STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525657	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Care Center	251 Forest Lane Montello, WI 53949

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on observation and staff and resident interview, the facility did not make a prompt effort to resolve a grievance for 1 Resident (R) (R15) of 1 sampled resident. In addition, the grievance was not contained in the facility's grievance file. During an interview on 7/30/24, R15 stated R15 called Family Member (FM)-L and asked FM-L to call the facility for assistance when staff didn't answer R15's call light. FM-L stated FM-L phoned the facility numerous times with no answer or ability to leave a message. R15 told staff the telephone wasn't answered and there was no way to leave a message. The facility did not follow-up with R15 and FM-L or resolve the grievance in a timely manner. Findings include: On 7/30/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with diagnoses including cerebral hemorrhage (stroke), hemiplegia (paralysis on one side of the body), and diabetes. R15's Minimum Data Set (MDS) assessment, dated 7/19/24, stated R15's Brief Interview for Mental Status (BIMS) score was 15 out of 15 which indicated R15 had intact cognition. On 7/30/24 at 12:48 PM, Surveyor interviewed R15 who stated when R15 did not get a response to R15's call light, R15 phoned FM-L to call the facility for assistance. R15 stated R15 notified Certified Nursing Assistants (CNAs) and nurses and was told they were busy and not able to answer the phone. On 7/30/24 at 12:48 PM, Surveyor interviewed FM-L who stated R15 called FM-L when staff did not answer R15's call light. FM-L stated FM-L called the facility numerous times with no answer. FM-L stated the facility's phone used to ring with no answer, but now the phone rings six times with a message that there is no mailbox. FM-L stated sometimes staff answer the phone during the day but do not answer the phone at night. FM-L stated FM-L spoke with CNAs, nurses, and business office staff but the issue was not resolved. FM-L stated FM-L has been tempted to call the police to do a welfare check on R15. On 7/30/24 at 9:15 AM, Surveyor phoned the facility twice at the number listed with the State Agency (SA). The phone rang six times and Surveyor received a message that there was no voicemail attached to the number. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 9:25 AM, Surveyor phoned the facility twice at the number listed on the facility's website. The phone rang six times and Surveyor received a message that there was no voicemail attached to the number. On 7/30/24 at 10:01 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the facility had issues with the phone system and there was no mailbox for messages. On 7/30/24 at 10:50 AM, Surveyor interviewed Social Services (SS)-H who stated the facility did not have separate phone lines for staff and family members had to call the facility's phone number and ask for assistance. SS-H verified there was not a message box attached to the phone line. SS-H stated SS-H informs families to email SS-H with issues.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48794 Based on staff interview and record review, the facility did not implement their abuse policy and complete timely and thorough background checks for 4 of 8 sampled staff. The facility did not obtain Integrative Background Information System (IBIS) or Department of Justice (DOJ) reports for Certified Nursing Assistant (CNA)-T. The facility did not obtain IBIS or DOJ reports for Dietary Aide (DA)-S. The facility obtained Physical Therapist (PT)-R's IBIS and DOJ reports after PT-R's hire date. The facility di not ensure a background check was completed within the last four years for CNA-U. In addition, the facility did not obtain IBIS or DOJ reports for CNA-U. Findings include: The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, with a revision date of April 2021, indicates residents have the right to be free from abuse, neglect, misappropriation, and exploitation. The facility prevention program consists of a facility-wide commitment and resource allocation to support the following objectives .4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: .a. Been found guilty of abuse, neglect, exploitation, misappropriation or mistreatment by a court of law; b. Had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment or misappropriation; or c. Has a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding. On 7/30/24, Surveyor completed a caregiver program compliance check for eight sampled staff and noted the following: CNA-T was hired on 6/26/24 and had a Background Information Disclosure (BID) form dated 6/10/24. The facility did not provide an IBIS or DOJ report for CNA-T. DA-S was hired on 6/1/24 and had a BID form dated 5/24/24. The facility did not provide an IBIS or DOJ report for DA-S. PT-R was hired on 5/6/24 and had a BID form dated 4/4/24. PT-R's IBIS and DOJ reports were dated 5/30/24 which was after PT-R started employment at the facility. CNA-U was hired on 9/18/12. CNA-U's most recent BID form was dated 8/18/16. CNA-U did not have a background check completed within the last 4 years. In addition, the facility did not provide IBIS or DOJ reports for CNA-U. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 9:50 AM, Surveyor interviewed Regional Director of Operations (RDO)-D who stated the facility did not have a current Human Resources (HR) Director and the previous HR Director may have thrown out some of the missing documents. RDO-D stated the facility was currently recruiting for a new HR Director, but in the interim all background checks were processed through the company's HR headquarters. RDO-D acknowledged the concern with missing background check information and stated the issue would be corrected when a new HR Director was hired.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff and resident interview and record review, the facility did not ensure incidents involving potential abuse were reported to the Nursing Home Administrator (NHA) and the State Agency (SA) for 3 Residents (R) (R24, R15 and R26) of 5 sampled residents. On 4/2/24, staff discovered R24 had an injury of unknown origin. The facility did not report the injury of unknown origin to the NHA and the SA. On 7/20/24, R15 had a physical altercation with R26. The facility did not report the resident-to-resident altercation to the SA. Findings include: The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, with revision date of April 2021, indicates: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .Objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; .e. Law enforcement officials . Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents .Within five business days of the incident, the administrator will provide a follow-up investigation report . 1. On 7/30/24, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] with diagnoses including frontotemporal neurocognitive disorder (a group of brain diseases that affect personality, behavior and language). R24's Minimum Data Set (MDS) assessment, dated 6/28/24, stated R24's Brief Interview for Mental Status (BIMS) score was 9 out of 15 which indicated R24 had moderate cognitive impairment. R24's medical record indicated R24's Power of Attorney for Healthcare (POAHC) was responsible for R24's healthcare decisions. R24's medical record contained a note, dated 4/2/24, which stated, . now also has a bruise to left eye area which was not present yesterday . On 7/30/24, Surveyor requested the facility's initial and five-day reports for R24's injury of unknown origin (bruise left eye area) noted on 4/2/24. The facility was unable to provide an initial or five-day report. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 1:35 PM, Surveyor interviewed Regional Director of Operations (RDO)-D who stated RDO-D found out about R24's injury of unknown origin when Surveyor asked for the facility's reports. RDO-D stated RDO-D was unsure if the facility's former NHA was aware because the facility had no documentation regarding the incident other than what was in R24's medical record. RDO-D verified the facility should have reported R24's injury of unknown origin to the SA. 49563 2. On 7/30/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with diagnoses including cerebral hemorrhage (stroke), hemiplegia (paralysis on one side of the body), and diabetes. R15's MDS assessment, dated 7/19/24, stated R15's BIMS score was 15 out of 15 which indicated R15 had intact cognition. On 7/30/24, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] with diagnoses including neurocognitive disorder Lewy bodies and fracture of unspecified part of neck of left femur. R26's MDS assessment, dated 6/18/24, stated R26's BIMS score was 1 out of 15 which indicated R26 had severe cognitive impairment. R26 had a guardian for healthcare decisions. On 7/30/24 at 12:48 PM, Surveyor interviewed R15 who stated R15 was attacked by R26 on 7/20/24 and R15's Family Member ((FM)-L) was not notified. R15 stated R26 made fists and hit R15 in the chest. R15's medical record contained a nursing progress note, dated 7/22/24, that indicated: Two days ago, R26's wheelchair bumped into R15's wheelchair and R15 stated ouch. R26 became angry and loud toward R15. R26 made fists and attempted to hit R15's shoulder when staff separated R26 from R15. R15 stated loudly to get away. On 7/22/24, R26 opened R15's door. There was no conflict but R15 did not want R26 to be around R15. On 7/30/24, Surveyor asked to review the facility's initial and five-day reports for the resident-to-resident altercation between R26 and R15. On 7/30/24 at 1:39 PM, Surveyor interviewed RDO-D who verified RDO-D was aware of the resident-to-resident altercation but was not aware of actual physical contact. RDO-D verified notification to the SA should have been completed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff and resident interview and record review, the facility did not ensure incidents involving potential abuse were thoroughly investigated for 5 Residents (R) (R24, R1, R21, R15 and R26) of 5 sampled residents. On 4/2/24, staff discovered R24 had an injury of unknown origin. The facility did not investigate the injury of unknown origin to rule out abuse. On 4/18/24, R1 and R21 were involved in a resident-to-resident altercation and R21 made contact with R1's face. The facility did not thoroughly investigate the resident-to-resident altercation. On 7/20/24, R15 and R26 were involved in a resident-to-resident altercation and R26 made contact with R15's chest. The facility did not investigate the resident-to-resident altercation. Findings include: The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, with a revision date of April 2021, indicates: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .Objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone .Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the Administrator is responsible for determining what actions (if any) are needed for the protection of residents .All allegations are thoroughly investigated . 1. On 7/30/24, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] with diagnoses including frontotemporal neurocognitive disorder (a group of brain diseases that affect personality, behavior and language). R24's Minimum Data Set (MDS) assessment, dated 6/28/24, stated R24's Brief Interview for Mental Status (BIMS) score was 9 out of 15 which indicated R24 had moderate cognitive impairment. R24's medical record indicated R24's Power of Attorney for Healthcare (POAHC) was responsible for R24's healthcare decisions. R24's medical record contained a nursing note, dated 4/2/24, that stated, .now also has a bruise to left eye area which was not present yesterday . On 7/30/24, Surveyor requested the facility's investigation for R24's injury of unknown origin (bruise left eye area) noted on 4/2/24. The facility was unable to provide an investigation. On 7/30/24 at 1:35 PM, Surveyor interviewed Regional Director of Operations (RDO)-D who stated RDO-D found out about R24's injury of unknown origin when Surveyor asked for the facility's investigation. RDO-D stated RDO-D was unsure if the facility's former Nursing Home Administrator (NHA) was aware of the injury of unknown origin because the facility had no documentation regarding the incident other than what was in R24's medical record. RDO-D verified the facility should have investigated R24's injury of unknown origin. 32768 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 4/18/24, the facility self-reported a resident-to-resident altercation between R1 and R21 in which R21 made contact with R1's face. Staff witnessed the altercation, immediately separated R1 and R21, and placed both residents on 15 minute checks. NHA-A and Director of Nursing (DON)-B were notified and an investigation was initiated. The IDT (Interdisciplinary Team) met, discussed R21's out of character behavior, and obtained a urinary analysis (UA) for R21 who was found to have a urinary tract infection (UTI). R1 and R21 remained on 15 minute checks until 4/24/24. On 7/30/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including dementia, psychotic disorder, anxiety disorder, and muscle wasting. R1's MDS assessment, dated 6/13/24, stated R1's BIMS score was 0 out of 15 which indicated R1 had severe cognitive impairment. On 7/30/24, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] with diagnoses including dementia, major depressive disorder, unspecified psychosis, and anxiety disorder. R21's MDS assessment, dated 5/27/24, stated R21's BIMS score was 3 out of 15 which indicated R21 had severe cognitive impairment. The investigation indicated a Registered Nurse (RN) who witnessed the incident was interviewed but the facility did not interview other staff. The facility also did not interview other residents to ensure there were no other abuse concerns. On 7/30/24 at 10:31 AM, Surveyor interviewed NHA-A who stated NHA-A was not employed at the facility at the time of the incident and the former NHA would have completed the investigation. NHA-A stated paperwork from the previous NHA and DON was either thrown away or misplaced by the Human Resources (HR) Department and the facility was trying to locate important information. NHA-A verified the facility's investigation appeared to be incomplete. 49563 3. On 7/30/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with diagnoses including cerebral hemorrhage (stroke), hemiplegia, and diabetes. R15's MDS assessment, dated 7/19/24, stated R15's BIMS score was 15 out of 15 which indicated R15 had intact cognition. On 7/30/24, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] with diagnoses including neurocognitive disorder Lewy bodies and fracture of unspecified part of neck of left femur. R26's MDS assessment, dated 6/18/24, stated R26's BIMS score was 1 out of 15 which indicated R26 had severe cogitative impairment. R26 had a guardian for healthcare decisions. On 7/30/24 at 12:48 PM, Surveyor interviewed R15 who stated R15 was attacked by R26 on 7/20/24 and R15's Family Member ((FM)-L) was not notified. R15 stated R26 made fists and hit R15 in the chest. R15's medical record contained a nursing progress note, dated 7/22/24, that indicated: Two days ago, R26's wheelchair bumped into R15's wheelchair and R15 stated ouch. R26 became angry and loud toward R15. R26 made fists and attempted to hit R15 in the shoulder when staff ran down to separate R26 from R15. R15 stated loudly to get away. On 7/22/24, R26 opened R15's door. There was no conflict but R15 did not want R26 to be around R15. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24, Surveyor requested the facility's investigation for the resident-to-resident altercation between R15 and R26. The facility was unable to provide an investigation. On 7/30/24 at 1:39 PM, Surveyor interviewed RDO-D who verified RDO-D was aware of the resident-to-resident altercation but was not aware of actual physical contact. RDO-D verified the facility should have investigated R15 and R26's resident-to-resident altercation.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on staff interview and record review, the facility did not ensure a written notification of transfer, including the reason for the transfer, location of the transfer, appeal rights, and contact information for the State Long-Term Care Ombudsman was provided for 1 Resident (R) (R6) of 2 sampled residents reviewed for hospitalization . R6 was not provided a written transfer notice when R6 was transferred to the hospital on 5/12/24. Findings include: The facility's Transfer or Discharge, Facility-Initiated policy states: The transfer .is necessary for the resident's welfare and the resident's needs cannot be met in this facility .Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility .The resident and representative are notified in writing of the following information: the effective date of the transfer .the specific location (such as the name of the new provider .to which the resident is being transferred .an explanation of the resident's rights to appeal the transfer . including the name, address, email and telephone number of the entity which receives such appeal hearing requests, information about how to obtain an appeal form .the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman .A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer .is provided to the resident From 7/29/24 through 7/31/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, diabetes mellitus type 2, chronic kidney disease stage 3, and neuropathic bladder with urinary retention. R6's Minimum Data Set (MDS) assessment, dated 6/22/24, stated R6 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R6 had intact cognition. R6 did not have an activated Power of Attorney for Health Care (POAHC). R6's medical record did not contain a written notification of transfer or notification of the Ombudsman for R6's hospitalization on [DATE]. R6's medical record also did not contain documentation of the reason for the transfer to the hospital or if the information was conveyed to the receiving provider, Surveyor reviewed an Event Report, dated 5/12/24, that indicated R6 had an unwitnessed fall with no injury. The Event Report did not indicate the reason for R6's transfer to the hospital, the date and time of the transfer, the mode of transportation, or communication with the receiving provider. R6 returned to the facility on [DATE] at 12:10 AM via ambulance and had a hematoma to the back of the head that required six staples. R6 was also diagnosed with a urinary tract infection (UTI). On 7/31/24 at 11:30 AM, Surveyor interviewed Regional Director of Operations (RDO)-D who stated RDO-D was not able to locate a transfer or Ombudsman notice for R6's transfer to the hospital on 5/12/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B expects staff to document the reason for a resident's transfer and communication with the receiving provider and provide a written transfer notice to the resident.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on staff interview and record review, the facility did not ensure 1 Resident (R) (R6) of 2 residents reviewed for hospitalization received written information of the duration of the bed hold policy, the reserve bed payment policy, and the right to return to the facility. R6 was transferred to the hospital on 5/12/24 and was not provided a bed hold notice. Findings include: The facility's Bed-Holds and Returns policy, revised October 2022, indicates: All residents/representatives are provided written information regarding the facility and state bed-hold policies which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies .at the time of transfer (or, if the transfer was an emergency, within 24 hours) .The written bed-hold notice provided to the resident/representative explains in detail: the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility, the reserve bed payment policy .the facility's policy regarding bed-hold periods, the facility's per-diem rate required to hold a bed .or to hold a bed beyond the stated bed-hold period and the facility's return policy. From 7/29/24 through 7/31/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, diabetes mellitus type 2, chronic kidney disease stage 3, and neuropathic bladder with urinary retention. R6's Minimum Data Set (MDS) assessment, dated 6/22/24, stated R6 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R6 had intact cognition. R6 did not have an activated Power of Attorney for Health Care (POAHC). R6's medical record indicated R6 was transferred to the hospital on 5/12/24. R6's medical record did not indicate a written bed hold notice was provided to R6 and the facility was unable to locate a copy of the signed bed hold policy. On 7/31/24 at 11:30 AM, Surveyor interviewed Regional Director of Operations (RDO)-D who verified the facility did not provide a bed hold notice for R6's hospital transfer on 5/12/24.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on staff interview and record review, the facility did not ensure Pre-Admission Screen and Resident Review (PASRR) requirements were met for 1 Resident (R) (R22) of 5 sampled residents. R22's medical record indicated R22 had a history of mental illness (MI) or mental disorder (MD) diagnosis upon admission and was prescribed psychotropic medication. R22's PASRR Level I Screen was marked no for major mental disorder, yes for psychotropic medication, and no for history of intellectual disability (ID). The facility did not complete a PASRR Level II Screen when R22 remained in the facility for long-term care. Findings include: According to the State of Wisconsin Department of Health Services (DHS), PASRR is a federal requirement that all applicants to Medicaid-certified nursing facilities be assessed to determine whether they might have an intellectual/developmental disability (ID/DD) and/or mental illness (MI). This is called a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require that they receive additional services for their ID/DD and/or MI. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or MI for PASRR purposes. This is a Level II Screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. Nursing facilities may seek county exemption (DHS form F-20822), for applicants with ID/DD and/or MI whose stay in the facility is expected to be recuperative care or short-term. The facility's Admission Criteria policy, dated March 2019, indicates: .9. All new admissions and readmissions are screened for mental disorder (MD); ID or related disorders (RD) per the Medicaid PASRR process. a. The facility conducts a Level I PASRR Screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for an MD, ID, or RD. b. If the Level I Screen indicates the individual may meet the criteria for an MD, ID, or RD, he or she is referred to the state PASRR representative for the Level II screening process. Between 7/29/24 and 7/31/24, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] with diagnoses including dementia, insomnia, and depression. R22's Minimum Data Set (MDS) assessment, dated 7/3/24, stated R22 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R22 had severe cognitive impairment. R22 had a guardian for healthcare decisions. A PASRR Level I Screen was completed on 10/4/23 and noted R22 had no MD or ID but was prescribed psychotropic medications including trazadone (an antidepressant medication) and Seroquel (an antipsychotic medication). At the time of the survey, R22 had an order for psychotropic medications including escitalopram oxalate (an antidepressant medication, order date 10/4/23), trazadone (an antidepressant medication used for insomnia, order date 4/29/24), and lorazepam (an antianxiety medication). The PASRR Level I Screen also indicated R22 had a 30-day exemption. R22's medical record did not indicate a county exemption was completed and the facility did not obtain a PASRR Level II Screen after R22 remained in the facility past 30 days. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 2:00 PM, Surveyor interviewed Director of Nursing (DON)-B and Licensed Practical Nurse (LPN)-C who verified the facility did not complete a PASRR Level II Screen for R22. LPN-C stated LPN-C spoke to the facility's Social Worker on 7/31/24 who submitted a PASRR Level II Screen on 7/31/24.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32768 Based on staff interview and record review, the facility did not develop a comprehensive plan of care following a smoking assessment for 1 Resident (R) (R25) of 15 sampled residents. R25's plan of care did not address R25's smoking assessment or include interventions specific to smoking at the facility. Findings include: The facility's undated Smoking Policy states: It is the policy of this facility to meet the needs and provide a safe environment for our residents that smoke. Smoking regulations will not be established to restrict the resident's smoking privileges. However, some restrictions will apply. The facility will have designated smoking areas. Smoking will be prohibited in any other area. If it becomes necessary to restrict an individual resident's smoking privileges because of safety and/or medical reasons, such information will be noted on the resident's care plan. Smoking policies will be reviewed with the resident and/or responsible party prior to or upon admission and as needed on an individual basis. This smoking policy includes the use of e-cigarettes. The procedures are the same. On 7/30/24, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] with diagnoses including ataxia, alcohol dependence, nicotine dependence, diabetes, debility, and glaucoma. R25's MDS (Minimum Data Set) assessment, dated 6/5/24, stated R25 required partial or moderate assistance with transfers, toileting and dressing. R25's Brief Interview for Mental Status (BIMS) score was 6 out of 15 which indicated R25 had severely impaired cognition. A smoking risk assessment, dated 7/7/24, indicated R25 was a potential unsafe smoker and included the following information: ~ Careless with smoking materials-drops cigarette/cigar butts or matches on floor, furniture, self, or others; burns fingertips; smokes near oxygen. Moderate problem ~ Begs or steals smoking materials from others. Moderate problem ~ General awareness and orientation including ability to understand the facility safe smoking policy. Moderate problem ~ General behavior and interpersonal interaction. Moderate problem ~ Mobility. Moderate problem ~ Capability to follow facility safe smoking policy. Moderate problem R25's medical record did not contain a smoking care plan. Surveyor requested R25's smoking care plan from Nursing Home Administrator (NHA)-A. When the care plan was provided, Surveyor noted the care plan was dated 7/30/24 (the same day). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 11:32 AM, Surveyor interviewed Director of Nursing (DON)-B who stated R25 did not smoke when R25 was admitted to the facility. DON-B stated when R25 indicated R25 wanted to smoke, staff completed a smoking assessment. DON-B stated the nurse who completed the assessment did not follow through with the care plan which was not completed until 7/30/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50479 Based on observation, staff and resident interview, and record review, the facility did not ensure 5 Residents (R) (R19, R15, R4, R6, and R31) of 6 sampled residents who required assistance with activities of daily living (ADLs) were assisted per their plans of care. R19 was not assisted with meals as indicated in R19's plan of care. R15, R4, R6, and R31 did not consistently receive weekly scheduled showers. Findings include: The facility's Assistance with Meals policy, dated March 2022, states: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident .Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting them with meals. 1. On 7/31/24, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] with diagnoses including dementia and failure to thrive. R19's Minimum Data Set (MDS) assessment, dated 6/16/24, indicated R19 required partial/moderate assistance with the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before R19. R19's medical record contained the following information: ~ A Speech Therapy evaluation and plan of treatment, dated 2/7/24, indicated R19 required repetitive multi-sensory cues for completion of functional skills, was dependent for all ADLs, and fed R19's self with set-up and cuing. ~ A Quarterly Nutrition Assessment, dated 6/13/24, indicated R19 ate at an assisted table for ongoing cuing and encouragement during meals. R19's expected intake was 76-100% of meals. ~ A care plan, dated 7/10/24, indicated R19 was at risk for weight loss, adult failure to thrive, and poor intake. The care plan indicated R19 should be encouraged to eat 75% of meals and provided encouragement during meals. On 7/31/24 at 11:41 AM, Surveyor interviewed Certified Nursing Assistance (CNA)-P who identified seven residents who required assistance with feeding and/or cueing. CNA-P stated CNA-P was typically responsible for feeding two to three residents at a time and indicated there were typically three staff in the dining room to assist residents who required feeding assistance. On 7/31/24 at 12:08 PM, Surveyor observed staff set up R19's meal tray in front of R19 who was seated at a table with five other residents who required feeding assistance. CNA-F and CNA-P assisted all six resident seated at the table. R7 and R19 were seated at opposite ends of the table. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 12:13 PM, Surveyor observed CNA-P sit down next to R19 and assist R19 with one bite of food. CNA-P then walked to R7, sat down next to R7, and assisted R7. On 7/31/24 at 12:15 PM, Surveyor noted there was not a feeding assistant sitting near R19. R19 sat with R19's head down and eyes closed, and did not attempt to eat independently from R19's tray. On 7/31/24 at 12:20 PM, Surveyor observed CNA-P stand up from assisting R7, walk to R19, assist R19 with a second bite of food, and then return to R7. CNA-P did not sit next to R19 when CNA-P assisted R19 with the second bite of food. On 7/31/24 at 12:23 PM, Surveyor observed CNA-P stand up from assisting R7, walk to R19, assist R19 with a third bite of food, and then return to R7. CNA-P did not sit next to R19 when CNA-P assisted R19 with the third bite of food. On 7/31/24 between 12:23 PM and 12:38 PM, Surveyor noted R19 did not attempt to eat independently. On 7/31/24 at 12:39 PM, Surveyor observed CNA-P stand up from assisting R7, walk to R19, assist R19 with a fourth bite of food, and then return to R7. CNA-P did not sit next to R19 when CNA-P assisted R19 with the fourth bite of food. On 7/31/24 at 12:59 PM, Surveyor interviewed CNA-P who stated sometimes CNA-P didn't feel that CNA-P had enough time to feed residents. CNA-P stated CNA-P preferred to sit with residents, but did not always have enough time to do so during meals. CNA-P stated sitting at eye level with residents was the best practice, however, CNA-P felt the need walk between residents during meal time. CNA-P stated CNA-P did not know the facility's expectation/standard for feeding residents. On 7/31/24 at 1:07 PM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B expects one CNA to sit at the table while feeding no more than two residents at a time. 40342 2. On 7/29/24 at 9:38 AM, Surveyor interviewed R15 who stated R15 was supposed to have a shower once per week but frequently missed showers due to short staffing. On 7/30/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. R15's medical record indicated R15 was responsible for R15's healthcare decisions. Surveyor reviewed R15's shower documentation for the thirteen weeks prior to 7/30/24. Surveyor noted R15 did not have shower documentation for four of the thirteen weeks. 3. On 7/29/24 at 9:55 AM, Surveyor interviewed R4 who stated residents did not receive showers for a couple months at the beginning of the year due to short staffing. R4 stated residents were supposed to receive showers at least once per week which did not always happen. R4 stated the concern was discussed at resident council meetings. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease. R4's medical record indicated R4 was responsible for R4's healthcare decisions. Surveyor reviewed R4's shower documentation for the thirteen weeks prior to 7/30/24. Surveyor noted R4 did not have shower documentation for three of the thirteen weeks. The documentation indicated R4 refused a shower another week. Surveyor reviewed the facility's Resident Council minutes which included an entry from the 3/7/24 meeting that indicated: R4 said showers are not being given on schedule, and R4 has not had a shower since 2/12/24. Surveyor reviewed a Grievance Form from R4, dated 4/8/24, that indicated: R4 said R4 asked for a shower and was told it was impossible to do that day. R4 is not getting R4's showers when they are scheduled. 4. On 7/29/24 at 10:49 AM, Surveyor interviewed R6 who stated it was difficult to receive regular showers. On 7/30/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. R6's medical record indicated R6 was responsible for R6's healthcare decisions. Surveyor reviewed R6's shower documentation. Surveyor noted between 4/1/24 and 7/30/24, R6 did not receive showers for five of the sixteen weeks. R6's medical record indicated R6 refused a scheduled shower on 4/19/24 but received a shower on 4/20/24. 5. On 7/30/24, Surveyor reviewed R31's medical record. R31 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus. R31's medical record indicated R31 was responsible for R31's healthcare decisions. R31 was discharged from the facility on 3/28/24. Surveyor reviewed R31's shower documentation. Surveyor noted between 3/7/24 and 3/28/24, R31 received one shower on 3/13/24. R31's medical record contained no documentation of care refusals. On 7/30/24 at 2:37 PM, Surveyor interviewed DON-B who stated R4 preferred a shower twice weekly. DON-B stated no documentation on shower documentation records meant a shower was not provided. DON-B verified R15, R4, R6, and R31 did not receive showers for the weeks indicated above.

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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** 45943 Based on observation, staff interview, and record review, the facility did not ensure 1 Resident (R) (R14) of 1 resident with an indwelling catheter received the appropriate care and services to prevent a urinary tract infection (UTI). During an observation on 7/29/24, staff did not keep R14's catheter drainage bag below the level of the bladder which prevented the flow of urine. Findings include: The facility's Catheter Care, Urinary policy, revised 4/2022, states: Maintaining Unobstructed Urine Flow: 3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. From 7/29/24 to 7/31/24, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] with diagnoses including quadriplegia C5-C7 complete, pressure injury sacral region stage 4, osteomyelitis, neurogenic bowel, diabetes mellitus type 2, extended spectrum beta lactamase (ESBL) resistance, urinary tract infections (UTIs), and neuromuscular dysfunction of the bladder. On 7/29/24 at 11:07 AM, Surveyor observed R14 in bed on R14's left side with the support of Certified Nursing Assistant (CNA)-E. Surveyor noted R14's catheter tubing ran down R14's left leg through R14's pants and R14's empty catheter drainage bag was on the bed. Approximately five minutes later, Licensed Practical Nurse (LPN)-G entered the room and completed a dressing change for R14's coccyx and right buttock. On 7/29/24 at 11:25 AM, CNA-F entered the room to assist with cares. R14's catheter bag did not contain urine at that time. Surveyor interviewed CNA-F who verified R14's catheter bag was lying on the bed at the level of R14's bladder. When CNA-F placed the catheter bag on the bed frame below the level of R14's bladder, urine immediately started flowing into the bag. CNA-F verified the bag should be kept below the level of R14's bladder. On 7/29/24 at 11:28 AM, Surveyor interviewed LPN-G who verified the CNAs put R14's catheter bag on R14's bed when they changed R14. LPN-G verified the bag should be kept below the level of the bladder. On 7/30/24 at 2:32 PM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B expects staff to keep a resident's catheter drainage bag below the level of the bladder when the resident is positioned on their side during cares and dressing changes. DON-B stated leaving the bag on the bed during cares and dressing changes was too long of a period for the bag to be at the level of the resident's bladder.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45943 Based on observation, staff interview, and record review, the facility did not ensure 1 Resident (R) (R20) of 3 sampled residents was offered fluid intake between meals. The facility did not provide fluids to R20 between meals. Findings include: The facility's Resident Hydration and Prevention of Dehydration policy states: .6. Nurse aides will provide and encourage intake of bedside, snack, and meal fluids on a daily and routine basis as part of daily care. From 7/29/24 to 7/31/24, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] with diagnoses including aphasia (the loss or impairment of one's capacity to use or comprehend language), dysphagia (difficulty swallowing), neurocognitive disorder with Lewy body dementia, epilepsy, and Parkinson's disease. R20's Minimum Data Set (MDS) assessment, dated 5/31/24, stated R20's Brief Interview for Mental Status (BIMS) score was 00 out of 15 which indicated R20 was rarely/never understood and had severe cognitive impairment. R20 had an activated Power of Attorney for Healthcare (POAHC). R20's care plan, dated 5/9/24, stated R20 was at risk for weight loss and aspiration related to dementia and Parkinson's disease and was on a general diet with nectar-thick liquids. On 7/29/24 at 10:14 AM, Surveyor interviewed R20's POAHC who stated R20 was supposed to have a pitcher of thickened liquids available. R20's POAHC stated unless R20's POAHC was present, R20 did not receive fluids in the AM. On 7/29/24 at 10:15 AM, Surveyor did not observe thickened liquids in R20's room. On 7/30/24 at 9:42 AM and 1:30 PM, Surveyor did not observe thickened liquids in R20's room. On 7/30/24 at 1:37 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-M and CNA-F who denied they provided R20 with fluids between breakfast and lunch. CNA-F verified there were no thickened liquids in R20's room. On 7/30/24 at 2:00 PM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B expects staff to provide residents with fluids between meals.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45943 Based on staff interview and record review, the facility did not ensure high-risk medications were monitored for 2 Residents (R) (R6 and R19) of 5 residents reviewed for unnecessary medications. The facility did not monitor R6 for side effects or adverse reactions of insulin and bumetanide. The facility did not monitor R19 for side effects or adverse reactions of apixaban and furosemide. Findings include: FDA.gov states drugs approved by the United States Food and Drug Administration (FDA) for sale in the United States must be safe and effective which means the benefits of the drug must be greater than the known risks .Side effects, also known as adverse reactions, are unwanted undesirable effects that are possibly related to a drug. Medline plus.gov states insulin is used to control blood sugar in people who have type 1 diabetes (a condition in which the body does not make insulin and cannot control the amount of sugar in the blood) or in people who have type 2 diabetes (a condition in which the blood sugar is too high because the body does not produce or use insulin normally) that cannot be controlled with oral medication alone. Some side effects of insulin include redness, swelling, and itching at the injection site, weight gain, constipation, rash, and/or itching over the whole body, shortness of breath, wheezing, dizziness, blurred vision, fast heartbeat, sweating, difficulty breathing or swallowing, weakness, muscle cramps, abnormal heartbeat, and swelling of the arms, hands, feet, ankles, or lower legs. Medlineplus.gov states bumetanide is a strong diuretic (water pill) that may cause dehydration and electrolyte imbalance. Side effects of bumetanide include frequent urination, dizziness, upset stomach, diarrhea, ringing in ears, loss of hearing, unusual bleeding or bruising, severe rash with peeling skin, difficulty breathing or swallowing, and hives. Medlineplus.gov states Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form. Side effects include bleeding gums, nosebleeds, heavy vaginal bleeding, red, pink, or brown urine, black tarry stools, coughing up or vomiting blood. Medline plus.gov states furosemide is a strong diuretic (water pill) and may cause dehydration and electrolyte imbalance. 1. On 7/30/24, Surveyor reviewed R6's medical record and noted the following orders: ~ Lantus Solostar U-100 Insulin (Insulin Glargine) insulin pen 100 unit/ml (milliliters); amount 5 units subcutaneous (SQ) once a day in the morning, dated 3/18/24. ~ Humalog KwikPen Insulin (Insulin Lispro) insulin pen 100 unit/ml; amount per sliding scale twice a day morning and evening, dated 4/29/24. (continued on next page)

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Montello Care Center	251 Forest Lane Montello, WI 53949

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Bumetanide 2 mg (milligrams) once a day in the morning, dated 3/18/24. R6's plan of care did not contain monitoring interventions for potential side effects or adverse reactions to insulin or bumetanide. On 7/31/24 at 2:06 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C and Director of Nursing (DON)-B who verified R6's plan of care did not contain monitoring interventions for side effects/adverse reactions to insulin or bumetanide. 50479 2. On 7/30/24, Surveyor reviewed R19's medical record. R19 had diagnoses including hypertension, syncope, and dementia. R19's medical record contained the following orders: ~ Apixaban 2.5 mg tablet by mouth twice a day ~ Furosemide 20 mg tablet by mouth once per day R19's care plan did not contain monitoring interventions for bleeding or other potential side effects or adverse reactions to apixaban. R19's care plan included an order to weigh R19 weekly related to diurectic use. Surveyor reviewed R19's recorded weights and noted R19 had not been weighed for ten of the twenty two preceding weeks. On 7/31/24 at 10:55 AM, Surveyor interviewed DON-B who acknowledged R19's care plan did not include monitoring for bleeding or bruising related to apixaban use. DON-B stated R19's care plan should include monitoring for side effects of apixaban. DON-B also stated DON-B expects staff to weigh R19 weekly as ordered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 32768 Based on staff interview and record review, the facility did not ensure assessment and rationale for psychotropic medications were completed for 3 Residents (R) (R1, R22, and R19) of 5 residents reviewed for unnecessary medications. R1 was prescribed lorazepam (an antianxiety medication) as needed (PRN) three times daily (TID) on 6/20/24. There was no rationale provided for continued use of the medication beyond 14 days. R22 was prescribed lorazepam 0.5 mg (milligrams) 1 tablet twice daily (BID) PRN on 2/7/24. There was no rationale provided for continued use of the medication beyond 14 days. R19 was prescribed lorazepam PRN TID on 6/20/24. There was no rationale provided for continued use of the medication beyond 14 days. Findings include: The facility's Psychotropic Medication Use Policy, dated July 2022, states: A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics .12. Psychotropic medications are not prescribed or given on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days .(1) For psychotropic medications that are not antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. 1. On 7/30/24, Surveyor reviewed R1's medical record. R1 had diagnoses including debility, renal failure, dementia, psychotic disorder, and anxiety disorder. R1's medical record contained an order for lorazepam 0.5 mg TID PRN for anxiety disorder (dated 6/20/24). The order did not contain an end date or a rationale for continued use of lorazepam beyond 14 days. On 7/31/24 at 12:34 PM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B could not find a rationale to indicate why there wasn't an end date for R1's PRN lorazepam order. DON-B verified there should be a rationale for use beyond 14 days or the medication should be discontinued. 45943 2. On 7/30/24, Surveyor reviewed R22's medical record. R22 had diagnoses including dementia, anxiety, depression, and insomnia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's medical record contained an order for lorazepam 0.5 mg twice daily PRN for anxiety disorder (dated 2/7/24). The order did not contain an end date. In addition, R22's medical record did not contain a rationale for the continued use of lorazepam beyond 14 days. On 7/31/24 at 2:03 PM, Surveyor interviewed DON-B and Licensed Practical Nurse (LPN)-C who verified R22's PRN lorazepam order did not contain an end date. DON-B verified there should be a rationale for the use of lorazepam beyond 14 days or the medication should be discontinued. 50479 3. On 7/30/24, Surveyor reviewed R19's medical record. R19 had diagnoses including dementia, metabolic encephalopathy, and generalized anxiety disorder. R19's medical record contained an order for lorazepam 0.5 mg TID PRN for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (dated 6/20/24). The order did not contain an end date. In addition, R19's medical record did not contain a rationale for the continued use of lorazepam beyond 14 days. Surveyor reviewed R19's Medication Administration Record (MAR) for June 2024 and July 2024. R19's MARs indicated R19 had not received any doses of lorazepam in June or July. On 7/31/24 at 10:03 AM, Surveyor interviewed DON-B who acknowledged R19's lorazepam PRN order should have an end date.

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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. 45943 Based on observation, staff interview, and record review, the facility did not ensure medications were stored appropriately for 1 Resident (R) (R4) of 6 residents observed during medication administration. On 7/31/24, Registered Nurse (RN)-N left two bottles of eye drops (fluorometholone and Sil-Optho) and a container of betamethasone valerate topical lotion that were prescribed to R4 and a scopolamine transdermal system 1 mg (milligram)/3 days patch that was not prescribed to R4 on R4's bedside table. Findings include: During an observation of medication administration on 7/31/24 at 6:59 AM, Surveyor observed a bottle of fluoromethalone 0.1 % ophthalmic suspension (a steroid medication used to treat eye inflammation) and a bottle of Sil-Optho eye lubricant (a silicone lubricant made for artificial eyes) labeled with R4's name on R4's bedside table. A scopolamine transdermal system (a medication to decrease secretions to prevent nausea and vomiting) 1 mg/3 days patch was also observed on R4's bedside table. On 7/31/24 at 6:59 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who stated the scopolamine patch did not belong to R4 and LPN-G did not know why the patch was on R4's bedside table. LPN-G stated the medications should not have been left at R4's bedside. On 7/31/24 at 7:03 AM, Surveyor interviewed RN-N who stated RN-N found the scopolamine patch on the floor by the medication cart and put the above medications and patch on R4's bedside table. RN-N verified the scopolamine patch did not belong to R4. RN-N stated RN-N left the medications on R4's bedside table when RN-N became distracted and had to leave the room. On 7/31/24 at 1:30 PM, Surveyor interviewed Director of Nursing (DON)-B who verified medication should be stored appropriately and not left at a resident's bedside. DON-B verified R4 did not self-administer medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48794 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 30 residents residing in the facility. Cooling logs were not completed for leftover foods. A refrigerator that stored food for resident consumption contained dried food debris and a sticky substance on the interior shelves. Food holding temperatures were not monitored or documented. Food items for resident consumption were not labeled with open or expiration dates and/or were beyond the labeled discard date. Findings include: On 7/29/24 at 9:36 AM, Surveyor began an initial tour of the kitchen with the Dietary Manager (DM)-O who stated the facility follows the State and Federal Food Codes. Cooling Logs: The Food and Drug Administration (FDA) Food Code 2022 documents at 3-501.14 Cooling: (A) Cooked Time/Temperature Control for Safety Food shall be cooled: (1) Within 2 hours from 135 Fahrenheit (F) to 70 F; and (2) Within a total of 6 hours from 135 F to 41 F or less. The facility's Food Temperature for Cooling Foods policy, dated 10/2/08, states the facility's policy is to log food temperatures for cooling foods within acceptable times on the Cooling Temperature Log Foods must be cooled from 135 degrees F to 70 degrees F within 2 hours and from 70 degrees F to 41 degrees F within the next 4 hours with the total cooling time not to exceed 6 hours. During an initial tour of the kitchen on 7/29/24 at 9:36 AM, Surveyor observed four containers of leftover food which contained meatballs (dated 7/28/24), chili (dated 7/27/24), hard boiled eggs (dated 7/28/24), and cooked carrots (dated 7/28/24). Surveyor observed the posted Food Temperature for Cooling Foods log, dated July 2024. The log contained one food item listed for the month which was not among the four containers observed in the cooler. Surveyor interviewed DM-O who stated the four containers of leftover food should have been listed on the cooling log. DM-O removed the containers from the cooler and indicated the items should have been discarded. DM-O stated DM-O expects staff to enter leftover food on the cooling log to ensure proper cooling procedures are followed. Cleanliness: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The FDA Food Code 2022 documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. The FDA Food Code 2022 documents at 4-602.13 Nonfood-Contact Surfaces: Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue. The facility's Refrigerators and Freezers policy, with a revision date of November 2022, states the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration .Refrigerators and freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary. On 7/30/24 at 10:19 AM, Surveyor observed the resident snack refrigerator and noted dry sticky debris on all three shelves. Surveyor also observed layers of cardboard food packaging stuck to the refrigerator shelves. On 7/30/24 at 1:36 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated dietary staff are responsible for cleaning the resident snack refrigerator. NHA-A stated kitchen staff do not have a cleaning log for the snack refrigerator. NHA-A stated NHA-A did not know when the refrigerator was last cleaned. On 7/31/24 at 10:02 AM, Surveyor interviewed DM-O and NHA. DM-O confirmed the facility did not have a cleaning log for the resident snack refrigerator. DM-O stated DM-O cleaned the refrigerator within the last month and also cleaned the refrigerator that morning. Food Holding Temperatures: The FDA Food Code 2022 documents at section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding .Time/Temperature Control for Safety Food shall be maintained: (1) At 57 C (Celsius) (135 F) or above, except that roast cooked to a temperature and for a time specified in 3-401.11; (B) or reheated as specified in 3-403.11; (E) may be held at a temperature of 54 C (130 F) or above; (2) At 5 C (41 F) or less. The facility's Temperature Control Through Service Held in Hot Holding Unit policy, dated 10/2/08, states food items will be cooked to the appropriate internal temperature and maintained at 135 degrees F or higher throughout service .Check the temperature for a second time before serving to the next set of residents. If the temperature is below 135 degrees F, reheat food to 165 degrees F for 15 seconds or more and return to hot holding unit. On 7/30/24 at 11:50 AM, Surveyor observed Dietary Manager in Training (DMT)-Q serve the lunch meal and obtain one set of food temperatures. DMT-Q stated staff should check temperatures right away when food is removed from the oven to ensure it is above 165 degrees F. DMT-Q stated food is taken out of the oven 5-10 minutes prior to serving and staff check the temperature one time. DMT-Q stated staff do not check holding temperatures before or after serving to ensure minimum holding temperatures are maintained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/31/24 at 10:02 AM, Surveyor interviewed DM-O who confirmed staff check food temperatures once and do not complete holding temperatures. DM-O stated DM-O will start having staff complete holding temperatures at the end of tray line service to ensure appropriate food temperatures are held. Food Labeling/Storage: The FDA Food Code 2022 documents at 3-501.17 Ready to Eat, Time Temperature Control for Safety Food Date Marking: (A) Except when packaging food using a reduced oxygen packing method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The FDA Food Code 2022 documents at 3-501.17 Commercially processed food open and hold cold: (B) . refrigerated, ready to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in paragraph (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. The FDA Food Code 2022 documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition: (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A) except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). The facility's Food Receiving and Storage policy, with a revision date of November 2022, states food shall be received and stored in a manner that complies with safe food handling practices .All foods stored in the refrigerator or freezer are covered, labeled and dated (use-by date) .refrigerated foods are labeled, dated and monitored so they are used by the use-by date, frozen, or discarded .All foods belonging to residents are labeled with the resident's name, the item and the use-by date. During an initial tour of the kitchen on 7/29/24 at 9:36 AM, Surveyor observed eight icy pops in the freezer that were not in the original container and were not labeled with an expiration or open date. Surveyor also noted cottage cheese in the cooler with an open date of 7/16/24 and no discard date. Surveyor interviewed DM-O who stated the icy pops may have been brought in by a staff member and wouldn't be dated if they were a staff member's. DM-O was unable to confirm if the icy pops were for resident consumption. DM-O verified the cottage cheese was beyond the recommended discard date. On 7/30/24 at 10:39 AM, Surveyor observed six additional icy pops in a freezer on a resident unit that were not in the original container and not labeled with an open, expiration, or discard date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50479 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infection. This practice had the potential to affect all 30 residents residing in the facility. The facility did not maintain monthly and quarterly infection surveillance data. The facility did not implement enhanced barrier precautions (EBP) for 3 Residents (R) (R15, R14, and R11) with a history of multi-drug resistant organisms (MDROs). Findings include: Infection Surveillance: The facility's Infection Control Manual, dated 2019, outlines the facility's procedure for creating monthly and quarterly infection summary reports. On 7/30/24 at 8:56 AM, Surveyor reviewed the facility's infection control binder which did not contain documentation of monthly and quarterly infection surveillance. On 7/30/24 at 9:19 AM, Surveyor interviewed Director of Nursing (DON)-B who was also the facility's Infection Preventionist (IP). DON-B stated the facility did not have monthly or quarterly infection surveillance. DON-B verified monthly and quarterly infection surveillance reports should be created as outlined in the facility's Infection Control Manual. Enhanced Barrier Precautions: The Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment in Nursing Homes to Prevent the Spread of Novel or Targeted Multi-Drug-Resistant Organisms, updated 4/2/24, indicates: Enhanced Barrier Precautions (EBP) expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staffs' hands and clothing. MDROs may be indirectly transferred from resident to resident during high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated when contact precautions do not otherwise apply for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Enhanced Barrier Precautions policy, dated August 2022, states: Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .4. EPS are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with the following: .f. Methicillin-resistant Staphylococcus areus (MRSA); g. Extended-spectrum beta-lactamase (ESBL)-producing enterobacterias; .10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. On 7/29/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] with a history of MRSA infection. R15's medical record did not contain an order for EBP. On 7/29/24 at 9:38 AM, Surveyor noted R15's room did not have a sign that indicated R15 required EBP. On 7/30/24, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] with a history of ESBL resistance. R14 had an open wound and a Foley catheter. R14's medical record did not contain an order for EBP. On 7/30/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] with a history of MRSA infection. R11's medical record did not contain an order for EBP. On 7/30/24 at 2:38 PM, Surveyor interviewed DON-B who confirmed R15, R14, and R11 did not have orders for EBP and were not on EBP. DON-B stated DON-B expects residents with indwelling lines and MDRO colonization to be on EBP. On 7/30/24 at 2:59 PM, Surveyor noted R14 and R11's rooms did not have signs that indicated R14 and R11 required EBP.