, and person. -5. Observe residents' patterns of speech and speech clarity. -6. Take temperature, pulse, respirations, and blood pressure. -7. Check pupil reaction a. Darken room, b. Open eyelid with your fingers, c. Turn on flashlight and observe size and reaction of pupil, d. Repeat the other eye. -8. Determine motor ability: a. Have resident move all extremities, b. Ask resident to squeeze fingers. Note strength bilaterally, c. Have resident plantar and dorsiflex. Note strength bilaterally. Ask resident if/she has any numbness or tingling in legs/feet/toes and document accordingly. -9. Determine sensation in extremities. Rub residents' arms at the same time to if resident has decreased sensation in either arm. Check sensation in lower extremities also and document accordingly. -10. Check gag reflex with tongue depressor, if safe for resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-11. Have resident smile to determine if there is any facial drooping and document accordingly. -12. Check eye opening, verbal, and motor responses using the Glasgow Coma Scale. Record observations. *Documentation should be recorded in resident's medical record: 1. Date and time procedure was performed. 3. All assessment data obtained during the procedure. *Reporting: 1. Notify the physician of any change in a resident's neurological status . According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. 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. (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 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. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. R1 was readmitted to the facility on [DATE] with diagnoses which included in part: Alzheimer's disease, atrial fibrillation, nonrheumatic mitral valve insufficiency, and atherosclerotic heart disease. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Minimum Data Set (MDS) assessment, dated [DATE], identified R1 scored 3 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was independent with eating, supervision for oral hygiene, partial assistance rolling from left to right in bed, and dependent on toileting, upper/lower body dressing, and personal hygiene. MDS dated [DATE] indicated significant change in status, and MDS was not completed to show R1's current physical functionality. Surveyor observed resident functionality as totally dependent on staff for all cares. Surveyor reviewed R1's care plan. Surveyor observed no updated care plan since 2021. Surveyor reviewed R1's progress notes: -Late entry entered on [DATE] by Registered Nurse (RN) K referring to [DATE] at 9:30 AM, .During am med pass resident was a little sleepy than usual. Assessment done, resident responding to name by opening eyes and sayings yes in a low voice. Resident had her shower a few minutes ago and shower aide reported resident was fully awake. Pupils equal and reactive to light. Bilateral hands with equal grab, squeeze and strength, bilateral lower resident able to push on my hand. Face equal symmetry, no facial droop noted. No s/s [signs/symptoms] of pain noted. Lung CTA. No signs of respiratory distress noted. VS ,d+[DATE], P83, res 16, O2 sats 94 at r/a. HOB at 30 degrees. Charge nurse and clinical manager following on resident`s condition . Surveyor did not observe a complete neurological assessment performed at this time. RN K did not assess orientation to time, place, and person. RN K did not assess full motor ability by assessing resident's movements of all extremities, asking resident if resident had any numbness or tingling in legs/feet/toes and document accordingly. -Late entry entered on [DATE] by Licensed Practical Nurse (LPN) C referring to [DATE] at 11:08 AM, . this writer went to give resident noon medication, resident still responding to name by opening eyes and going to sleep. No signs of TIA 3/stroke noted. Neuro assessment remains WNL [within normal limits]. B/P , d+[DATE], P 81, R 17, O2 97 AT R/A. Lab done and results pending at this time . Surveyor did not find a comprehensive neurological assessment completed by a Registered Nurse for the entry above. A Licensed Practical Nurse cannot assess. -Late entry entered on [DATE] by LPN D referring to [DATE] at 11:15 AM, .this Writer was notified by an employee that they wanted me to go down and evaluate resident as she seemed very sleepy. Writer went down to the resident's room. Resident was rousable and did talk to me. I did a check on her vitals which were all WNL. I had the resident squeeze hands and both L and R upper extremities were able to move and squeeze my fingers. Had resident move BLE [bilateral extremities] and resident had movement on both sides. I touched her toes and feet and resident was able to move those as well. Resident was sleeping when writer left the room. Writer went to the desk and asked the nurses to please monitor her frequently and to notify the doctor of any changes . Surveyor did not find a comprehensive neurological assessment completed by a Registered Nurse for the note above. A Licensed Practical Nurse cannot assess. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Late entry entered on [DATE] by LPN C referring to [DATE] at 11:30 AM, .Completed a skin assessment on resident and patient was asleep. Checked resident VS: BP:,d+[DATE], P: 89, RR:16, Temp: 97.8, SPO2: 97% RA WNL. Patient was able to respond to stimuli and grasped my hand when checking pulse and blood pressure. Patient responded to name but was drowsy. Notified Physician and was told to monitor. Notified house clinical nurse, and evening nurse. Labs were ordered CBC & CMP . Surveyor did not find an accurate neurological assessment completed by a Registered Nurse for the 11:30 a. m., late entry note. A Licensed Practical Nurse cannot assess. - Late entry entered on [DATE] by LPN D referring to [DATE] at 12:10 PM, .Writer spoke to Nurse at the cart and discusses ordering some lab work to ensure that we are not dealing with something that we do not know about as resident is still sleepy but still responding to stimuli. Writer put call into NP to get orders for CBC and CMP. - Late entry entered on [DATE] by LPN D referring to [DATE] at 12:10 PM, .NP was notified of Change of condition and labs were ordered. STAT Labs placed in 4-[NAME], printed, and drawn by nurse. Sent to lab asap . - Late entry entered by Medical Doctor (MD) P on [DATE] referring to [DATE] at 6:20 PM, .On-Call Telemedicine Visit: Nurse called FNP in follow up stating the patient is really lethargic. She is not really letting us really wake her up. Chart was reviewed. Nurse called FNP [family nurse practitioner] in follow up stating the facility staff said that she did not get up today because she was too sleepy but he just went in and checked her. She is lying in bed. Her left arm is flaccid. She is responding but just barely, just mumbling verbally. Chart was reviewed. Nurse called in MD stating this elderly patient is CPR status. The facility staff said that she was sleeping so they did not want to get her out of bed. MD just went in and checked on resident on robot. She is still sleeping. He tried to arouse her and she does open her eyes. She kind of mumbles and that is the extent of it. She is able to move her right side but her left arm is flaccid. She is not moving it. She is moving her right leg but her left leg she is not moving that well at all. It does move some though but he cannot get her to move the left arm at all. He cannot get her to respond. She has not been out of bed today. Chart was reviewed. A/P: Flaccid hemiplegia affecting left dominant side Slowness and poor responsiveness Unspecified speech disturbances Contusion of left thigh, subsequent encounter; Other abnormalities of gait and mobility; Pain in left knee; Pain in right knee; Low back pain, unspecified; Essential (primary) hypertension; Hyperlipidemia, unspecified; Morbid (severe) obesity due to excess calories - CBC and CMP. - To consider to send patient out. - IV F NS 1 liter bolus. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Follow up to assess at bedside. - Continue to monitor. - Continue with other plan of care . -On [DATE] at 11:44 PM, a change of condition for R1 was entered by RN M, .At approx. 1715 I went into resident's room to administer medications. Report received from dayshift nurse stated that resident was sleepy, so they hadn't gotten her up; she was still lying in bed. Attempted to rouse resident; she opened her eyes but was only able to mumble incoherently. Noted that she had movement in her RUE and RLE but only limited movement in her LLE, and her left arm was completely flaccid. Requested assist from East wing RN, who verified assessment findings and checked V/S: ,d+[DATE], pulse = 119/irreg, O2 sat = 95%, Temp = 97. 2. Called MD and attempted to describe resident's status but he insisted that I call him back on an on-call number. Called MD again and described resident's status; advised him that I wanted to send resident to ER for eval and he stated that he wanted to assess resident via mobile computer portal first. Notified DON at 1740 and informed her that it was my desire to have resident evaluated in the ER immediately, and she said she would call MD. Notified (resident's daughter and POA for healthcare) at 1745 and informed her of resident's condition; she stated that she wanted her mother to be sent to ER immediately, and she would go to the hospital to meet her. MD had re-appeared on the computer screen robot at that point and I notified him of POA's decision to have resident evaluated in the ER. East nurse contacted 911 and paramedics arrived to transport resident at 1755, left facility with resident at 1805. East nurse called hospital at 2245 and was informed that resident did in fact have a CVA and would be kept in the hospital overnight, further updates to follow tomorrow . -On [DATE], discharge hospital note indicated, .On [DATE], [AGE] year female chronic atrial fibrillation not on anticoagulation secondary to falls and history of hematoma following anticoagulation. Patient was brought to the emergency department from nursing home with concerns of facial droop and sleepiness. Patient was noted to have facial droop around 8am today, and during the day was noted to be sleepy, and did not communicate much. She is generally talkative at baseline. In view of left-sided facial droop and likely weakness of left upper and lower extremity, patient was seen in the emergency room . In the emergency room patient was lethargic and evaluated. Hospital course: Patient underwent an MRI which showed right MCA [Middle Cerebral Artery] distribution infarcts involving temporal parietal and frontal lobes. Patient remained drowsy and lethargic and evaluated by speech and due to significant impairment with swallowing it was not safe to proceed with swallow evaluation. Alternative forms were discussed with family and family did not want to pursue these avenues. Patient continued to have left hemiplegia and was drowsy and lethargic not following any commands. Family ultimately decided they did not want to pursue any more medical care and wanted to pursue hospice placement. Patient was discharge to SNF today [DATE] for enrollment in hospice . Progress note: -On [DATE] at 11:43 AM, .eighty-seven-year-old female readmitted from hospital to NH with new diagnosis of Acute right MCA stroke with left hemiplegia. Alert but does not verbalize. NPO and now admitted to hospice . (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 8:40 AM, Surveyor interviewed Family Member (FM) R and asked FM R about R1's condition before [DATE] and then about the stroke event that occurred on [DATE]. FM R indicated that R1's normal condition before [DATE] was that R1 was very active and would be up early every morning in wheelchair. FM R indicated that facility staff usually would get R1 up in the mornings into R1's wheelchair and R1 would [NAME] around the facility in wheelchair, rummaging through dresser drawers and visiting staff. FM R indicated that R1 loved to see what was going on in hallways and stayed busy with organizing R1's room. On [DATE], FM R received a phone call from RN M who sounded frantic. RN M indicated to FM R that R1 was not responding like normal and couldn't move left side at all. RN M indicated to FM R that R1 was not responding to staff starting this morning on [DATE]. RN M indicated to FM R that RN M wanted to send R1 to the emergency room . FM R requested to RN M that RN M send R1 to the emergency room now. FM R indicated that when FM R arrived at the emergency room , the provider indicated that R1 most likely suffered a stroke. On [DATE] at 12:09 PM, Surveyor interviewed Hospitalist Y and asked Hospitalist Y if Hospitalist Y could walk Surveyor through the events that occurred when R1 was transferred to the hospital from the facility on [DATE]. Hospitalist Y indicated that R1 was transferred from the facility and appeared not responsive, lethargic, and had complete paralysis on the left side upper and lower extremity. Surveyor asked Hospitalist Y if R1 was brought in earlier in the day could the hospital do anything further for R1. Hospitalist Y indicated that R1 had underlying AFIB that was not being treated due to family request of not being on a blood thinner due to recent falls with hematomas. Hospitalist Y indicated if R1 would have been brought to hospital earlier the hospital could have started R1 on some Tissue Plasminogen Activator (TPA) medications to bust up the clot that occurred. Hospitalist Y indicated that if any other interventions were to be placed then R1 would have had to be transferred to a higher level for further care as hospital had limited resources. On [DATE] at 2:31 PM, Surveyor interviewed LPN C and asked about the events on [DATE] that led to R1's transfer to the emergency department. LPN C indicated that LPN C was only involved with completing the treatments for R1 such as the skin assessment and that LPN C was not the primary nurse for R1. LPN C indicated that when LPN C went into R1's room around 11:30 AM, R1 was extra sleepy which was unusual as R1 is very active and tootles around in R1's wheelchair. LPN C indicated that she let charge nurse LPN D know. On [DATE] at 3:25 PM, Surveyor interviewed RN L and asked RN L about the events that led to R1 transferring to the emergency department on [DATE]. RN L indicated that RN L came on shift on [DATE] at 2:00 PM. RN L was called from east wing to assist RN M in R1's room around 5:15 PM. RN L indicated that RN M sounded very alarmed. RN L indicated that when RN L entered R1's room RN L could clearly see that something was very wrong with R1. RN L indicated that R1 was not responding and lethargic. RN L could see that R1 could not move left side at all. RN L indicated that RN L immediately told RN M to call the provider. RN L indicated that RN M called the provider, and the provider came in with telehealth robot and ordered RN M to start IV and infuse saline 250ml. RN L indicated the provider refused to send R1 to the hospital at RN M's request. RN L indicated that RN M immediately called R1's family which then FM R indicated to send R1 to the emergency room immediately. RN L indicated to Surveyor that no one reported to nursing staff at shift change that anything was wrong with R1 all day other than R1 being extremely sleepy. RN L indicated that R1 being extremely tired was not R1's normal for R1's day to day status. (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 3:31 PM, Surveyor interviewed LPN D and asked about the events that led to R1 transferring to the emergency department on [DATE]. LPN D indicated that R1 was sleepy in the morning of [DATE] but that LPN D assessed R1 around 11:00 AM. LPN D indicated that R1 had equal hand grasps and vitals were stable. LPN D indicated that LPN D was still slightly concerned so LPN D contacted Nurse Practitioner (NP) X on call. NP X did not answer at first. LPN D called again about 30 minutes later. NP X ordered labs and to continue to monitor. LPN D indicated that R1's vitals were good throughout the day. LPN D indicated that staff did not notify R1's family timely about the sleepiness. Surveyor asked LPN D what monitor for changes meant from NP X's order. LPN D indicated that staff was to just keep checking on R1 and monitor vitals. Surveyor asked LPN D why did documentation show that LPN D did not notify NP until 12:15 PM even though LPN D felt there was something wrong around 11:15 AM. LPN D indicated that LPN D didn't get a chance to call NP until around 12:15PM, then NP did not answer right away. NP called back around 12:45 PM and ordered labs to be drawn for R1 and continue to monitor. Surveyor asked LPN D exactly what time labs were ordered. LPN D indicated that after receiving the order at 12:45 PM staff drew blood and sent immediately to lab. Surveyor asked LPN D when labs were resulted. LPN D indicated that LPN D was done with shift and left at 2:30 PM, and at that time labs were not back yet. LPN D looked on computer and indicated that labs were resulted at 3:14 PM. LPN D indicated LPN D did not know what the results were as LPN D left facility when shift was over. On [DATE] at 4:55 PM, Surveyor interviewed RN K and asked about the events that led to R1 transferring to the emergency department on [DATE]. RN K indicated that R1 was the medication nurse that day for R1. RN K indicated that Certified Nurse Assistant (CNA) O reported to RN K in the morning time that R1 was not feeling well. RN K indicated that RN K went into R1's room around 9:30 AM and R1 was sleepy but vitals were stable. RN K indicated that R1 usually fights the nebulizer machine when administering, and this time R1 did not resist nebulizer. RN K indicated that R1 was extra sleepy and thought at that point there was a change of condition and so RN K let LPN D know of vitals and extra sleepiness. RN K indicated that RN K thought the charge nurse and supervisor would take over caring for R1 to figure out what was going on so RN K did not do anything further. LPN D indicated to RN K that LPN D would assess R1 and then call provider. RN K continued passing medications throughout the day. RN K left shift at 2:00 PM and saw that complete blood count and a comprehensive metabolic panel were ordered for labs but no results were in at that time. RN K admitted to not documenting until the next day as RN K is contracted and only has set hours to work. RN K completed documentation the next day on [DATE]. RN K indicated there was a huddle that took place on [DATE] that involved Director of Nursing (DON) B, LPN C, LPN D, and CNA O reviewing the events that transpired on [DATE]. RN K indicated that staff were told to go back into chart and document on R1 pertaining to neurological assessment completion. RN K indicated there was a lot of pointing fingers and about who CNA O informed about R1's condition early morning on [DATE], when CNA O gave R1 a bath. RN K indicated to Surveyor that CNA O did not report to RN K until around 9 AM. RN K indicated that CNA O did not report the elevated blood pressure to RN K at all. (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 5:15 PM, Surveyor interviewed RN M and asked about the events that led to R1 transferring to the emergency department on [DATE]. RN M indicated that on [DATE], RN M arrived at work and finished report around 3:00 PM. RN M had 1 nurse to 25 residents so RN M likes to get RN M's bearings, make to do list and treatments. RN M did a quick walk down the hallway around 3:30 PM and peeked into R1's room where R1 appeared to be sleeping. RN M started medication pass and around 5:15 PM noticed that R1 was not up in the dining room for dinner. RN M asked CNA W on that evening where R1 was and CNA W indicated to RN M that during report staff told CNA W that R1 was not getting up all day due to being extra sleepy. RN M decided to go check on R1 in room. When RN M entered R1's room, RN M noticed that R1 wasn't responding like normal, and RN M assessed facial drooping and left side flaccid. RN M indicated that adrenaline kicked in and knew the situation was an emergency. RN M quickly called east wing RN L for a second opinion. RN M indicated that RN L said call the provider quickly and transfer R1 out to the emergency room . RN M contacted NP X right away and NP X indicated that since it's an emergency NP X cannot give orders to send to the ED and to call MD P. RN M quickly called MD P and tried to explain it was an emergency. MD P quickly became aggravated and told RN M to call back on the correct number as the number RN M called wasn't the correct one. RN M then found the other cell number for MD P and called MD P. RN M indicated to MD P that R1 had been extra sleepy all day and now has facial drooping with left side paralysis. RN M asked MD P if RN M could send R1 to the emergency department as it is severe. RN M indicated that MD P wanted to jump on the telehealth robot first to assess R1. RN M indicated that MD P remoted into the telehealth robot and wheeled down the hallway with the computer into R1's room. RN M indicated that MD P indicated to start IV fluids bolus 250ml and keep monitoring. RN M indicated to MD P the importance of needing to send her into the emergency room . MD P indicated monitor R1 and infuse the normal saline fluids. RN M immediately called FM R and informed FM R what occurred and R1's condition. FM R insisted that RN M send R1 into the emergency room right away. RN M indicated that RN M called DON B and explained the situation and that RN M would be sending R1 out to the emergency room . DON B indicated to RN M that DON B would call MD P and speak with MD P about the situation. RN M indicated to RN L to call 911 now. RN L called 911 and stated that EMS would be arriving shortly. RN M indicated to Surveyor that MD P never did call back and give the order to transfer R1 out to the hospital nor did RN M hear from DON B again that night. RN M indicated that when EMS arrived, EMS stated that it was good facility called them in for R1. Surveyor asked RN M if RN M observed anyone go in and check on R1 between the time RN M started shift at 2:30PM until 5:15 PM. RN M indicated that RN M did not observe anyone go into R1's room. RN M indicated that CNA W who was on shift was pulling a double shift that day, and CNA W indicated to RN M at dinner time that day shift reported they did not get R1 up at all today due to R1 being extremely sleepy. On [DATE] at 7:59 AM, Surveyor interviewed CNA O and asked about the events that led to R1 transferring to the emergency department on [DATE]. CNA O indicated that CNA O was R1's bath aide on [DATE]. CNA O indicated that R1 wasn't R1's self. CNA O stated that R1 usually resists baths and will swing arms at CNA O but R1 did not do this, this time. CNA O indicated that CNA O completed vitals and reported to RN K that R1's blood pressure was ,d+[DATE] which was not R1's norm. CNA O indicated that once RN K did not go check on R1, CNA O went to Social Services Director AA and Activities Director Z. Then Social Services Director AA and Activities Director Z went to LPN D. (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 8:09 AM, Surveyor interviewed LPN C again and asked for clarification on when LPN C went into R1's room to complete skin assessment. LPN C indicated that LPN C was not R1's primary nurse and went into R1's room to perform skin assessment which would be the time indicated on her late entry of around 11:30 AM. LPN C noticed R1 was extra sleepy and could only mumble softly to LPN C. LPN C reported R1's sleepiness and minimal responsiveness to RN K who was R1's primary nurse. On [DATE] at 8:15 AM, Surveyor interviewed LPN D and asked for clarification on events that led to R1's event on [DATE]. LPN D indicated that LPN D was notified by Activities Director Z at 11:00 AM that CNA O reported to RN K that R1 was extra sleepy and off. LPN D entered R1's room around 11:00 AM, but unsure of exact time and started assessing R1. LPN D indicated that LPN D rubbed R1's arms and chest vigorously. LPN D indicated that R1 opened eyes and when LPN D asked R1 was R1 ok, R1 responded in a low voice yes. LPN D indicated that LPN D grabbed R1's hands and R1 grasped equal. LPN D indicated that LPN D felt around on both feet and pushed a little and then gathered a set of vitals. LPN D indicated that R1 seemed very sleepy but ok. LPN D indicated that LPN D indicated to RN K to monitor closely for any changes. LPN D asked RN K around noon if there were any changes for R1. RN K indicated there was not a change in R1 so LPN D contacted NP and had to leave a message. Surveyor asked LPN D what monitoring closely meant. LPN D indicated that RN K was to follow the change of condition and neurological assessment policy. Surveyor asked LPN D what expectation is for documenting events in the Electronic Health Record (EHR). LPN D indicated that expectation is everything is documented shortly after the event or the same day. LPN D indicated that [DATE] was so busy that LPN D charted in the EHR the next day. Surveyor asked LPN D was LPN D sure of time frames since documentation was the next day on [DATE]. LPN D indicated that LPN D did best at remembering time frames. Surveyor asked LPN D who was the primary nurse for R1 on [DATE]. LPN D indicated the shifts are split into sections. LPN D indicated the treatment nurse is the primary nurse, then there is a nurse who does the medication portion at the cart, and there is a charge nurse, and then a clinical manager which is I LPN D. LPN D indicated that LPN C was the primary nurse for R1 on [DATE]. On [DATE] at 8:27 AM, Surveyor interviewed LPN C again for clarification on who was the primary nurse for R1 on [DATE] as LPN D indicated that LPN C was primary nurse for R1 on [DATE]. LPN C immediately became defensive and explained to Surveyor there are some fishy things going on with R1's situation on [DATE]. LPN C indicated that LPN C was the treatment nurse but was never told by anyone of R1's condition. When LPN C went into complete skin assessment, R1 did not seem like R1's self and LPN C reported this to LPN D, the clinical manager. LPN C indicated that LPN C never saw LPN D set foot into R1's room and that LPN D's documentation is fake. LPN C indicated that the next day on [DATE] there was a huddle meeting and DON B and LPN D indicated that everyone needed to back document neuro assessments on R1 from [DATE]. LPN C indicated that LPN C didn't do a neuro assessment but only performed a skin assessment. LPN C indicated that during the huddle there was a lot of pointing fingers on who CNA O reported to. LPN C indicated at first CNA O stated she reported to a different RN then reported to LPN C. LPN C indicated that CNA O never reported R1's condition to LPN C. (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 10:20 AM, Surveyor interviewed DON B and asked for the timeline on events that led to R1's event on [DATE]. DON B indicated that DON B didn't know all the details of the event on [DATE] but that staff did their best at trying to make sure there were no obvious changes during the day shift that led up to R1 being transferred out to the emergency department. Surveyor asked what DON B's expectation was for assessing R1 for possible stroke. DON B indicated that staff were to follow the facility's neurological assessment if staff were suspicious that R1 was having a stroke. DON B indicated that all staff that were involved documented their interactions with R1 on [DATE]. Surveyor indicated to DON B that progress notes were reviewed and noted that all entries were documented the next day, and the documentation did not follow the facility's neurological assessment protocol. Surveyor asked DON B why entries were documented late. DON B indicated that DON B didn't realize that no one documented that day on [DATE] so DON B asked staff to document the next day on [DATE]. DON B indicated that documentation is something the facility is working on with staff. DON B's expectation is that documentation is completed the day of or shortly after the event. DON B indicated that next day charting is not acceptable. Surveyor asked DON B what DON B did when RN M notified DON B of R1 having a possible stroke. DON B indicated that DON B called provider to see about transferring R1 out. DON B indicated that around 3:30 PM DON B checked on R1 before leaving for the day and didn't seem to have any obvious concerns other than being extra tired. Surveyor asked where that documentation was, and DON B indicated that DON B did not document that. The failure to assess and provide appropriate interventions for R1 led to serious harm for R1, which created a finding of immediate jeopardy. The facility removed the immediate jeopardy on [DATE] when it completed the following: *All nursing staff to be educated on change of condition policy and when to notify MD. *Facility will do a house sweep to identify any other residents with a change of condition, with appropriate MD notification. *Nursing staff will be educated on symptoms of a stroke by using the FAST (face, arms, speech, time) assessment. Nursing staff will be educated on proper neurological assessment. * On [DATE], facility reviewed policies and

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview, and record review, the facility did not ensure residents with pressure injuries received necessary treatment and services to promote healing and prevent infection, and did not ensure residents received care and treatment to prevent development of pressure injuries. This occurred for 2 of 5 residents (R) reviewed for pressure injuries. (R1 and R11). R1 did not have a care plan with interventions in place to prevent a pressure injury and developed a deep tissue injury on the left heel, causing actual harm. R1 was not repositioned to prevent the development of pressure injuries. R11 did not have weekly assessments documented for a stage 4 pressure injury. Example 1: According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, 2019: Staff should assess and document the physical characteristics of the wound bed and the surrounding skin and soft tissue at least weekly. Weekly wound assessment and documentation should include, in part: Anatomical location, category/stage, size and surface area, tissue type, color, periwound condition, wound edges, exudate, and odor. NPIAP guidance also recommends repositioning all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated. Determine repositioning frequency with consideration to the individual's level of activity and ability to independently reposition. Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved. According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, 2019: Deep Tissue Injury (DTI) is purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. R1 was readmitted to the facility on [DATE] with diagnoses which included in part: Alzheimer's disease, atrial fibrillation, nonrheumatic mitral valve insufficiency, and atherosclerotic heart disease. R1's Minimum Data Set (MDS) assessment, dated 07/23/24, identified R1 scored 3 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was independent with eating, supervision for oral hygiene, partial assistance rolling from left to right in bed, and dependent for toileting, upper/lower body dressing, and personal hygiene. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	MDS dated [DATE] indicated significant change in status, after R1 suffered a stroke. The MDS was not completed to show R1's current physical function. During the survey, Surveyor observed resident being totally dependent on staff for all cares. Surveyor reviewed R1's care plan. Surveyor observed no care plan for pressure injuries (PIs) or skin integrity. Surveyor reviewed Braden scale completed on 09/13/24 indicating that R1 scored 12 and was at high risk for pressure injuries. Surveyor reviewed R1's skin assessments: -On 09/13/24, R1 had a turning and repositioning program in place and no pressure injuries noted. -On 09/16/24, R1 had pressure injury device on bed and a turning and repositioning program in place with no pressure injuries noted. -On 09/17/24, indicated R1 had a new stage 1 pressure injury to the left heel. Skin prep heels and pad and protect interventions were put into place. On 09/16/24 at 10:33 AM, Surveyor observed R1 lying in bed supine with heels directly lying on bed with no elevation or pillow placed underneath R1's heels for off-loading measures. On 09/16/24 at 12:20 PM, Surveyor observed R1 lying supine in same position sleeping in bed. R1's heels were directly lying on bed with no elevation or pillow placed underneath R1's heels to prevent skin breakdown from occurring. On 09/16/24 at 12:29 PM, Surveyor observed Licensed Practical Nurse (LPN) C enter R1's room and apply a nebulizer mask. Surveyor did not observe LPN C reposition R1. Surveyor observed R1 lying supine looking around in bed. R1's heels were directly lying on bed with no elevation or pillow placed underneath R1's heels to prevent skin breakdown from occurring. On 09/16/24 at 12:41 PM, Surveyor observed LPN C and Certified Nursing Assistant (CNA) I reposition R1 to R1's partial right side. LPN C placed a pillow behind R1. Surveyor observed R1's heels lying directly on the mattress. Surveyor did not observe LPN C or CNA I off load R1's heels to prevent further breakdown. On 09/17/24 at 7:32 AM, Surveyor observed R1 lying in bed supine with heels directly lying on uncovered mattress on bed with no elevation or pillow placed underneath R1's heels. Surveyor observed the fitted sheet to be bunched up to R1's bottom/back and not under R1's lower extremities. On 09/17/24 at 9:12 AM, Surveyor observed Family Member (FM) R upset and request CNA I and CNA N come in and reposition R1. (continued on next page)

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Heritage Lakeside	1016 Lakeshore Dr Rice Lake, WI 54868

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 09/17/24 at 9:16 AM, Surveyor observed CNA I and CNA N enter R1's room. CNA I rolled R1 back to the right side facing the window. Surveyor observed a red purplish spot the size of a golf ball on the bottom and lateral side of R1's left heel. Surveyor asked CNA I and CNA N if they have seen that on the bottom of R1's heel and CNA I and CNA N indicated they have not. Surveyor asked CNA I and CNA N if there are any protective measures in place to prevent skin breakdown. CNA I and CNA N indicated that there is not but would let the nurse know that is on duty. Surveyor did not observe CNA I and CNA N reposition R1's heels to off-load. Surveyor observed R1's heels directly lying on R1's bed. On 09/17/24 at 1:20 PM, Surveyor brought LPN D into R1's room to discuss R1's left heel. LPN D uncovered R1's left heel. LPN D looked at R1's left heel and indicated that R1's left heel is starting to breakdown. LPN D indicated that R1's left heel is slightly boggy and is red/purple in color about the size of a golf ball. LPN D indicated that R1's left heel is the start of a deep tissue injury due to R1's heels being directly on the mattress without off-loading and R1 should have some kind of protection on R1's heels to prevent further breakdown. Surveyor asked LPN D what measures are in place for R1 to prevent skin breakdown since R1 was readmitted on [DATE] after a stroke that impaired R1's mobility. LPN D indicated that at this time there are no measures, but LPN D would get an order and podus boots in place to prevent further breakdown. Surveyor asked LPN D how often staff are to reposition R1 and if R1 should have heels elevated to off load. LPN D indicated that staff should be repositioning every 2 hours and off-loading heels. Surveyor observed LPN D roll a blanket up and try to place under R1's heels, but Surveyor observed R1's left heel still touching the mattress. On 09/17/24 at 1:38 PM, Surveyor interviewed LPN C and asked about a skin assessment completed on 09/16/24 at 9:34 AM. LPN C indicated that LPN C did not see anything wrong with R1's left heel. Surveyor asked LPN C if anyone had reported to LPN C that R1's left heel was starting to break down. LPN C indicated that on 09/16/24 whenever hospice staff were at facility, hospice staff reported to LPN C that R1's left heel was red/purple in color. Surveyor asked LPN C if LPN C assessed R1's left heel after it was reported from staff of the discoloration of R1's left heel. LPN C indicated that LPN C did not assess R1's left heel. Surveyor asked LPN C if LPN C placed any interventions to prevent further breakdown from occurring. LPN C indicated no, LPN C did not do anything different, but LPN C will go off load R1's heels now. Surveyor did not observe LPN C enter R1's room. On 09/18/24 at 7:45 AM, Surveyor observed R1 lying in bed supine with podus boots up to knees not covering R1's heels. R1's heels were lying directly on the mattress with no off-loading in place. On 09/18/24 at 9:00 AM, Surveyor observed FM R in room visiting with R1. Surveyor observed podus boots to be up to knees not providing off-loading measures and R1 still lying supine in bed. On 09/18/24 at 12:35 PM, Surveyor observed FM R in room visiting with R1. Surveyor observed R1 still lying supine in bed. Surveyor interviewed FM R and asked if staff have been in to reposition R1. FM R indicated that R1 has not been repositioned, but FM R requested to staff that staff assist with repositioning for R1. On 09/18/24 at 1:30 PM, Surveyor interviewed CNA U who was on R1's hall. CNA U indicated that CNA U and the other CNA have not been in R1's room since earlier this morning around 7:30 AM. CNA U did not reposition since this morning. CNA U asked Surveyor isn't R1's family in R1's room. Surveyor asked CNA U does that mean that family provides repositioning. CNA U indicated well sometimes they help but that CNA U should have probably been in R1's room earlier to reposition. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 09/18/24 at 1:44 PM, Surveyor observed family reposition R1 onto left side and placed podus boots on R1's feet to off-load R1's heels. Surveyor interviewed FM R and asked if staff came in to reposition R1 and FM R stated, No, my daughter and I had to reposition mom and provide oral cares. FM R indicated that FM R repositioned R1 so R1 was comfortable. On 09/18/24 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked about repositioning residents who are dependent on total staff care. DON B indicated that totally dependent residents and who are at risk for a PI should be repositioned every 2 hours and as needed. Surveyor did not observe a pressure injury device on R1's bed or repositioning every 2 hours through all observations from 09/16/24-09/18/24. Surveyor observed podus boots placed on R1's heels 09/18/24 after Surveyor's interview with the wound nurse. 40181 Example 2 Record review identified R11 was admitted to the facility on [DATE]. R11 had the following diagnoses, in part, encephalopathy, type 2 diabetes mellitus, and unspecified dementia. R11 did not have any pressure injuries present at the time of admission. During R11's stay in the facility, R11 developed a pressure injury on the spine. Record review identified R11 was hospitalized from 06/21/24 through 06/27/24 for surgical intervention of the stage 4 pressure injury of the lumbar spine. Hospital records identified R11 had osteomyelytis of L1 vertebra. R11 returned to the facility with a wound vac to the wound and IV antibiotic therapy. The wound vac treatment was discontinued on 06/30/24 and IV antibiotic treatment was completed on 08/03/24. Record review identified the most recent Weekly Wound Observation Tool documentation for the stage 4 pressure injury on the lumbar spine was dated 08/22/24. The document labeled the wound as a surgical wound. The comments section of the document noted, Skin area located on the low back that is leaking clear fluid. No infection present, healed otherwise from back surgery. The documents listed measurements of 0.75 centimeters (cm) by 0.4 cm by 0.01 cm. Surveyor was unable to find any other weekly assessment documentation of the lumbar spine pressure injury with measurements and description of wound condition or drainage after that date. Surveyor did find skin/wound notes that documented the lumbar spine pressure injury continued to have drainage from the area, but there was no description of the wound, surrounding tissue, or measurements. Surveyor identified a progress note titled Infection Note, dated 09/16/24, which stated in part, Resident has orders to begin antibiotic treatment for an infected wound on his back . On 09/17/24 at 5:54 AM, Surveyor observed wound care on R11's left heel pressure injury and lumbar spine injury provided by LPN D and LPN J. The dressing removed from the lumbar spine stage 4 pressure injury showed evidence of drainage from the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 09/18/24 at 12:33 PM, Surveyor interviewed LPN D, who stated they were the certified wound nurse for the facility. Surveyor asked why they were not documenting a weekly wound assessment with description of the wound, measurements, and description of drainage for the stage 4 pressure injury to R11's lumbar spine. LPN D stated they were not aware the wound was a pressure injury and was told by previous wound nurse the wound was a surgical wound. LPN D stated they were not aware they should continue to document on the wound because they considered it healed because it had no measurable size. Surveyor asked LPN D if the wound was healed if it continued to have drainage. LPN D stated no, there was probably something still present. LPN D confirmed the NP from the wound clinic cultured the lumbar spine wound last week and identified an infection and ordered antibiotics. LPN D stated they would resume weekly assessments with documentation of the lumbar spine pressure injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility did not ensure the resident was assessed for removal of the catheter and had no orders in place for a foley catheter. For 1 of 1 residents (R) R1 reviewed with urinary catheters. R1 has an indwelling foley catheter without a physician order to direct the care and treatment for the catheter. Staff did not assess and prevent complications of catheter during R1's care. Findings include: Facility policy titled, Catheter Care, Urinary, dated 08/22, states in part, - .Input/output: 1. Observe the residents urine level for noticeable increases or decreases. -Maintain unobstructed urine flow: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 4. If the catheter material contributes to obstruction, notify the physician, and change the catheter if instructed to do so. 5. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction. -Complications 1. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately. B. if urine has an usual appearance (i.e. color, blood, etc); d. if the resident complains of burning, tenderness, or pain in the urethral area . Surveyor reviewed physician orders include: .-On 09/17/24 Change and date catheter bag on shower days every Monday. -On 09/17/24 Check indwelling foley catheter, provide catheter care, and monitor output every shift for urine output. Update MD for skin concerns around catheter site every shift. R1 was readmitted to the facility on [DATE] with diagnoses which included in part: Alzheimer's disease, atrial fibrillation, nonrheumatic mitral valve insufficiency, and atherosclerotic heart disease. R1's Minimum Data Set (MDS) assessment, dated 07/23/24, identified R1 scored 3 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was independent with eating, supervision for oral hygiene, partial assistance rolling from left to right in bed, and dependent on toileting, upper/lower body dressing, and personal hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS dated on 09/19/24 indicated significant change in status, and MDS was not completed to show R1's current physical functionality. Surveyor observed resident functionality as totally dependent on staff for all cares. Surveyor reviewed R1's care plan. Surveyor observed no updated care plan since 2021. On 09/16/24 at 10:33 AM, Surveyor observed R1 lying in bed supine. Surveyor could smell heavy urine within R1's room. Surveyor observed R1's catheter bag lying on the floor. Surveyor observed very little output unmeasurable, and urine was reddish dark brown with slight sediment in the catheter bag. On 09/16/24 at 12:41 PM, Surveyor observed Licensed Practical Nurse (LPN) C and Certified Nursing Assistant (CNA) I reposition R1 to R1's partial right side. Surveyor observed R1 moan out when repositioned. LPN C picked catheter off floor and reattached to bed. On 09/17/24 at 7:32 AM, Surveyor observed R1 lying in bed supine. Surveyor observed R1 moaning and grimacing like in pain. Surveyor could smell heavy urine within R1's room. Surveyor observed very little output unmeasurable, and urine was reddish dark brown with slight sediment in the catheter bag. On 09/17/24 at 9:16 AM, Surveyor observed CNA I and CNA N enter R1's room. Surveyor observed fitted sheet soaked through with dark brown liquid and a dry circle around the whole wet spot-on bed. Surveyor interviewed CNA I and CNA N and asked if the leaking urine was normal for R1. CNA I and CNA N indicated that it was not normal to find urine all over the bedding. CNA I and CNA N indicated CNA I and CNA N would let nurse know when done. Surveyor did not observe CNA I and CNA N report to nurse of R1's catheter leak. On 09/17/24 at 1:42 PM, Surveyor interviewed LPN C and asked about R1's catheter leaking. LPN C indicated that LPN C is aware of the catheter leaking. LPN C indicated that LPN C is monitoring catheter and already checked for kinks. LPN C indicated that staff replaced the catheter bag yesterday on 09/16/24 and that the nurse supervisor LPN D did not want LPN C to change the catheter bag to prevent introducing infection when not needed again today on 09/17/24. LPN C indicated that LPN C is keeping an eye on it. Surveyor asked LPN C asked what keeping an eye on it meant. LPN C indicated just looking at it periodically. On 09/17/24 at 2:00 PM, Surveyor observed CNA N enter R1's room to empty catheter bag. CNA N tried draining catheter bag into graduate but stated there was no measurable output. Surveyor observed drops come out of catheter bag but nothing measurable was attained. Surveyor asked CNA N if no output for R1 was concerning. CNA N indicated that no urine output was concerning, but R1 was not eating or drinking anything. CNA N indicated that usually CNA N will inform nurse on duty of the urine output results. CNA N exited R1's room and walked down the hallway and into another room. Surveyor never observed CNA N report to the nurse on duty. On 09/18/24 at 9:00 AM, Surveyor observed Family Member (FM) R in room with R1 visiting. Surveyor observed R1 moaning and R1 had right hand over abdomen. FM R asked R1 if R1 was ok. R1 moaned some more and closed eyes. FM R asked if R1 was having pain. R1 stated, Yes. FM R asked if the pain is in R1's abdomen. R1 moaned again and stated, Yes, then rubbed right hand up from abdomen and up to R1's chest. FM R asked R1, Do you have pain in your abdomen going up to your chest? R1 stated, Yes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 1:30 PM, Surveyor interviewed CNA U who was on R1's hall. CNA U indicated that CNA U and the other CNA have not been in R1's room since earlier this morning around 7:30 AM. Surveyor asked CNA U if R1's catheter is leaking or when they changed R1 did they observe the sheets to be wet. CNA U indicated yes in fact R1 was an entire bed change, but that CNA U didn't know to think the catheter may be kinked or not working. CNA U indicated that CNA U would let the nurse know about the catheter leaking. Surveyor observed CNA U walk down the hallway but did not report to the nurse of R1's leaking catheter. On 09/18/24 at 1:44 PM, Surveyor observed family reposition R1 onto left side as R1 was moaning and holding abdomen with right hand. Surveyor observed very little output unmeasurable, and urine was reddish dark brown with slight sediment in the catheter bag. On 09/18/24 at 1:46 PM, Surveyor interviewed LPN C and asked if LPN C knew about R1's leaking catheter. LPN C indicated that LPN C knew about R1's leaking catheter yesterday on 09/17/24 and all was fine. Surveyor indicated to LPN C that R1's catheter is still leaking, and that CNAs reported to Surveyor that the catheter is still leaking as R1's bed linens were completely soaked this morning on 09/18/24. Surveyor asked LPN C does LPN C assess abdominal distention or output. LPN C indicated that LPN C did not assess R1 for abdominal distention and that LPN C would need to figure out what was going on. LPN C continued down the hallway and conversed with other staff. Surveyor did not observe any staff go back into R1's room to address the catheter leaking. On 09/18/24 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked about R1's output status pertaining to R1's leaking catheter. DON B indicated staff should be checking for abdominal distention and discomfort. DON B indicated that staff should be checking that R1's catheter is draining appropriately. DON B expects that staff follow the facility's catheter policy.

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on observation, record review, and interview, the facility failed to ensure residents received adequate fluid and food intake to maintain acceptable parameters of hydration and nutrition for 3 of 3 residents (R) (R2, R1, R19). R2 was admitted to the facility on [DATE]. R2 was sent to hospital on 03/16/24 and returned on 03/23/24 with diagnosis of failure to thrive and laboratory results of elevated blood urea nitrogen (BUN) and creatinine indicating dehydration. R2 was hospitalized on [DATE] with elevated BUN, creatinine, and albumin levels, resulting in R2 being transferred to another critical care hospital and expiring on 05/27/24. The facility failed to ensure R2 received adequate fluid intakes to maintain acceptable parameters of hydration to include the following: * failure to assess daily fluid intake; * failure to accurately assess and complete assessments for signs and symptoms of dehydration (e.g., sunken eyes, cool/clammy skin, dry tongue, dark colored urine, and sticky saliva); * failure to develop a plan of care to encourage fluid intake and prevent dehydration; * failure to recognize dehydration and put interventions in place to prevent further dehydration; * failure to communicate R2 not meeting the recommended daily fluid intake with the physician. The facility's failure to assess R2's hydration and develop a plan of care for hydration created a finding of immediate jeopardy that began on 05/20/24. Surveyor notified Nursing Home Administrator of the immediate jeopardy on 09/18/24 at 11:55 a.m. The immediate jeopardy was removed on 09/19/24; however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan and as evidenced by: R1 was readmitted after having a stroke with no nutritional assessment or updates to the nutritional care plan to maintain nutritional and hydration status. R19 is at risk for dehydraton and has no care plan for hydration interventions. This is evidenced by: The facility's Resident Hydration and Prevention of Dehydration policy with the revised date of October 2017, reads in part: 1. The dietitian will assess all residents for hydration as part of the comprehensive assessment, at least quarterly, and more often as necessary per resident need. 2. Minimum fluid needs will be calculated and documented on initial, annual, and significant change assessments, using current standards of practice. 5. Nurses will assess for signs and symptoms of dehydration during daily care. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Nurses; aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. A. intake will be documented in the medical records. B. Aides will report intake of less than 1200ml/day to nursing staff. 7. If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. A. ADL status, diagnosis, individual preferences, habits, and cognitive and medical status will be considered in all interventions. B. The physician will be notified. 11. If laboratory results are consistent with actual dehydration, the physician may initiate IV hydration. hospitalization will be recommended, as necessary. 12. Nursing will monitor, and document fluid intake and the dietitian will be kept informed of status. The interdisciplinary team will update the care plan and document resident response to interventions until the team agrees that fluid intake and relating factors are resolved. R2 was admitted on [DATE] with diagnoses of nontraumatic intracerebral hemorrhage in brain stem, type 2 diabetes with diabetic neuropathy, morbid obesity, muscle weakness, anxiety disorder, hemiplegia left dominant side, chronic pain, cerebral infarction, chronic embolism and thrombosis right femoral vein, lobar pneumonia, chronic kidney disease stage 2, and edema. Minimum Data Set (MDS) 5 day admission assessment, dated 02/12/24, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating R2 had moderate cognitive impairment. R2 had impairment to one side of the upper extremity. R2 requires staff to provide set-up assistance with meals. MDS quarterly assessment, dated 05/14/24, documents a BIMS score of 8, indicating R2 had moderate cognitive impairment. R2 had impairment to one side of the upper extremity and impairment to both sides of the lower extremities. R2 was independent eating meals. Care plan: dated 02/06/24 with revision date of 02/13/24 Focus: The resident has nutritional problem or potential nutritional problem r/t (related to) Bilateral Lower Extremity Edema, Chronic GERD, CKD State 2, Chronic Pain, Decreased mobility & endurance, Hypertension, Super Obesity, CMT2 w/ diabetic neuropathy MNA screening score 9. Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight within +/- 5% of 345#, no s/sx (signs and symptoms) of malnutrition, and consuming at least 75% of at least 3 meals daily through review date. Revised 02/13/24 Intervention: 02/06/24 Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 02/06/26 RD to evaluate and make diet change recommendations PRN, 2/13/24 Resident status monitored by nutrition at risk team. 04/25/24: Provide and serve supplements as ordered: LPS BID Ensure Plus with meals Gelatein Plus with PM & HS Snack Pass High Protein Orange Juice TID with meals, Provide, serve diet as ordered. Monitor intake and record q (every) meal. CCHO diet, IDDSI 5-Minced & Moist texture (No Bread) with thin liquids. Note the care plan does not address dehydration with interventions. Dehydration risk observation/assessment on 02/06/24 was not completed to identify a score or determination if R2 was at risk for dehydration. The assessment documented R2 having no weight loss, having bladder incontinence, having a history of dehydration, and having 3 or more predisposing factors. The facility did not complete further dehydration risk assessments. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nutrition Evaluation Comprehensive assessment dated [DATE] was completed by the Registered Dietician. The assessment documented fluid needs of 2,400 ml, and meals calories 1,728 would be 75% of meal intake to meet the required calories. Nutrition Evaluation Comprehensive assessment dated [DATE] documented fluid needs of 2,400 ml, Resident is at high nutritional risk related to dx, MNA screening score of 9, intakes less than 75%, wounds continue to be healing. Refuses to roll. The assessment did not address R2's low fluid intakes or risk of dehydration. Review of the Nutrition at Risk (NAR) assessments for wound care show they document R2's meal intakes and do not address fluid intakes or risk for dehydration. The assessments document meal intakes for 02/15/24 - 68%, 02/22/24 - 62%, 02/29/24 - 48% with the addition of a mighty shake, 03/23/24 no meal intake, 04/04/24 - 58% with change of mighty shake to ensure plus. 04/11/24 - 56%, 04/18/24 - 56%, 04/25/24 - 51% encourage healthy snacks, 05/02/24 - 49%, 05/09/24 - 47%. There are no further assessments. Review of prior fluid intakes for the month of February: R2 refused fluids seven shifts and staff did not document fluid intakes for six shifts. Of the documented daily fluid intakes, R2 had an approximate daily fluid intake of 449 ml. In March, R2 refused fluids nine shifts and staff did not document fluid intakes for 18 shifts. Of the documented daily fluid intakes, R2 had an approximate daily fluid intake of 416 ml. In April, R2 refused fluids five time and staff did not document fluid intake for 12 shifts. Of the documented daily fluid intakes, R2 had an approximate daily fluid intake of 625 ml. Documentation of fluid intakes: 5/1/24 & 5/2/24: 240 ml 5/3/24: 480 ml 5/4/24: 480 ml 5/5/24: 840 ml 5/6/24: 540 ml 5/7/24: 320 ml 5/8/24: 320 ml 5/9/24: 480 ml 5/10/24: 340 ml 5/11/24: 240 ml - resident refused fluids AM and PM shift (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/12/24: 240 ml - resident refused fluids AM 5/13/24: No documentation of fluids 5/14/24: 510 ml 5/15/24: 420 ml 5/16/24: 520 ml 5/17/24: 370 ml 5/18/24: 480 ml 5/19/24: 440 ml 5/20/24: 400 ml on the afternoon shift. Resident refused fluids during AM shift. Documentation of Foley catheter urine output: 5/1/24: 575 ml 5/2/24: 500 ml 5/3/24: 600 ml 5/4/24: 500 ml 5/5/24: 500 ml 5/6/24: 475 ml 5/7/24: 600 ml 5/8/24: 550 ml 5/9/24: 75 ml - no documentation of output for the night shift 5/10/24: 300 ml - no documentation of output for the PM shift 5/11/24: 450 ml 5/12/24: 650 ml 5/13/24: 525 ml 5/14/24: 800 ml (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/15/24: 600 ml 5/16/24: 250 ml 5/17/24: 200 ml 5/18/24: 700 ml 5/19/24: 150 ml - no output for PM shift 5/20/24: 30 ml Note on 05/19/24: foley catheter urine output was 100 ml during AM shift, no urine output for PM shift, and 50 ml during night shift. The facility did not consult with a physician regarding R2 having no output on the PM shift on 05/19/24. Surveyor's review of R2's medical record did not identify completed laboratory tests. Surveyor asked Director of Nursing (DON) B to provide any laboratory results for R2 and no documentation was provided. Review of nurse's note documents on 05/09/24 3:54 PM, communication with physician. Pt with low urine output of 25 ml for day shift. Medical Doctor (MD) P updated, he orders as follows: Flush foley catheter with 500 ml NS every shift. Note R2's vital signs on 05/09/24: 103/49 blood pressure, 16 Respirations, 97.4 temperature, 99% oxygen saturations on room air. Total fluid intake from 05/08/24 was 320 ml with urine output on 05/09/24 AM shift of 25 ml and PM shift of 50 ml and no documentation of urine output for night shift. No further nurse's notes were documented in R2's chart until 05/20/24. Nurse's notes on 05/20/24 at 1:51 AM, documented in part: PM shift reported res had little to no output on their shift and very little on the AM shift. Urine in tubing of res catheter is very dark amber color, not cloudy but only approx 100mL. Woke res and enc her to drink. Res initially refuses but is unable to tell writer why she does not want to drink anything. Res normally eats ice chips and freq c/o nausea or states she is going to vomit. Note res does develop hiccups shortly after taking a few sips of water. VSS except res is a little tachycardic at 111 and O2 sats are 90% on RA. Res was lying flat at this time and was also expressing her dislike for being roused from her sleep. Res appears dehydrated with sunken eyes and dry skin and lips. CNAs performed cares on res and also noted that she did not appear as she normally does and is not as verbally responsive as she was and seems to have a staring, unblinking gaze at times until she is interrupted and then is able to focus again. Res offers no complaints and in fact when asked how she was feeling stated everything feels fine. Nurse will cont to push fluids with res and monitor output and vitals. Nurse will call NP [nurse practitioner] in early AM to obtain orders for labs this AM. Res is currently resting in bed with her eyes closed and in no acute distress. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/20/24 at 4:49 AM, Change of Condition Note Text: Assessed res this AM. Vitals stable though BP trending down. Res cont to state she feels fine. Res has taken approx. 100mL of fluid from writer and small sips from other staff but is mostly refusing to drink. Call placed to NP and he gave orders for CMP and CBC this AM and to give res duoneb and recheck oxygen saturations. Discussed res continuing to be her own person and continuing to make detrimental choices regarding her health. NP states they will get labs and then go from there. Note of vital signs: 05/20/2024 1:34 AM, blood pressure (b/p) 106/48, temperature (T) 97.4 F Temporal Artery, pulse (P) 111 bpm, respirations 18 breaths/min, and oxygen saturations (O2) 90.0% Room Air. 05/20/2024 4:47 AM, b/p 99/42, T97.4 F Temporal Artery, P101 bpm, respirations 20 breaths/min, and O2 88. 0% Room Air. 05/20/2024 6:10 AM, O2 88.0% Room Air. 05/20/2024 10:26 AM, b/p 105/42, T97.4 F Forehead (non-contact), P90 bpm Regular, respirations 16 Breaths/min, and O2 91.0% Room Air. Progress notes on 05/20/24 read in part: Late Entry: Note Text: DOS 05/20/24. On-Call Telemedicine Visit: S: Nurse called in stating patient has not been eating or drinking anything and nursing staff told nurse yesterday that she had only 50 CC of output on day shift and thenonly [sic] 50 cc on p.m. shift too. There is about 100 cc of dark urine. Nurse has been pushing fluids with her all night. She drank 120 cc and that was after encouraging her. She does not give the nurse any indication of why she does not want to drink. Nurse asked her if it makes her nauseous. She did say a couple of times she wanted to throw up but she did not throw up. It is very common that she says that. She refused her meds yesterday including her Reglan which could be helping her but she is not taking them, so nurse was wondering if nursing staff could do labs on her this morning. Monday .She has had sporadic intake. Her wounds are not healing .Lung sounds are absent on the right side and very hard to hear on the left side .A/P (Assessment and Plan): Hypoxemia, Other specified symptoms and signs involving the circulatory and respiratory systems, Dehydration, Anuria and oliguria, Anorexia, Other signs and symptoms involving food and fluid intake, Morbid (severe) obesity due to excess calories; Muscle weakness (generalized); Essential (primary) hypertension; Chronic kidney disease, stage 2 (mild). CBC (complete blood count), CMP (complete metabolic panel). Continue to monitor . On 05/20/24 at 4:50 PM, Change of Condition, Note Test: Resident was transferred to [hospital] via ambulance due to a change of mental status, increased nausea, increased edema in upper and lower extremities, and decreased urine output . On 05/20/24 at 9:54 PM, Communication - Note Text: Writer spoke with [Name] RN (Registered Nurse) at [Hospital Name] ED, RN stated that resident will be transferred to a higher level of care due to critically high labs, CR of 3.5, dehydration, elevated WBC requiring Levaquin, the need for norepi due to blood pressure issues, and wound care . On 05/23/24, the facility called the second hospital and found resident was in the intensive care unit and was on palliative care and would not be returning to the facility. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the emergency room (ER) report dated 05/20/24, which read in part: .while in route EMS noted that she had a b/p in the mid 80's .full sepsis workup had been ordered .Patient on exam does have stage III pressure ulcers on her buttocks as well as her left thigh. Patient became hypotensive, started lab Levophed (Norepinephrine is a vasoconstrictor, similar to adrenaline, used to treat life-threatening low blood pressure.) . laboratory studies were obtained, patient is meeting sepsis criteria. Elevated liver enzymes from an unknown source. Pro-cal is elevated to 6.7. Patient started on levofloxacin therapy we have replaced albumin as well as the calcium . National Library of Medicine documented 05/08/23: Untreated hypotension can be a significant cause of morbidity and mortality. Norepinephrine is a first-line agent for hypotension that does not respond to fluid therapy and can be a powerful adjunct in managing a critically ill patient. Review of ER laboratory results: Creatinine: 3.5 is high with normal range of 0.40 -1.00. BUN: 42 is high with normal range of 6-24. Albumin: 1.8 is low with normal range of 3.7 - 5.2. AST: 238 is high with normal range of 13-39. ALT: 170 is high with normal range of 7-38. Procalcitonin 6.7 is high with normal range of 0.00 -0.07. Interpretation: Significant bacterial infection likely: patient is at increased risk for bacterial sepsis and/or septic shock. WBC: 20.7 is high with normal range of 4.1 - 10.9. Blood culture and urinalysis were negative. CT of chest identified a fatty liver, small left pleural effusion, and opacity right middle lobe suggesting probable atelectasis. On 05/20/24, R2 was transferred from the hospital emergency room by helicopter to another critical care hospital and admitted until passing on 05/27/24. On 09/17/24 at 2:53 PM, Surveyor interviewed RN L asking about R2's condition and intakes prior to transfer. RN L indicated R2 was having continued decline with intakes and the physician was not doing anything. On 05/20/24, the resident was declining and when MD P was updated, MD P would not transfer resident to the ER and said for us to monitor. RN L went to resident and said if she wanted to go to the ER and we will send her, and resident agreed. Surveyor asked about R2's status between 05/09/24 and 05/20/24 since there were no notes in the chart. RN L indicated there should be notes daily on R2 and she was declining. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/18/24 at 9:47 AM, Surveyor interviewed Certified Nursing Assistant (CNA) Q about monitoring of resident's fluid intake and reporting of low intakes. CNA Q indicated the CNAs are to document in the computer and should notify the charge nurse when there is low intake. The charge nurse should notify the Director of Nursing and dietician. Surveyor asked how R2's fluid intakes were during the entire stay at the facility. CNA Q indicated R2 had low fluid intake and only liked ginger ale and apple juice and did not like water. R2 continued to decline during her entire stay at the facility. On 09/18/24 at 9:55 AM, Surveyor interviewed DON B about R2's fluid intakes. DON B indicated she could not speak to what occurred with R2 as she was not the DON at that time. DON B indicated her expectations are for the nurses to document if the resident is on fluid restrictions and that would be documented in the treatment record. Offers of free fluids would not be documented only if specific reason. The dietician would be tracking fluid intakes and reviewing. If the resident was at nutritional risk they would be reviewed weekly and otherwise monthly. DON B indicated she believes R2 was looked at weekly for nutrition at risk. Surveyor reviewed with DON B the nutrition at risk documentation reviewed only meal intakes and did not address fluid intakes. On 09/19/24 at 8:35 AM, Surveyor interviewed MD P and asked when MD P would expect staff to notify MD P when a resident is not taking in the recommended number of fluids that registered dietician has recommended for the individual. Surveyor stated, For example someone who has ordered to intake 2400mls but only intakes 200-480 mls a day. MD P indicated that staff would need to notify nurse practitioner following the facility's protocols for eating and drinking. MD P indicated that every situation is different such as residents refusing or not feeling good for the day but if a resident has not eaten or drank in over 24 hours, MD P expects staff to follow protocol, figure out the cause of resident not eating, follow up with dietician to seek preferences, and notify provider right away. The failure to assess and provide appropriate hydration interventions for R2 led to serious harm and death for R2, which created a finding of immediate jeopardy. The facility removed the immediate jeopardy on 09/19/24 when it completed the following: All nursing staff educated on facility policy for tracking fluids/hydration at the facility, including reviewing hydration, notifying MD, and new hydration assessments. Facility completed a house sweep for all residents at risk for dehydration, using a dehydration assessment to determine who is at risk. All at risk residents with less than 1500ml daily intake will be reviewed weekly at Resident at Risk Meetings. All residents at risk for dehydration will have updated care plans. On 9/19/2024, facility reviewed the dehydration procedures in coordination with Nursing, IDT, and Dietitian, including how the facility tracks hydration, reviews dehydration, and follows up on residents at risk. Facility updated the hydration assessment and follows residents who scored an 8 or higher. All residents at risk who consume less than 1500ml will be reviewed and physician will be notified. Hydration policy updated related to required components on dehydration being available for nurses to use/follow. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility will review dehydration assessments/update care plans on admission, quarterly, and as needed. 46693 Example 3 R19 was admitted to the facility on [DATE] with diagnoses which included: paranoid schizophrenia, stroke, malnutrition, heart failure, altered mental status, dysphagia, and hemiplegia. R19's Minimum Data Set (MDS) assessment, dated 07/05/24, identified R19 scored 9 during a Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R19 is paralyzed on one side of body. R19 was independent with eating, max assist for oral hygiene, max assist for rolling from left to right in bed, and dependent on toileting, upper/lower body dressing, and personal hygiene. Surveyor reviewed R19's dehydration assessment, dated 09/18/24, that indicates R19 scored an 8 meaning R19 is at high risk for dehydration. Surveyor reviewed R19's care plan that had no mention of the risk for dehydration except for one sentence that was added the day of survey, 09/23/24. The sentence under goal section reads, Resident will have no s/sx of dehydration. On 09/23/24, Surveyor reviewed the Registered Dietitian (RD) assessment dated [DATE] that notes R19's daily fluid requirement should be 2700ml. Fluids were not met on 09/20/24 and 09/22/24, therefore the facility placed R19 on the Nutrition at Risk list that is looked at weekly. Surveyor reviewed weights and labs and found them to be within normal limits. Labs dated 08/19/24 are as follows: Sodium 138, BUN 10, and Creatinine 0.67. On 09/23/24 at 2:00 PM, Surveyor interviewed Director of Nursing (DON) B and RD V. Surveyor asked both to identify where on R19's care plan that shows R19's risk for dehydration, the causes, and interventions/revisions to address it. DON B stated the care plan was not revised yet because the team has not met yet for the week. They are also in the process of placing collection hats in the toilets for measuring intake and output. DON B stated that R19 is on the list for monitoring, but it is still a work in progress. On 09/23/24 at 2:53 PM, Surveyor interviewed DON B and asked about R19's nutrition, hydration, and output status. DON B indicated that R19 can feed self after set up. DON B stated that she thought that once the hydration assessment was completed, it would pull to the care plan and automatically create it like the other areas, but it did not. Surveyor asked DON B how staff are monitoring that R19 is not becoming dehydrated. DON B indicated that staff should record intakes and outputs. Surveyor asked DON B if anyone has addressed R19's hydration status. DON B stated, Not completely at this time. Surveyor did not find an updated care plan in place to address R19's risk for dehydration, the causes, and interventions/revisions to address it. 48793 Example 2: (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 was readmitted on [DATE] with diagnoses which included in part: Alzheimer's disease, atrial fibrillation, nonrheumatic mitral valve insufficiency, and atherosclerotic heart disease. R1's Minimum Data Set (MDS) assessment, dated 07/23/24, identified R1 scored 3 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was independent with eating, supervision for oral hygiene, partial assistance rolling from left to right in bed, and dependent on toileting, upper/lower body dressing, and personal hygiene. MDS dated on 09/19/24 indicated significant change in status, and MDS was not completed to show R1's current physical functionality. Surveyor observed resident functionality as totally dependent on staff for all cares. Surveyor reviewed R1's care plan. Surveyor observed no updated care plan since 2021. On 09/17/24 at 8:40 AM, Surveyor interviewed Family Member (FM) R and asked FM R about R1's condition and R1's NPO (nothing by mouth) status. FM R indicated to Surveyor that FM R has been requesting to the facility staff to offer pleasurable foods as R1 has become more aware of surroundings and responding to yes and no questions. FM R indicated to Surveyor that FM R doesn't understand why R1 is not being offered some kind of foods and fluids now that FM R is back to the facility. FM R indicated that FM R is aware that while R1 was in the hospital FM R denied wanting tube feeding placement, but FM R now wants that to be changed for R1 as R1 is coming around more after the stroke. On 09/18/24 at 1:50 PM, Surveyor observed FM R feeding R1 pudding and requested to LPN C that R1 start being offered pleasurable foods as FM R keeps asking staff and no one will provide R1 with food. LPN C indicated that R1 is NPO and has not been assessed to eat yet. On 09/18/24 at 1:53 PM, Surveyor interviewed Director of Nursing (DON) B and asked about R1's nutrition, hydration, and output status. DON B indicated that R1 is NPO. Surveyor asked DON B how staff are monitoring that R1 is not becoming dehydrated as Surveyor has not observed any intake or urine output for R1 in the 3 days being on survey. DON B indicated that staff should be using swabs for R1's mouth to moisten R1's lips but staff should be also monitoring intakes and outputs. Surveyor asked DON B if anyone has addressed R1's hydration status. DON B stated, I guess not. On 09/18/24 at 3:11 PM, Surveyor interviewed Dietician V and asked if Dietician V has addressed R1's hydration and intake since R1 has been readmitted to facility 09/13/24. Dietician V indicated no, Dietician V has not addressed, but Dietician V knows that R1's intake needs to be addressed. Dietician V indicated that a meeting was supposed to take place soon but it has not been scheduled yet to address. Surveyor did not find an updated nutritional care plan in place to address R1's intake. Surveyor did not find a speech therapy assessment to address safe nutritional intake for R1.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40181 Based on observation and interview, the facility did not ensure staff followed procedures for the accurate administration of insulin. Staff did not complete a safety check by priming the needle on two insulin pens to ensure the injectable pens were dispensing insulin before administration for 2 of 3 residents (R), (R8 and R11). Findings include: Manufacturer's instructions for insulin pens state in part.Priming your pen: Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin . Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat the priming steps, but not more than 4 times. If you still do not see insulin, change the Needle and repeat the priming steps . On 09/18/24 at 7:38 AM, Surveyor observed Licensed Practical Nurse (LPN) C take a Humalog insulin pen out of the medication cart and verify the label with the orders. LPN C took a needle out of the drawer, wiped the end of the insulin pen with an alcohol wipe, and attached the needle to the insulin pen. LPN C dialed the pen to 14 units per the order on the Medication Administration Record (MAR). LPN C carried the insulin pen to R8's room, wiped R8's abdomen with an alcohol wipe and administered the insulin injection with the pen. LPN C did not prime the needle with 2 units prior to dialing the pen to the 14-unit dose to verify the pen was working correctly and to ensure R8 received the correct dose of insulin. On 09/18/24 at 11:53 AM, Surveyor observed LPN C take a Novolog insulin pen from the medication cart and verify the label with the orders on the MAR. LPN C took a needle out of the cart, wiped the end of the insulin pen with an alcohol wipe and attached the needle to the pen. LPN C dialed the pen to 8 units per the order on the MAR. LPN C carried the pen to R11 and asked where they wanted their insulin injection. LPN C wiped R11's abdomen with an alcohol wipe and injected the insulin with the pen. LPN C did not prime the needle with 2 units prior to dialing the pen to the 8-unit dose to verify the pen was working correctly and to ensure R11 received the correct dose of insulin. Immediately following the procedure, Surveyor asked LPN C what the facility policy was for priming the needle on insulin pens prior to dialing the prescribed dose. LPN C stated it was not required to prime the needles on insulin pens. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 12:41 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the facility policy and procedure was for priming insulin pens prior to administering the prescribed dose. DON B stated staff should prime the needle with 2 units prior to dialing the pen to the prescribed dose. Surveyor explained the observations of LPN C administering insulin with a pen to both R8 and R11 without priming the needles. DON B stated LPN C was not following the correct procedure.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation and interview, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional. Staff did not ensure that medications that could be potentially harmful were secured. This occurred for 1 of 1 resident's (R13) rooms observed. Findings include: Facility policy, entitled, Medication Labeling and Storage, dated February 2023 states, If the facility has discontinued, outdated or deteriorated medication or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these issues . Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each residents' medications and biologicals are locked when not in use . On [DATE] at 1:38 PM, Surveyor observed insulin pens sitting on the bedside table in R13's room unattended. R13 was not in the building and was receiving dialysis. R13's door was open and insulin pens could be seen from the doorway. One insulin pen was Humalog with 140 units left; this pen was labeled Do not use after [DATE]. The insulin pen did not have an open date and was not capped upon further review. The second pen was Insulin Glulisine and had 60 units left, with an expiration date of February 2026. On [DATE] at 2:15 PM, Surveyor interviewed R13 regarding their insulin administration and storage. R13 said that they do have a lock box in their room for the insulin, but the location is not the best as they cannot access it from their bed. R13 needs assistance to get into their wheelchair and the lock box is on the other side of the room. So R13 doesn't need to call staff each time they have a snack, they have been keeping their insulin pens on the bedside table. When asked what they do with used up or expired insulin pens, R13 said they put them in the sharps container. When asked about the currently expired Humalog, R13 said they did not realize it was expired and had not needed it in over a week; that was their fast acting medication and they have been good with their diet recently and have not needed much insulin. Record review of R13's care plan indicated that, Resident is young, wants to go home as soon as possible and wants to self-administer medications such as his insulin. Resident understands his risk of giving to much, to little, insulin. Medication is in a locked box that resident can easily. Resident has poor eyesight, is on dialysis, knows his medications, what they are for. On [DATE] at 4:00 PM, Surveyor interviewed Director of Nursing (DON) B regarding proper storage of insulin pens. DON B did not realize that R13 was storing their own insulin in their rooms as they had not been here long, and they would expect those medications to be locked away. DON B would also not expect medications that are expired to be available to residents and they would need to look further into the insulin administration for R13.

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47807 Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility did not ensure staff used proper hand hygiene when distributing food. This has the ability to affect 5 of 43 residents (R11, R14, R15, R16, R17) residing in the facility. Findings Include: The facility policy, entitled, Food Preparation and Service, dated April 2019, states, Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and are discarded after each use. On 09/16/24 at 11:52 AM, Surveyor observed the serving of food by Dietary Aide (DA) S. DA S was touching the meal tickets which were not a cleanable surface and then touching ready to eat foods. DA S grabbed R14's bun with gloved hands after touching tickets and then placed the bun on R14's plate for distribution. With the same gloved hands, DA S did the following: DA S touched the pizza and peas on R15's plate then distributed the food. DA S touched the pizza on R11's plate then distributed the food. DA S touched the pizza when cutting up R16's pizza then distributed the food, touching the meal tickets. DA S grabbed R17's bun, after touching paper tickets, and then placed the bun on R17's plate for distribution. DA S did not change gloves or use hand hygiene and directly touched residents' food, and tickets were touched throughout the service. On 09/17/24 at 1:15 PM, Surveyor interviewed Kitchen Supervisor (KS) T regarding hand hygiene during meal service. KS T said they would have expected staff to use tongs to distribute the buns and use proper hand hygiene when needing to directly touch residents' food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40181 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Staff did not sanitize the mechanical lift after use in another resident room, prior to using it for resident (R)11. Staff did not perform hand hygiene with glove changes during incontinent cares for R11 and R1 Staff did not wear proper personal protective equipment (PPE) when entering a resident room (R9) labeled Droplet Precautions. Staff did not wear gloves when obtaining a blood sample for blood glucose monitoring for R11. Staff did not wear proper personal protective equipment for enhanced barrier precautions when providing care for R18 and R3. Findings include: According to CDC Guidelines for Environmental Infection Control in Health-Care Facilities, multi-use patient care equipment should be properly cleaned and disinfected between patients. Facility policy and procedure entitled, Handwashing/Hand Hygiene states in part, .Use of alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situtations: .before donning sterile gloves .before moving from contaminated body site to a clean body site during resident care . after removing gloves .The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Single-use gloves should be used: .b. when anticipating contact with blood or body fluids . Facility policy and procedure entitled, Isolation - Initiating Transmission-Based Precautions states in part, . When a resident is place on transmission-based precautions, appropriate notification is placed on the room entrance door .so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs staff of the type of CDC precautions, and instructions for use of PPE .Droplet Precautions . Masks will be worn when entering the room. Gloves, gown and goggles should be worn if there is risk of spraying respiratory secretions . Example 1 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/16/24 at 1:53 PM, Surveyor observed Certified Nursing Assistant (CNA) E push a mechanical lift out of a resident room after use and place it outside R11's room. CNA E did not wipe the lift with a sanitizer wipe after using it in the other resident's room. At 2:03 PM, Surveyor observed CNA E use hand sanitizer and put on a gown and gloves to enter R11's room. CNA E pushed the same mechanical lift into R11's room and placed it in front of R11. CNA E and CNA F attached the lift sling that was under R11 in the chair to the mechanical lift. CNA E and CNA F used the mechanical lift to transfer R11 from chair to bed. Neither CNA wiped the mechanical lift with a sanitizer wipe prior to using it to transfer R11. Example 2 On 09/17/24 at 11:04 AM, Surveyor observed a sign outside R9's door that stated Droplet Precautions. Surveyor observed CNA H and CNA I enter R9's room with gloves on. Neither CNA H nor CNA I put on a procedure mask before entering the room. Both CNA H and CNA I used a mechanical lift to transfer R9 from bed to wheelchair. R9 was observed coughing multiple times during the procedure. Both CNAs removed gloves and used hand sanitizer before leaving R9's room. Immediately following the procedure, Surveyor asked CNA I if R9 was on any type of transmission-based precautions (TBP). CNA I stated they were a new employee and did not know. Surveyor pointed to the Droplet Precaution sign outside R9's room and asked CNA I what that meant. CNA I stated that it meant R9 was on droplet precautions. Surveyor asked CNA I it they needed to wear any PPE to enter that room. CNA I stated they did not know and would have to ask someone. On 09/17/24 at 11:20 AM, Surveyor asked CNA H if R9 was on any type of TBP. CNA H stated they did not think so. Surveyor asked what the Droplet Precautions sign outside R9's door meant. CNA H stated they thought that was old because R9's wounds were all healed up. Surveyor asked CNA H if R9 had been on droplet precautions for wounds, and CNA H stated they thought that was the reason for the precautions. On 09/17/24 at 11:30 AM, Surveyor interviewed Licensed Practical Nurse (LPN) J and asked if R9 was on droplet precautions. LPN J stated R9 was on droplet precautions because R9 had some respiratory symptoms. Surveyor asked LPN J what PPE staff should wear when entering that room. LPN J stated everyone should put on a procedure mask and eye protection every time they enter that room. On 09/17/24 at 11:35 AM, Surveyor interviewed Director of Nursing (DON) B who stated they were filling the Infection Preventionist duties at this time. Surveyor explained the observation of staff entering R9's room without any PPE on and R9 had a Droplet Precaution sign outside the door. DON B was not sure if or why R9 was on droplet precautions but would investigate it. DON B stated if there was a Droplet Precautions sign outside R9's door all staff should be wearing an N95 mask to enter the room. While Surveyor was interviewing DON B, LPN J returned and stated it was a mistake and R9 should no longer be on droplet precautions. LPN J stated R9 was cleared, and the droplet precautions should be discontinued. DON B stated even if the sign was up by mistake, staff should have followed the directions on the sign until they were certain R9's TBP were cleared. DON B stated staff did not appear to know what PPE to wear for droplet precautions and needed education. Example 3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/18/24 at 11:53 AM, Surveyor observed LPN C use hand sanitizer and take a blood glucose monitor out of the medication cart. LPN C took a strip out of a container and placed it in the glucose monitor. LPN C asked R11 which finger they wanted LPN C to poke. LPN C wiped R11's finger with an alcohol pad, took the cap off a lancet and poked R11's finger without gloves on. LPN C squeezed R11's finger to express blood and applied the blood to the test strip. LPN C held the alcohol pad on R11's finger for a minute, without wearing gloves,then threw the pad away. LPN C threw the lancet and the test strip in the sharps container on the medication cart and took a sanitizer wipe and wiped the blood glucose monitor and placed it in a drawer of the medication cart. LPN C then used hand sanitizer. On 09/18/24 at 12:41 PM, Surveyor interviewed DON B about the observation of LPN C performing a finger stick for blood glucose check on R11 without wearing gloves. DON B stated LPN C did not follow their policy for standard precautions. DON B stated LPN C should have worn gloves due the possible contact with blood. Example 4 On 09/16/24 at 2:10 PM, Surveyor observed CNA F and CNA G provide incontinent cares for R11 while R11 was lying in bed. CNA G and CNA F were both wearing gowns and gloves. CNA G assisted R11 roll onto one side in bed, pulled R11's pants down, and unfastened R11's brief. CNA G used pre-moistened wipes from a package to clean feces from R11's bottom. CNA G threw the soiled wipes in a plastic bag at the bedside, removed the gloves, threw them in the plastic bag and reached under gown and took a clean pair of gloves out of uniform pocket. CNA G did not wash hands or use hand sanitizer after removing the soiled gloves. CNA G put the clean gloves on, tucked a clean brief under R11. CNA K took a tube of barrier cream out of the drawer and handed it to CNA G. CNA G put some barrier cream on a gloved hand and spread the cream on R11's bottom. CNA G and CNA F assisted R11 to roll to the other side. CNA F pulled the soiled brief and linens out and placed them in the plastic bag. CNA F used the pre-moistened wipes to clean feces from R11's other side. CNA F removed the soiled gloves and threw in the plastic bag. CNA F reached into CNA G's uniform pocket and took out a pair of clean gloves. CNA F did not wash hands or use hand sanitizer after removing the soiled gloves. CNA F put on the clean gloves and put barrier cream on R11's other side. CNA F stated it appeared R11's catheter was leaking urine. CNA F used a pre-moistened wipe and wiped the barrier cream off the gloves. CNA F then took a second wipe out of the package and wiped around the catheter at the tip of R11's penis to determine if the urine was by-passing the catheter. CNA G turned the call light on to call the nurse in to assess the catheter. After the nurse finished assessing the catheter, CNA F and CNA G repositioned R11 in bed, fastened brief, pulled up pants and covered R11. CNA F did not change gloves or wash hands after wiping around the catheter. CNA F removed all PPE and washed hands with soap and water in R11's room. CNA F then put on clean gloves, pushed the lift out of the room and wiped with a sanitizer wipe. CNA G removed all PPE and threw in the trash. CNA G did not wash hands or use hand sanitizer. CNA G reached in uniform pocket and took out a clean pair of gloves. CNA G tied plastic bags and carried them out of the room to the soiled utility room. On 09/16/24 at 2:40 PM, Surveyor interviewed CNA G and asked what their policy and procedure was for hand hygiene after removing soiled gloves. CNA G said they were probably supposed to wash their hands or use hand sanitizer, but it was not convenient to do that when they provided incontinent cares for R11. 48793 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 5 On 09/17/24 at 9:16 AM, Surveyor observed CNA I and CNA N enter R1's room. CNA I and CNA N applied gloves and started taking R1's covers off R1. Surveyor did not observe CNA I and CNA N sanitize when entering R1's room or before applying gloves. CNA I and CNA N took R1's gown off and CNA N applied powder under R1's breasts. CNA I and CNA N then took R1's brief off and started wiping R1's genital area. Surveyor observed fitted sheet soaked through with dark brown liquid and a dry circle around the whole wet spot-on bed. CNA N used contaminated gloves to push R1's hair backwards, and CNA N adjusted R1's pillow underneath R1's neck. CNA I assisted CNA N with rolling R1 back and forth, and CNA N untucked the contaminated soiled fitted sheet and threw contaminated linens on the floor. CNA I and CNA N placed a new fitted sheet underneath R1 and rolled R1 back and forth to tuck new fitted sheet. Surveyor did not observe CNA I and CNA N remove contaminated gloves. Surveyor did not observe CNA I and CNA N sanitize the soaked mattress after removing the contaminated soiled linens. CNA I rolled R1 back to the right side facing the window. CNA I and CNA N placed clean brief under R1 with contaminated gloves and rolled R1 back. CNA I and CNA N readjusted R1 up into bed and then readjusted R1's pillow under R1's head again with contaminated gloves. CNA I grabbed the bed remote with contaminated gloves and lowered R1's bed to the floor. CNA I and CNA N removed gloves and gathered the soiled linens off the floor and exited R1's room. Surveyor did not observe CNA I and CNA N sanitize hands before or during R1's cares. 31086 Example 6 On 09/17/24 at 6:29 AM, Surveyor observed on R18's door a sign stating enhanced barrier precautions, providers and staff must also wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, providing hygiene, changing briefs, or assisting with toileting. R18's door was opened with privacy curtain pulled halfway. R18 was sitting on edge of the bed near the foot of the bed. Surveyor observed CNA N wearing gloves and no gown while providing cares to R18. CNA N handed the urinal that contained urine to R18, then CNA N wet a washcloth and washed R18's back. Surveyor interviewed CNA N and asked what type of precautions is R18 on and what type of personal protective equipment should be worn. CNA N indicated she did not know and had to read the sign on R18's door. CNA N stated she did not know why R18 was on precautions, and she did not wear a gown when providing cares. 47807 Example 7 On 09/16/24 at 9:45 AM, Surveyor observed R3's room for infection control concerns. On R3's door was a sign indicating enhanced barrier precautions were to be used for R3 when staff were transferring the resident; this included gown and gloves. R3 was wheeled down the hallway after a shower. CNA I and CNA O entered the room and performed a transfer using a Hoyer lift. There were no concerns with the transfer. Neither CNA was wearing a gown and CNA O had on gloves only during the transfer. Once transferred to bed, both CNAs left the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/16/24 at 9:52 PM, Surveyor interviewed CNA I regarding the use of PPE for a resident who is on enhanced barrier precautions. CNA I did say they were new, and she was not sure exactly, but believed they should have put on gowns and gloves. When asked if they did during the transfer for R3 CNA I admitted they did not use proper PPE. When asked where they would look to know that a resident was on transmission-based precautions, CNA I was able to say they look for the bins outside of the rooms and signs on the walls, but in this case, they must have just missed them.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49353 Based on record review and interviews, the facility did not ensure 2 out of 5 Certified Nursing Assistants (CNA), (CNA BB, CNA DD), employed at the facility for more than one year received a minimum of 12 hours of in-service training each year. This has the potential to affect all 43 residents in the facility. This is evidenced by: On 09/23/24, Surveyor requested in-service training hours for CNA BB and CNA DD for review. CNA BB's date of hire is 09/16/22, and the facility did not provide 12 hours of in-service training, which included communication, behavioral health, and dementia care. CNA DD's date of hire is 12/22/15, and the facility did not provide 12 hours of in-service training, including communication, behavioral health, and dementia care. CNA BB and CNA DD have the potential to work with all residents in the facility. Surveyor requested in-service training completion for CNA BB and CNA DD from both the Director of Nursing (DON) B and the Nursing Home Administrator (NHA) A three different times during the survey. The facility did not provide Surveyor with the requested documentation. On 09/23/24 at 2:51 PM, Surveyor interviewed NHA A regarding lack of in-service training documentation. Surveyor asked NHA A for the third time if the facility was able to provide documentation of completing the required 12 hours of in-service training for CNA BB and CNA DD. NHA A stated they were unable to locate training. Surveyor asked NHA A what the current process was for ensuring CNAs completed 12 hours of in-service training annually. NHA A stated the facility currently did not have a process in place, and this was currently being reviewed by the facility to correct. The lack of providing staff with the required in-service training has the potential to impact the quality of care for the residents.