STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525662	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morrow Memorial Home	331 S Water St Sparta, WI 54656

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46694 Based on observation and interviews, the facility did not ensure residents (R) were treated with dignity and respect and cared for in a manner to enhance their quality of life during dining. This occurred for 4 (R4, R1, R6 and R40) out of 60 residents. Findings: On 03/27/24 at 8:11 AM, Surveyor observed Registered Nurse (RN) D wipe egg yolk from R4 with the clothing protector. On 03/27/24 at 8:24 AM, Surveyor observed Certified Nursing Assistant (CNA) F standing over R1, feeding R1 applesauce then eggs and talking with CNA G across the table during breakfast meal. On 03/27/24 at 12:08 PM, Surveyor observed CNA E and CNA G sitting and assisting residents with eating during lunch time. CNA G assisted R6 with feeding. CNA E assisted R40 with feeding. CNA G and CNA E were talking across the table with each other instead of the residents they were assisting. On 03/27/24 at 1:35 PM, Surveyor asked CNA F, Is it okay to stand while assisting a resident in the dining room? CNA F replied, Sometimes I stand, I guess I was never told not to. Surveyor asked, Is it ok to talk across the table to other staff while assisting residents in the dining room? CNA F replied, Normally I talk to whoever I am feeding. Surveyor asked, How about using the resident's clothing protector as a napkin if the resident has something like egg yolk or mashed potato on their cheek? CNA F replied, Yes, I usually use the clothing protector to wipe their face clean. On 03/27/24 at 1:38 PM, Surveyor asked CNA E, Is it okay to stand while assisting a resident in the dining room? CNA E replied, Not all of the time sometimes it is. Surveyor asked, Is it ok to talk across the table to another staff member while assisting residents in the dining room? CNA E replied, Yes, it is appropriate. Surveyor asked, How about using the resident's clothing protector to wipe off egg yolk or mashed potato to wipe their face clean? CNA E replied, At first I use a clothing protector because it's right there. On 03/27/24 at 1:41 PM, Surveyor asked CNA G, Is it okay to stand while assisting a resident in the dining room? CNA G replied, No I don't. Surveyor asked, Is it ok to talk across the table to another staff member while assisting residents in the dining room? CNA G replied, Yes, that's ok. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/24 at 8:00 AM, Surveyor conducted an interview with Nursing Home Administrator (NHA) A and Director of Nursing (DON) B regarding the observations below. 1) Staff wipe resident's mouth with clothing protector 2) Staff conversing across the table with each other not focusing on the residents 3) Staff standing over the resident while assisting with feeding. NHA A acknowledged this was not dignified treatment of residents. On 03/28/24 at 8:00 AM, Surveyor asked, What is the expectation for staff when assisting residents with meals. DON B stated, The staff should be treating the residents with dignity and respect and not be standing over the resident.

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F 0580 Level of Harm - 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** 47284 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. This occurred for 1 of 2 residents (R39) reviewed for physician notification and consultation. R39 presented with new symptoms of cardio-respiratory complications in addition to a significant weight gain. Staff did not immediately notify R39's provider of this occurrence resulting in R39 being admitted to the hospital 4/30 - 5/4/23, one week after the start of these symptoms, with a diagnosis of heart failure and atrial fibrillation with RVR (rapid ventricular rate). Findings include: The facility policy, entitled Notification of Change, revision date 7/21, states: .Significant changes in a resident's condition or treatment are promptly .reported to the attending physician or designee .Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident .Requirement of notification of resident's physician: .A significant change in the resident's physical, mental or psychosocial status in either life-threatening conditions or clinical complications .The nurse will notify the resident's physician for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician (utilize Interact 4.0 guidelines and nursing judgement) . The Interact Version 4.0 states: Change in condition: When to report to the MD/NP/PA (Provider) Immediate Notification: Any symptoms, sign or apparent discomfort that is: acute or sudden in onset, and: a marked change (i.e. more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Non-Immediate Notification: new or worsening symptoms that do not meet above criteria . R39 was admitted to the facility on [DATE] with diagnoses that included in part, Crohn's disease, major depressive disorder, hyperlipidemia, Alzheimer's, vascular dementia, cerebrovascular disease, paroxysmal atrial fibrillation post-surgery resolved (2016). 5/4/23: acute pulmonary edema, acute/chronic heart failure (CHF), atrial fibrillation with RVR. R39's provider orders: Prior to 4/30/23 - Aspirin 81mg daily for anticoagulant therapy. R39's provider notes in part: 3/27/23 Primary provider note indicated nursing staff do not report any acute concerns. No recent hospitalization s or ER visits in last year. Patient's weight is stable at 208 pounds. R39's nurse progress notes in part: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	4/17/23 weight 205 pounds standing scale. 4/23/23 at 2:04 AM [R39] came up to the nursing station complaining of not feeling well. Skin is cool, moist and pale. She is able to talk and seems anxious and restless. Hands fly in the air when she tries to say exactly how she feels. Blood pressure elevated 160/93, pulse 95, O2 sat 95% RA, Temp 96.9 with hair wet from sweating. Respiratory rate 28. Given Tylenol and melatonin as she complains she can't sleep. Assisted back to her room and laid down with HOB (head of bead) slight elevated. She [R39] is now fast asleep. Unsure what the cause was. Denies chest pain but did say heavy. Pulse fast but regular. If she woke from a bad dream, anxiety, worry, dementia, unsure will monitor. *Note no provider notification completed. 4/24/23 at 12:55 AM The past two nights, [R39] has talked with the nursing staff about feeling restless and out of sorts. States I am tired but cannot sleep. Note occasional nonproductive cough, fine crackles in upper lung fields. Temperature 96.8, oxygen saturation 94% on room air. Sat at nursing station for 20 minutes. Gave her Tylenol and melatonin to help her rest. Will continue to monitor. Respirations audible wheezing, lung sounds crackles heard upon auscultation upper bilateral lobes, nonproductive cough. Continue to observe, encourage coughing and deep breathing, head of bed elevated, repositioned, encouraged to rest. Covid 19 test done: negative results. *Note no provider notification completed. 4/24/23 at 6:48 AM weight 212 pounds (weekly) standing scale - weighed x 2. *Note a 7-pound weight gain over one week along with two nights of new symptoms of cardio-respiratory complications. No provider notification completed. 4/24/23 at 10:43 AM Pulse 100, respiratory rate 24 and shallow, respiratory findings: shortness of breath or trouble breathing when sitting at rest (on room air), lung sounds: no wheezing noted. Resident on her way to activities like she does every day. I don't know why I am short of breath. *Note no provider notification completed. 4/24/23 at 11:24 PM Shortness of breath noted when talking and when self-propelling in hall. *Note no provider notification completed. 4/29/23 at 12:15 AM [R39] was escorted to nursing station this NOC (night shift) with complaints of chest heaviness and hard time breathing. Patient is being monitored. Blood pressure (b/p) 156/106, pulse 113, temp 96.8, respiratory rate 27. 4/29/23 at 12:25 AM feeling better, [R39] said she felt hot with shortness of breath. b/p 157/94, pulse 120, oxygen saturation 94% on room air. 4/29/23 at 12:35 AM b/p 151/94, pulse 121. 4/29/23 at 12:50 AM b/p 130/88, pulse 111. [R39] feeling better, back to her room with escort. Will monitor. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	*Note no provider notification completed. 4/29/23 at 11:48 PM b/p 137/83, pulse 121, respiratory rate 22, oxygen saturation 92% on room air. Patient requested to see RN (registered nurse), heaviness on chest while laying down and again when up right in her wheelchair. Lung sounds with wheezing bilateral upper lobes. Called on call provider: ordered on time Albuterol nebulizer treatment, if not effective to send to ER (emergency room). After treatment, [R39] stated feeling better, decreased wheezing on auscultation. Will monitor. 4/30/23 at 11:18 AM b/p 142/72, pulse 91, respiratory rate 22. [R39] was coughing quite a bit with breakfast. Dose sound audibly wheezy. Crackles in upper lungs. Denied shortness of breath. Did give her a prn (as needed) dose of cough medication with improved results. Weight is 214 pounds. Bilateral lower extremities with 2-3 + edema. 4/30/23 weight 214 pounds standing scale. Weight gain of 9 pounds from weight on 4/17/23. *Note no provider notification completed. 4/30/23 at 8:43 PM Writer was passing by [R39]'s room this evening and heard resident shouting, Someone help me, I can't breathe. Found resident to be visibly short of breath, resident skin was clammy, and hair was damp. Oxygen at 2 liters per minute started per nursing measure. b/p 183/133, pulse 150, oxygen saturation 97% (taken after oxygen applied), respirations 28. Resident is a full code. Dispatch notified and resident sent to the hospital. Provider and guardian notified. R39 was admitted to the hospital from 4/30/23 through 5/4/23 with a new diagnosis of congestive heart failure and atrial fibrillation with RVR. 4/30/23 Emergency department note indicated R39 was admitted to the hospital with a diagnosis of CHF and atrial fibrillation with RVR. R39 was started on a Cardizem infusion [to control the atrial fibrillation rate], and Lasix [to help remove excess fluid the heart was unable to pump out] injection. Chest Xray indicated central vascular congestion secondary to pulmonary edema with small right sided effusion. BNP (lab test for heart failure) level was 8,386. EKG indicated atrial fibrillation with RVR. 5/1/23 Hospital history and physical note indicated R39's significantly elevated BNP and pulmonary edema are indicative of heart failure likely secondary to her atrial fibrillation. Will continue further evaluation of her ejection fraction via TTE (transthoracic echocardiogram) in the morning and continue to pull off fluid with Lasix for now. 5/4/23 Hospital discharge summary note indicated R39's TTE result stated: the left ventricular internal cavity size was mildly increased. Concentric left ventricular hypertrophy. Moderately decreased left ventricular ejection fraction. Normal right ventricular size and ejection fraction. Left atrium appears severely dilated. Ejection Fraction of 33% and global hypokinesis. Weight at discharge 205 pounds 8 ounces. R39's physician orders post hospitalization on [DATE]: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Eliquis 5mg twice per day for cerebrovascular accident prophylaxis, Digoxin 125mcg daily for atrial fibrillation RVR hold for pulse less than 60, Lasix 20mg daily for chronic heart failure with reduced ejection fraction, Metoprolol ER 100mg twice per day for atrial fibrillation. On 3/26/24 at 1:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN) K and asked what the process for resident weights was if there was a weight increase. LPN K said some of the residents have orders to notify provider if 3 pounds in one day or 5 pounds in one week. Other residents have if the weight was increased, we would re-weigh the resident. If the weight was increased, we would do an assessment to look for edema and lung sounds and notify the provider and my supervisor. Surveyor asked if a resident complained of chest heaviness, restless, vital signs off what would you do. LPN K said she would think cardiac and would assess the resident, get vital signs, and notify the provider and my supervisor. On 3/26/24 at 2:15 PM, Surveyor interviewed RN J and RN H and asked if a resident had an increase in weight, what would be the process. Both RNs said we would reweigh the resident, assess the resident, start the fluid volume overload protocol, and notify the provider to see what to do for the resident. Surveyor asked RN J and H if a resident stated they had chest heaviness, restlessness, and elevated vital signs, what would you do. RN J said she would assess the resident and it all depends on the situation. If it was cardiac or anxiety. If it was only one time and the resident calmed down, there would not be an immediate notification to the provider but notify in the provider notification book. If the symptoms continued, then I would for sure notify the provider. Surveyor asked if R39 had a diagnosis of anxiety. RN J looked at R39's chart and RN H looked at R39's electronic record. Both RNs said R39 did not have a diagnosis of anxiety. On 3/26/24 at 4:11 PM, Surveyor interviewed Director of Nursing (DON) B and asked if a resident had an increase in weight what would be the process if the resident does not have a congestive heart failure (CHF) diagnosis. DON B said we would at least do a routine notify to provider about the weight gain every Monday. DON B looked up to see if this was done for R39 when R39's weight increased from 205 to 212 pounds. DON B said there was no notification to R39's provider. Surveyor and DON B looked at R39's nurse progress notes from 4/23/23 through 4/30/23. Surveyor asked DON B if provider should have been notified based on R39's signs and symptoms and weight gain. DON B said the expectation to notify provider was for the nurse to use their judgement. On 3/26/24 at 4:38 PM, DON B provided Surveyor with the policies and documentation requested. DON B said the only time R39's provider was notified was on 4/29/23 at 11:48 PM when they received an order for an Albuterol nebulizer treatment and again on 4/30/23 at 8:43 PM when R39 was sent to the hospital. On 4/1/24 at 10:40 AM, Surveyor interviewed R39's Medical Doctor (MD) P and explained the weight gain along with the signs and symptoms R39 developed from 4/23/23 through 4/30/23. Surveyor interviewed MD P asking what the expectation was for staff to notify the provider due to weight gain and new cardiac symptoms. MD P said with these symptoms and weight gain we would be concerned about heart attack, heart failure, or atrial fibrillation. When the heart rate was above 100, that would be concerning of atrial fibrillation. Weight gain is tricky, but with the combination of the weight gain and acute symptoms, I would expect the facility to notify the provider right away. MD P said she was not sure why the facility did not notify her or the nurse practitioner who visits the facility regularly concerning R39's weight gain along with acute symptoms. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Surveyor asked MD P what you would have done if notified earlier of R39's weight gain and symptoms. MD P said anything concerning chest pain/heaviness and shortness of breath, we would send the resident out to be evaluated at the emergency department for possibility of heart attack, heart failure, or atrial fibrillation. MD P said she should have been notified when the symptoms started on 4/23/23 and would have sent R39 to the emergency department. Surveyor asked MD P would an earlier notification to you with earlier interventions for R39 result in less damage to the heart. MD P said this was hard to predict because it sounds like a gradual worsening onset. Also, what started first the atrial fibrillation or the heart failure. Atrial fibrillation puts a person at risk for stroke. Surveyor asked MD P how R39's cardiovascular status was now compared to before the hospitalization at the end of April 2023. MD P stated now R39 was prescribed Digoxin and Metoprolol (to control the atrial fibrillation rate), Lasix (to help remove excess fluid the heart was unable to pump out), and Eliquis (a blood thinner to prevent blood clots formed while the heart is in atrial fibrillation as there is a risk for stroke). MD P said R39 continued to be in the atrial fibrillation rhythm but does not currently have any edema or shortness of breath. R39's symptoms were well controlled on the current medications. MD P said she was surprised the facility did not notify her about this and allowed the symptoms to go on for that long. That was unusual for this facility.

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F 0686 Level of Harm - Minimal harm or potential for 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** 47284 Based on observation, interview and record review, the facility did not provide care consistent with professional standards to prevent development of a pressure injury and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for one of one resident reviewed for pressure injuries (R40). R40 developed an unavoidable stage 3 pressure injury while at the facility. Observations of poor infection control occurred during wound care. Findings include: The facility policy, entitled Nursing Skin Protocol, revision date 7/23, states: .Keep bed clean, dry, smooth, and free of [NAME] .The use of clean technique will be assumed for all dressing changes that are not specifically ordered as requiring sterile technique . The facility policy, entitled Hand Hygiene, revision date 7/23, states: .The following is a list of some situations that require hand hygiene: before and after changing a dressing .after contact with a resident's mucous membranes and body fluids or excretions . R40 had diagnoses that include in part dementia, chronic kidney disease (CKD) stage 4, anemia, diabetes, osteoarthritis, gout, hypothyroid, low back pain, pressure ulcer of right heel (upon admit), pressure ulcer of coccyx, chronic obstructive pulmonary disease (COPD), asthma, heart failure, and edema. R40's Minimum Data Set (MDS) assessment, dated 1/24/24, indicated that R40's mobility was substantial/maximal assistance - helper does more than half the effort. R40's Brief Interview for Mental Status (BIMS) score of 00 indicating severe impairment. R40's Care Plan, dated 1/17/24, states: I have a skin injury on my heel upon admission because I am a diabetic, have poor tissue perfusion, have trouble feeling certain sensations, sometimes get confused or can't remember things, can't move around well on my won, lose my balance sometimes and can fall or bump into things. Interventions include: -reduce pressure and friction between myself and my bed or chair, -elevate my heels when I'm lying in bed, -check my skin with cares, -provide me with wound care, -utilize a pressure redistribution cushion on any surface that I sit on, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-provide me with my heel lift cushion in my bed/recliner/chair when my heels may potentially come in contact with any surface, -place an air mattress on my bed 1/29/24 Intervention added: pressure redistribution boot to my RLE (right lower extremity) on at all times except for hygienic cares, skin checks and transfers. 3/20/24 Intervention added: lay me down in bed between meals to offload pressure. Upon entrance to the facility on [DATE], Surveyor observed R40 to have proactive air plus air mattress, air cushion for Broda chair, right heel pressure redistribution boot on at all times with heels elevated with heel lift cushion, and R40 was only up in the Broda chair during meals otherwise R40 was lying in bed offloaded from the coccyx wound and repositioned right to left side at least every two hours. R40's Braden assessments completed upon admit and weekly indicated R40 was high to moderate risk for skin breakdown. R40 was admitted to the facility with a stage 3 pressure injury to the right heel with initial measurement of 6.5 cm (centimeters) x 5.4 cm x 0 with 100% yellow slough with copious amounts of serous and slough like drainage present with scant [NAME] bleeding present, odor noted. Now, on 3/26/24, the right heel pressure injury measured 0.8 cm x 0.8 cm x <0.1 cm a great improvement. R40's general skin condition note dated 1/17/24 stated R40 was admitted to the facility with no open area to coccyx. R40 does have an old scar on the coccyx where she did have an open area at one time. R40 had in place pressure reducing device for chair and bed, receives turning/reposition program, ointments/meds applied, continue to observe, encourage to rest, and reposition. R40's weekly wound assessments were completed at the facility by the wound care nurse for both the right heel and coccyx pressure injuries. These assessments included measurements, description, education provided, interventions, provider, and Power of Attorney (POA) updated, and treatments were updated/changed per the provider orders. R40's had norovirus in Februray causing continuous loose stools, and the need to sit up to prevent aspiration while vomiting. On 2/22/24 an open area noted to coccyx 2 cm x 0.5 cm yellow slough observed to wound bed, no redness/drainage or odor noted. Foam border patch applied, and provider and family notified. With slough present, this wound would be unstageable. Weekly assessments, and frequent physician notification with wound care order changes have been done. On 3/27/24 at 10:35 AM, Surveyor observed Registered Nurse (RN) D and Licensed Practical Nurse (LPN) K perform wound care to R40's coccyx and right heel pressure injuries. RN D performed the care and LPN K helped to hold R40. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Both RN D and LPN K used hand hygiene before donning a gown and gloves. RN D and LPN K then helped to roll R40 onto her left side while LPN K held R40 in position. RN D unsecured R40's brief, laying the brief flat on bed without providing a clean barrier under the wound. R40 at this time had a small amount of soft stool in the brief. The stool was not in the wound, but it was approximately less than two inches away from the coccyx wound. The stool was not cleaned prior to R40's wound care to the coccyx and the brief remained on R40 during the wound care to the coccyx. With the same gloves on, RN D removed the old dressing of Dakin's gauze and foam border dressing, threw this away in the garbage and removed gloves. RN D used hand sanitizer and donned new gloves. The wound to the coccyx was open and appeared dark inside with the peri wound (wound edges) red. The old gauze was covered with brown/gray slough. There was an odor, and RN D said this odor was from the wound. RN D with new gloves on, sprayed wound cleanser inside the wound and used a clean gauze to clean out the wound. RN D threw the gauze away but did not change gloves. RN D then grabbed new gauze and poured Dakin's solution on it, wringed it out and packed the Dakin's-soaked gauze into the wound, with contaminated gloves. RN D then took border foam dressing and applied over the wound. RN D did not change gloves. RN D then started to clean the stool and RN D and LPN K helped to remove the old brief and apply a new one. When completed with cleaning R40, RN D and LPN K removed gloves and gown and performed hand hygiene. On 3/27/24 at 11:05 AM, RN D left the room to get pain medication. On 3/27/24 at 11:10 AM, RN D returned to the room, hand hygiene performed, gown and gloves donned. RN D then gave R40 oral Tramadol for pain. RN D did not remove the gloves she was wearing and then went right away to the right heel and removed the heel protector boot with same gloves on, took scissors and cut the kerlix off, removed the old dressing and threw away. RN D threw away gloves, hand hygiene and new gloves applied. RN D sprayed wound cleanser on the right heel wound and wiped with gauze and threw in garbage. RN D then took the scissors to the sink to cleaned them with soap and water, dried with paper towel and with same contaminated gloves, RN D took the scissors, and cut the needed size calcium alginate with silver and applied to R40's right heel with ABD pad and kerlix. RN D did not change gloves. RN D with the same gloves on, placed tubi-grip (compression sock) to R40's right leg and placed the heel protector back on. RN D then removed gloves and performed hand hygiene. On 3/28/24 at 7:30 AM, Surveyor interviewed Certified Nursing Assistant (CNA) N and asked about what kind of repositioning was done for R40 before the development of the coccyx wound. CNA N said we would reposition R40 at least every two hours before the coccyx wound and after the wound developed, we would offload R40 from the coccyx by laying her down in bed rotating each side keeping R40 off the back. On 3/28/24 at 7:47 AM, Surveyor interviewed RN J and asked if coccyx wound care needed to be done and stool was present, what should be done about the stool. RN J said the stool would need to be cleaned first before doing the wound care. On 3/28/24 at 8:17 AM, Surveyor interviewed RN I and asked if stool was present when going to do a coccyx wound care what would you do. RN I said clean the stool first. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morrow Memorial Home	331 S Water St Sparta, WI 54656

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 8:49 AM, Surveyor spoke with RN D and asked about the stool present during the wound care yesterday and what should have been done. RN D said the dressing was starting to fall off, so I wanted to get the new one on before cleaning the stool. RN D said she wanted the wound to be cleaned and covered before cleaning the stool. On 3/28/24 at 9:00 AM, Surveyor asked DON B how the coccyx wound started for R40. DON B said the coccyx wound started due to the norovirus outbreak we had in February. R40 had multiple incontinent episodes of loose stools and urine, needed to be upright due to vomiting with risk of aspiration and her health status of being unhealthy, low hemoglobin, diabetes, poor perfusion, and progressive dementia. Surveyor asked DON B if the coccyx wound was avoidable. DON B said based on the clinical condition of R40, R40's coccyx wound was unavoidable. We started interventions immediately upon admit for R40 to include air mattress, air Broda chair cushion, toilet plan, reposition every 2 hours and then added offload coccyx area once the wound started. The family/POA wanted comfort cares for R40 and not to be sent out for treatments and to treat only for comfort. We provided education to the family and offered hospice, but they wanted the staff here to treat R40. The provider and POA discussed foley placement to help with wound healing of coccyx and the POA agreed, so we added this for R40. Surveyor advised DON B what observations were seen during the wound care treatment for R40 concerning the glove changes, and stool present during wound care. DON B said the glove changes should have been completed after cleaning the dirty area and applying the clean dressing. DON B said she will need to look at the standards of practice to verify this. DON B asked Surveyor if the observation of RN D with the same glove change process followed for the coccyx wound and the heel wound was observed. Surveyor said yes, the same process was followed. DON B said R40's heel wound has greatly improved even if that process was followed. DON B said concerning the stool present during the wound care that R40 was incontinent of stool and there was no way to prevent stool in a wound of an incontinent resident. On 3/28/24 at 10:00 AM, Surveyor interviewed R40's provider, Nurse Practitioner (NP) M, and the Infection Preventionist RN L. Surveyor asked about the history of R40's coccyx wound. NP M said she believes R40 had a coccyx wound before but would have to look at the records to see. The POA/family have been well educated about risk versus benefits of treatment for R40's coccyx wound, and they understand that they want comfort care. NP M said we did offer hospice care, but R40's POA/family would rather the staff here to care for R40. Surveyor asked how R40 developed the coccyx wound and if the wound was avoidable. NP M and RN L both said R40 developed the coccyx wound due to the norovirus that occurred at the facility in February. R40 had multiple incontinent stool and urine episodes, and R40 needed to be elevated due to vomiting with risk of aspiration. NP M said the coccyx wound was unavoidable due to R40's clinical condition of failing dementia, poor perfusion, diabetes, poor intake, and norovirus. R40 had all the interventions in place with standards of practice followed prior to and after development. We also discussed with POA about foley catheter placement to help with wound healing if okay with the POA. POA agreed, so we implemented this. NP M said R40 was very at risk for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor advised NP M and RN L what observations were seen during the wound care treatment for R40 concerning the glove changes. RN L said concerning the glove changes that staff should have removed the old dressing, cleaned the wound out and then performed hand hygiene and get a new pair of gloves to apply the new dressing.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47284 Based on observation, interview and record reviews, the facility failed to adequately assess and treat pain and provide necessary care and services to attain or maintain the highest practicable physical wellbeing for 1 (R40) of 1 resident reviewed for pain. R40 had verbal (moaning, crying out) and non-verbal expressions of pain during wound care. Staff continued to perform the wound care treatment without doing an adequate pain assessment and waiting for the pain medication to be effective. Findings include: The facility policy, entitled Nursing Skin Protocol, revision date 7/23, states: .Pain levels should be determined during dressing changes and discuss offering resident pain medication prior to dressing changes and update MD (medical doctor) as needed. Nursing and therapy staff may offer non-pharmacologic measures like e-stim, distraction, individualized comfort approaches . The facility policy, entitled Pain Assessment and Management, revision date 7/23, states: .Evaluate if the resident is able to effectively communicate discomfort. If there are concerns with communication or comprehension, look for nonverbal indicators of pain such as: a. Crying, whining, gasping, moaning, or groaning b. Verbalizations of pain (that hurts, ouch, stop) c. Grimacing, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw d. Bracing, guarding, or massaging a body part e. Clutching or holding a body part during movement .Ensure scheduled or prn (as needed) analgesia is offered prior to potentially painful activities (i.e. wound care, ADLs (activity of daily living), transfers). Prior to administering analgesics, discuss and offer nonpharmacological pain relief interventions to resident if applicable . R40 was admitted to the facility on [DATE], and had diagnoses that include in part dementia, chronic kidney disease (CKD) stage 4, anemia, diabetes, osteoarthritis, gout, hypothyroid, low back pain, pressure ulcer of right heel, pressure ulcer of coccyx, chronic obstructive pulmonary disease (COPD), asthma, heart failure, and edema. R40's Minimum Data Set (MDS) assessment, dated 1/24/24, indicated that R40's mobility was substantial/maximal assistance - helper does more than half the effort. R40's Brief Interview for Mental Status (BIMS) score of 00 indicating severe impairment. R40's pain management stated the following: Should pain assessment interview be conducted? Yes, was selected; No (resident is rarely/never understood) was the other option. Pain assessment interview: Pain presence? No was selected; Yes, and unable to answer were the other options. No further questions about pain were answered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's Provider Orders: Tramadol 50mg 1 tab daily for pain and 50mg twice a day as needed for pain start date 1/17/24. Acetaminophen 1000mg twice per day for pain start date 1/17/24. R40's care plan, dated 1/17/24, states: I need to be comfortable because I sometimes hurt and get aches and pains, have arthritis. I show this by grimacing or showing nonverbal signs of pain, becoming impatient/irritable. I need my nurses to ask me if I hurt, distract me with conversation. I need all staff to provide the Standard of Cares for pain. My goal is to maintain a level of comfort that allows me to participate in the activities I want to. Goal date 4/30/24. R40's pain assessments were completed weekly and indicated resident receives scheduled Ultram (Tramadol) daily and twice daily Tylenol. Has chronic pain in her extremities. Has dementia and not able to make her needs known so staff monitor for nonverbal signs of pain. Will note moaning and grimacing with transfers or repositioning. Once settled in bed or recliner or Broda chair she is quiet and does appear comfortable. Review of R40's PRN (as needed) pain medication given the past month indicated the following: *3/17/24 at 11:18 AM Tramadol 50mg given for pain restless, moaning - per son visiting, pain level 3-4, location all over, non-pharmacological intervention attempted: yes. *3/21/24 at 9:33 PM Tramadol 50mg given for pain level 5/10, non-pharmacological intervention attempted: yes repositioning. 10:45 PM med effective. *3/27/24 at 11:25 AM Tramadol 50mg given for pain all over. 2:09 PM med effective resolved no further crying. *3/27/24 at 9:07 PM Tramadol 50mg given before treatment. 9:41PM med effective. *3/28/24 at 10:36 AM Tramadol 50mg given for pain and pretreatment to make her comfortable. 11:40 AM med effective resting. R40's provider note dated 3/27/24 stated, .Staff report she has been crying out in pain with transfers or dressing changes of her sacral ulcer. Pain seems transient and she quickly settles back to normal. Current pain regimen is 50mg Tramadol every morning and 2 times daily as needed. They are giving this 2 times with dressing changes . On 3/27/24 at 10:35 AM, Surveyor observed Registered Nurse (RN) D and Licensed Practical Nurse (LPN) K perform wound care to R40's coccyx and right heel pressure injuries. RN D performed the care and LPN K helped to hold R40. R40 started to whimper and sounded like she was in pain. R40 was unable to verbalize needs. Surveyor asked RN D if R40 had any pain medication today. RN D said she had given R40 pain medication during morning med pass. RN D continued with the wound care. LPN K spoke with R40 to help calm her down and to notify of what was going on, but R40 continued to increase her moaning and crying out. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Review of R40's Medication Administration Record (MAR), Tramadol and Tylenol were given at 9:00 AM before the wound care treatment.) Once the wound care to the coccyx was complete, RN D then started to clean the stool. R40 continued to cry and make sounds that she was in pain. RN D and LPN K helped to remove the old brief and applied a new one. R40 started to cry out even more and her face was with mouth frowned and she appeared in much pain with tense body. LPN K suggested to RN D, let's let R40 rest as it was close to lunch time, and we can do the heel wound later because R40 was crying in pain. RN D said no, I want to finish the heel wound dressing change because the surveyor was here to see it and wants to see it done and we are here ready to do it. Surveyor told RN D that we can do the heel wound at a later time to let R40 rest. RN D said no we need to get it done. LPN K said again to RN D we should let R40 rest, and that the Surveyor was willing to wait to see the dressing change to R40's heel at a later time. Surveyor again said to RN D we can wait as R40 was in pain. RN D then said, I will get R40 some pain medication and RN D left the room at 11:05 AM. LPN K attempted to console R40 as she was crying out with visible facial grimacing noted. At 11:10 AM, RN D returned to the room with the PRN pain medication tramadol and then gave R40 the oral tramadol for pain. RN D then went right away to the right heel and removed the heel protector boot, cut the kerlix off, removed the old dressing and started with the wound care. R40 was making noise in pain, moaning, and crying during this procedure with tense body and facial grimacing. RN D said to R40 you just had a pain pill you will be okay. After a moment, RN D asked if R40 would like lunch. RN D stated lunch will be here soon. After another moment, RN D asked R40 what's the matter, what can I do for you. Remember I gave you an extra pain pill. RN D then placed tubi-grip (compression sock) to R40's right leg and placed the heel protector back on. R40 continued to moan, grimace, and cry out in pain during all of this. When RN D was completed working with R40 at 11:20 AM, Surveyor asked RN D if R40 was in pain during the wound care changes. RN D said R40 was more in pain than normal so that's why she went to get the PRN pain medication. Surveyor asked RN D if R40 was able to verbalize her pain by speaking. RN D said no, R40 was unable to verbalize pain, but does makes noises or facial grimaces to indicate pain. On 3/27/24 at 1:35 PM, Surveyor interviewed Certified Nursing Assistant (CNA) F and asked if they had witnessed R40's response during wound dressing changes. CNA F said R40 tenses up and sometimes tries to roll back while holding her. On 3/27/24 at 1:38 PM, Surveyor interviewed CNA E and asked if they had witnessed R40's response during wound dressing changes. CNA E said it looks painful. On 3/28/24 at 7:30 AM, Surveyor interviewed CNA N and asked if R40 had any pain during wound care treatments. CNA N said yes R40 had pain with any movement but with wound care it was worse, you can really tell a difference between regular pain compared to wound care pain. Surveyor asked what the nurses did when they saw R40 in pain during wound care. CNA N said some nurses will make sure the pain medication was given, some will wait and be gentle, others will just get the wound care done and not stop to address R40's pain. Surveyor asked CNA N what RN D did for pain when doing wound care for R40. CNA N said RN D was the worst at this. CNA N said RN D does not stop and just continues to work through the wound care while R40 was crying out in pain during the wound care treatments. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 7:47 AM, Surveyor interviewed RN J about what pain scale the facility used for nonverbal residents. RN J said we use the FACES pain scale. Surveyor asked RN J what you would do if a resident who was nonverbal appeared to be in much pain with calling out and facial grimacing during a coccyx wound change that was completed and still needed to do heel wound care. RN J said she would see if a PRN pain medication could be given and allow time for it to work, give resident a rest and help comfort her and then come back to the other wound once pain was under control and medication working. On 3/28/24 at 8:17 AM, Surveyor interviewed RN I and asked if a resident was nonverbal in pain after wound care and another wound needs to be completed, what would you do. RN I said they would give resident a break and help her to be comfortable before doing another wound care. On 3/28/24 at 8:49 AM, Surveyor spoke with RN D and asked what pain level used for nonverbal resident. RN D said FACES pain scale. Surveyor asked RN D what level R40's pain was at yesterday during the wound care Surveyor observed. RN D said I would say at least a 6. RN D said she spoke with the provider yesterday who said it was okay for R40 to have a PRN pain medication before the wound treatment and that was what RN D will do today for the wound care. On 3/28/24 at 9:00 AM, Surveyor interviewed Director of Nursing (DON) B concerning what pain scale was used for a resident who was non-verbal. DON B said they would use FACES pain scale. Surveyor advised DON B what observations were seen during the wound care treatment for R40 concerning pain. DON B said R40 was getting scheduled tramadol for pain as R40 doesn't swallow well and that small amounts of scheduled medications would be better than having PRN medications also. R40's provider visited and said it was okay to give PRN pain medication prior to wound care. DON B said the resident's pain should have been addressed and not complete the wound care just for the surveyor to observe. Surveyor reiterated that yes, residents come first and that was why Surveyor agreed with LPN K that the wound care of the heel could wait. Surveyor asked DON B when does oral tramadol start to work. DON B said she would have to look it up to be exact, but a good rule of 30-60 minutes for it to start to be effective. On 3/28/24 at 10:00 AM, Surveyor interviewed R40's provider, Nurse Practitioner (NP) M, and the Infection Preventionist RN L. Surveyor advised NP M and RN L what observations were seen during the wound care treatment for R40 concerning pain. NP M asked if R40 was consistently being in pain during wound care treatments and was wondering if a short acting pain medication would better suit this situation. NP M thanked the surveyor for bringing this to her attention and will look into and discuss with R40's POA (power of attorney) the possibility of trying a different medication for comfort. Surveyor asked when tramadol would start to take effect. RN L looked up tramadol in the medicine nurse handbook and stated the onset time was one hour and peak at two hours. On 3/28/24 at 12:15PM, Surveyor spoke with NP M after assessing R40. NP M said she had written an order to start Ativan and Morphine for R40 if it was okay with R40's POA. The creator of the Wong-Baker FACES pain scale states, This self-assessment tool must be understood by the patient, so they are able to choose the face that best illustrates the physical pain they are experiencing. It is not a tool to be used by a third person, parents, healthcare professionals, or caregivers, to assess the patient's pain. There are other tools for those purposes. The facility utilized this scale for R40's pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pain Assessment in Advanced Dementia (PAINAD) scale is a tool used to determine pain by having the nurse assess the resident concerning five categories: breathing independent of vocalization, negative vocalization, facial expression, body language and consolability. This assessment was more appropriate to be used to assess R40's pain but was not utilized by the facility to determine more accurate pain assessments for R40.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43352 Based on interview and record review, the facility did not ensure 1 of 3 residents (R) R5's drug regime was free from unnecessary medication use without adequate indications for use for an antibiotic. Findings include: R5 was admitted to the facility on [DATE], with diagnoses that include pneumonia, acute and chronic respiratory failure, and hyperthyroidism. Record review reveals a doctor's order on 12/15/22 for Nitrofuration Monohyd Macro (an antibiotic)100 mg cap by mouth daily 0800 for uninary tract infection (UTI) prophylaxis. On 03/28/24, Surveyor reviewed R5's chart and could not find a rationale for the indication for use of a prophylactic antibiotic or that the pharmacists had made any recommendations on the long term use of the antibiotic stating this medication was needed. The physician progress notes were reviewed and include information that R5 is on comfort cares, with comfort focused treatment. The physician documents medications were reviewed and reconciled. The physician progress notes do not include a detailed evaluation of mental, physical, functional, psychosocial benefit, or comorbid conditions that describe adequate indication for the continued use of the antibiotic. On 03/28/24 at 11:55 AM, Surveyor interviewed Registered Nurse (RN) D and asked if R5 took a prophylactic antibiotic. RN D indicated that R5 has been taking the antibiotic for as long as RN D has been working with R5. Surveyor asked if the facility had ever looked at removing the antibiotic. RN D indicated that R5 does not like change. On 03/28/24 at 1:10 PM, Surveyor interviewed RN L and asked if there was a clinical rationale for R5 to be on a prophylaxis antibiotic. RN L indicated that R5 had a hysterectomy, ovarian cyctectomy and has urogenital implants. Surveyor asked if the facility ever considered discontinuing the antibiotic. RN L indicated, no. RN L stated the facility emailed the pharmacists today about reviewing the antibiotic as there is no evidence the medication is needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47657 Based on random 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 and help to prevent the development and transmission of communicable diseases and infections for 2 residents (R) (R60 and R21) Example 1 Facility policy titled, Hand Hygiene, reviewed 07/2023, The following is a list of some situations that require hand hygiene: .Before and after wearing gloves . On 03/26/24 at 6:49 AM, Surveyor observed Certified Nursing Assistant (CNA) C, provide incontinence care for R60. CNA C conducted hand hygiene and donned a pair of clean gloves, removed incontinent product, provided incontinence care and proceeded to do the following: apply barrier cream to abdominal folds, apply clean brief, placed mechanical sling under R60, applied deodorant, picked up a emery board off of floor, positioned lift towards resident, hooked sling to lift and using controls turned on and positioned resident to recliner, unhooked and removed sling. No observation of changing gloves and conducting hand hygiene was observed as CNA C moved task to task with contaminated gloves. On 03/28/24 at 8:58 AM, Surveyor interviewed CNA C regarding expectation of hand hygiene between glove changes. CNA C stated training did not include hand hygiene between glove changes. 46694 Example 2 On 03/26/24 at 6:41 AM, Surveyor observed CNA E and CNA G perform morning cares on R21. Proper hand hygiene was performed, and Personal Protective Equipment (PPE) was donned, as this resident has a catheter and is on transmission-based precautions. CNA E cleaned R21's upper body without any issues. R21's pants were removed and catheter pulled through the pant leg by CNA E. CNA G put the catheter through the new pant leg. CNA E cleaned the peri area with new washcloth and then dried. R21's attends tucked, and resident rolled onto the right side. Dirty attends taken out from under R21. R21's buttocks were cleaned and dried. CNA E removed the dirty gloves, put on new gloves without using hand hygiene between glove changes. CNA E then applied skin barrier cream on R21's buttocks, put on a new incontinent product, pulled up R21's sweatpants, while rolling R21 to the left side. CNA E then placed the Hoyer sling under the resident. CNA E removed the dirty gloves and put on new gloves without performing hand hygiene between glove changes. CNA G brought the Hoyer lift to the resident's bedside. Hoyer sling attached to the Hoyer and both CNAs assisted R21 into the wheelchair. CNA E removed gloves and put on new gloves without hand hygiene between glove changes. CNA E then wiped left down with sanitizer wipes. Both CNAs performed hand hygiene after removing their gloves and exiting the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/24 at 8:00 AM, Surveyor interviewed Director of Nursing (DON) B, explaining the observations made during morning cares on R21 with no hand hygiene between gloves changes. DON B stated, This should not be. The staff should all know that hand hygiene is the standard of care. On 03/28/24 at 8:47 AM, Surveyor asked CNA F, What do you do just before putting on gloves or immediately after taking off your gloves? CNA F replied, I would use hand sanitizer.