STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525678	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careview Health and Rehab of Minocqua	9969 Old Hwy 70 Rd Minocqua, WI 54548

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility did not immediately report to the resident's physician when a resident had difficulty breathing and was transferred via Emergency Medical Services (EMS) to the Emergency Department (ED). This occurred for 1 of 1 resident (R) reviewed, (R21). Findings include: R21 was admitted to the facility on [DATE] with diagnoses including in part, congestive heart failure, atherosclerotic heart disease, essential hypertension, edema, non-ST elevation myocardial infarction, and dilated cardiomyopathy. On 10/01/24 at 6:45 AM, Surveyor noticed R21 not in R21's room. Surveyor interviewed Registered Nurse (RN) F and asked where R21 was as Surveyor did not observe R21 in R21's room. RN F indicated that R21 had been having some shortness of breath and difficulty breathing the last few days and was finally sent out in the middle of the night via EMS. Review of R21's medical record identified the following note: - .On 10/01/24 at 1:39 AM, Resident sent to Hospital ED for difficulty breathing. Hospital returned update with resident being sent out related to myocardial infarction . Surveyor reviewed 24-hour report/change of condition report sheets for 09/19/24 and 09/23/24 and R21 was not listed to follow up with labs or change in condition. Record review identified no other documentation found that facility notified physician of R21's transfer to the ED. On 10/02/24 at 2:34 PM, Surveyor interviewed Nurse Practitioner (NP) H and asked NP H to explain the events that led up to R21's admission to the hospital. NP H indicated that it wasn't until today on 10/02/24 at 8:55 AM that NP H was notified of R21's condition and transfer to the ED which led R21 to be admitted to the hospital. NP H indicated that NP H cannot give Surveyor any more information as NP H is still unclear what transpired with events leading to R21's transfer to the ED. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 3:14 PM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B knew why NP H was not notified of R21's disposition of not feeling well and the transfer to the ED. DON B indicated that DON B would look in R21's chart to see if physician or someone was notified. After looking through the Electronic Health Record (EHR) and the call log system that provides physicians' notifications, DON B could not find that NP H was contacted until 10/02/24 at 8:55 AM. DON B indicated there was no notification to any providers of R21's change of condition and transfer to the ED. Surveyor asked DON B what the expectation is for updating the physician of change in condition and notifying the physician of a transfer out. DON B indicated that DON B's expectation would be the standards of practice, which is that the physician is notified within 15-30 minutes of change in condition and for further direction. DON B indicated that the nurse on should have contacted a physician with R21's change in condition and informed nurse was sending R21 to the ED.

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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** 44863 Based on record review and interview, the facility did not conduct a Preadmission Screening Resident Review (PASRR) Level II screen for R7, who has a serious mental disorder and is taking psychotropic medication to treat symptoms of major mental disorder to ensure he received care and services to meet his needs. The facility practice affected 1 of 3 residents (R7) reviewed. This is evidenced by: 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. This is a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require they receive additional services for their ID/DD and/or mental illness. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or mental illness 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 mental illness whose stay in the facility is expected to be recuperative care or short-term. R7 was admitted on [DATE] with diagnoses that include schizoaffective disorder. R7 was prescribed the following psychotropic medications: Haldol, ziprasidone, and sertraline. On 10/26/23, a Level I PASRR screening noted R7 had a major mental disorder and has taken psychotropic medications to treat symptoms or behaviors of a major mental disorder, indicating a Level II PASRR should be completed. On 10/26/23, form F-20822 was completed, indicating R7 had a mental illness, and nursing facility placement was recommended with short term exemption from a Level II screening. The options for short-term exemptions are: -Hospital Discharge Exemption (30 day maximum) -Emergency Placement (7 day maximum) -Respite Care (30 days per year maximum) There was no option for short-term exemption chosen on form F-20822. Per form F-20822, The person may need nursing facility placement beyond the permitted timeframes of the short-term exemptions, Level II screening is required. Surveyor reviewed R7's record and could not locate a Level II PASRR screening. On 10/01/24 at 11:33 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A confirmed a Level II PASRR was not completed for R7.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice (N6 Wisconsin Nurse Practice Act,) the comprehensive person-centered care plan, and the resident's choice for 2 of 12 sampled residents (R6 and R21.) R21 did not have comprehensive Congestive Heart Failure (CHF) assessments completed or labs completed to determine worsening CHF. R21 was hospitalized with exacerbation of CHF and Non-ST segment elevation myocardial infarction. This example is cited at actual harm. R6 has multiple non pressure wounds that were not assessed weekly and had missed wound care appointments. Findings include: Example 1: According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. R21 was admitted to the facility on [DATE] with diagnoses including in part, congestive heart failure, atherosclerotic heart disease, essential hypertension, edema, non-ST elevation myocardial infarction, dilated cardiomyopathy, diabetes mellitus type 2 with underlying condition with foot ulcer, and cellulitis of right and left lower limb. R21's Minimum Data Set (MDS) assessment, dated 05/15/24, identified R21 required substantial maximal assistance for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. On 09/30/24 at 10:17 AM, Surveyor observed Certified Nurse Assistant (CNA) G enter R21's room. CNA G stated to R21, Oh you look better today. I know you have not been feeling well the last few days. R21 stated to CNA G, I feel a little bit better this morning but still having shortness of breath, maybe it's just anxiety. CNA G then indicated to R21 that CNA G was just checking to see if R21 needed anything. R21 declined needing any services at the time. On 09/30/24 at 10:25 AM, Surveyor interviewed R21 who indicated that R21 had been feeling cruddy last few days with some shortness of breath and nausea but seemed to not be nauseated this morning. On 10/01/24 at 6:45 AM, Surveyor noticed R21 not in R21's room. Surveyor interviewed Registered Nurse (RN) F and asked where R21 was as Surveyor did not observe R21 in R21's room. RN F indicated that R21 had been having some shortness of breath and difficulty breathing the last few days and was finally sent out in the middle of the night on 09/30/24 into early morning 10/01/24 via EMS. Review of R21's medical record identified the following note, which stated in part: -On 09/19/24 at 12:47 PM, [Nurse Practitioner (NP) H] had provider visit with [R21]. Facility staff had concerns with [R21] complaining of shortness of breath. [NP H] recommended to continue monitoring for signs of fluid overload or decompensated heart failure. [NP H] ordered Basic Metabolic Panel (BMP) and B-type Natriuretic Peptide (BNP) today. -On 09/19/24 at 2:45 PM, nurse note indicates monitor for fluid overload, increased edema, shortness of breath, abnormal lung sounds, update provider if changes noted every shift for Congestive Heart Failure (CHF), [NP H] ordered Metolazone 2.5mg started today and continues for 3 days. Recheck BMP and BNP on 09/23. -On 09/19/24 at 3:19 PM, nurse note indicates new order for metolazone, and follow up labs due to edema. Resident updated and aware. -On 09/23/24 at 10:51 AM, nurse note indicates one attempt of left hand unsuccessful. Resident tolerated well. Will attempt later. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 09/23/24 at 5:16 PM, nurse note indicates BMP and BNP one time only for monitoring for 2 days. Unable to collect. -On 09/30/24 at 6:35 AM, Ipratropium-Albuterol solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally every 6 hours as needed for wheezing, shortness of breath given for complaint of dyspnea. -On 09/30/24 at 7:36 AM, Ipratropium-Albuterol solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally every 6 hours as needed for wheezing, shortness of breath effective, sp02 99-100% pre and post nebulizer, lungs with no adventitious sounds, respirations 18 even and relaxed. - On 10/01/24 at 1:39 AM, Resident sent to Hospital ED for difficulty breathing. Hospital returned update with resident being sent out related to myocardial infarction . Surveyor reviewed hospital note that stated in part: On 09/30/24 9:39 PM, [R21] stated [R21] has had increasing shortness of breath at rest over the last few days with some intermittent episodes of substernal chest pain. [R21] is found to have an Non-ST segment elevation myocardial infarction (N-STEMI) and CHF exacerbation. [R21] was then transferred to a higher level hospital for cardiac care. Surveyor reviewed all progress notes and assessments in R21's medical record and found no CHF assessments completed. Interviews: On 10/02/24 at 8:59 AM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B knew why R21 had not had labs drawn for monitoring CHF as ordered from NP H on 09/23/24. DON B indicated the day nurse on 09/23/24 could not draw the lab and the nurse had reported this to the night shift nurse. DON B indicated that then the night nurse attempted and could not draw lab. DON B indicated it was not relayed in report to the next day shift, and the lab was cancelled. DON B indicated that R21's labs were not completed. On 10/02/24 at 2:15 PM, Surveyor interviewed Registered Nurse (RN) F and asked what events led up to R21 being hospitalized on [DATE] in the early hours. RN F indicated that RN F did not know much about the transfer other than R21 had to request to the night nurse that was on that R21 needed to go to the hospital as R21 was having a hard time breathing. Surveyor asked RN F to explain what a CHF assessment is and does RN F complete the CHF assessments regularly. RN F indicated that RN F listens to lungs, heart, and takes vitals. RN F monitors for edema and monitors weights daily. Surveyor asked RN F if the CHF assessments have been being completed and where they are documented. RN F indicated they should be getting done and would need to review R21's medical record to see if RN F documented this. RN F reviewed documentation and indicated that when R21 is having shortness of breath and RN F does not to a CHF assessment, RN F documents when a nebulizer treatment is given that there is shortness of breath noted and if it is effective or not. RN F indicated there is no comprehensive CHF assessment documented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/02/24 at 3:14 PM, Surveyor interviewed DON B and asked what DON B's expectation is for monitoring CHF for residents. DON B indicated that residents should be weighed daily, and a full head to toe assessment should be completed which entails heart sounds, lung sounds, edema, and vitals. Surveyor asked DON B to review R21's medical record and show Surveyor the CHF assessments. DON B reviewed R21's medical record and stated, [R21] does not have any completed at all. Not even a change in condition related to breathing issues or notification to physician of the change in [R21's] status. No further documentation was given. 44863 The facility's policy titled Skin Integrity, Pressure Injuries Nursing Protocol, read in part .The resident will receive care, consistent with professional standards of practice, to prevent pressure injuries and will not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and the resident with pressure injuries will receive necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers from developing. A. Identify if the resident is at risk for developing pressure injury on admission and thereafter. D. If a pressure injury is present, provide treatment to heal it and prevent development of additional pressure injuries. R6 was admitted to the facility on [DATE], with deep tissue injury (DTI) to left heel. R6's diagnoses included type 2 diabetes mellitus, polyneuropathy, peripheral vascular disease, dependence on renal dialysis, and amputation of right lower leg. R6's physician orders included, To left heel and foot: If dressing becomes dislodged/soiled: Cleanse with soap and warm water, Cleanse with wound cleanser. Apply aquacel ag and adhesive foam, and secure with gauze roll and elastic bandage wrapped lightly. Keep heel suspension boots on at all times. R6's record did not contain a comprehensive skin assessment upon admission. On 09/26/23, a comprehensive skin assessment was completed on R6. The next comprehensive skin assessment was completed 14 days later, on 10/10/23. On 10/17/23, a comprehensive skin assessment was completed. The next comprehensive skin assessment was completed 14 days later, on 10/31/23. R6's comprehensive skin assessments were completed timely through 12/08/23, when R6 was referred to wound care clinic. The facility did not provide comprehensive skin assessments for R6 after 12/08/23. On 12/15/23, the wound care clinic ordered a podiatry referral and an arterial blood flow study to determine healing ability of R6's wound. R6's record did not contain evidence R6 was referred to podiatry or arterial blood flow study. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/05/24, R6 attended wound care clinic for treatment of left heel DTI; no measurements of this wound were completed at the appointment. Wound care clinic documentation indicated R6 developed two additional wounds to his left anterior foot and left lateral foot. The documentation is not specific to indicate if these wounds are pressure, vascular, or diabetic related. The facility did not complete a comprehensive assessment of R6's wounds. On 01/19/24, R6 attended wound care clinic for treatment; no measurements of wounds were completed at this appointment. The facility did not complete a comprehensive assessment of R6's wounds. On 01/30/24, R6 attended wound care clinic, with a note to return on 02/02/24. R6 did not attend wound care clinic until 02/06/24, four days after he was scheduled to attend. R6's treatment administration record confirmed the facility did not provide dressing change or treatment between 01/30/24 and 02/06/24. On 02/09/24, R6 was hospitalized for abscess on left foot. R6 was readmitted to the facility on [DATE]. On 02/12/24, R6 was hospitalized for multiple necrotic wounds of left foot. On 02/22/24, R6 required a left below the knee amputation. R6 was readmitted to the facility on [DATE]. On 09/30/24 at 10:26 AM, Surveyor interviewed R6. During the interview, R6 rolled his eyes and sighed when asked questions, but he denied any concerns related to his care. R6 confirmed he had wounds to both bilateral legs resulting in amputations, stating the wounds were from his diabetes. R6 confirmed he attended wound care clinic for treatment of his wounds, and denied any concerns related to transportation to appointments. R6 confirmed he had a wound on his buttocks, but it has healed. R6 reported his only skin concern was he had eczema and confirmed staff provide a topical treatment. On 10/02/24, Surveyor interviewed wound care clinic nurse. Nurse reported R6's wounds and amputation were unavoidable due to R6's co-morbidities, including poor wound healing related to diabetes and vascular disease. 10/02/24 at 1:35 PM, Surveyor interviewed DON B. DON B confirmed R6's wounds and amputation were unavoidable related to his co-morbidities and his non-compliance of interventions. DON B confirmed comprehensive skin assessments should be completed within 24 hours of admission, and residents with wounds should be assessed weekly. The facility expectation is assessments be comprehensive and include measurements, description, and location. DON B confirmed there was not a comprehensive skin assessment completed upon R6's admission, and not until 09/26/24, four days after admission. DON B reported if a wound care appointment is missed, the expectation is staff call the wound care clinic for direction; if the resident has a PRN (as needed) order, staff can complete the treatment if directed to do so by wound care clinic. DON B confirmed the facility did not complete PRN treatment orders for R6. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/02/24, Surveyor requested documentation to support R6's provider was updated with wound changes, concerns, or missed appointments; the facility did not provide further documentation. DON B confirmed she could not find evidence of this in R6's record. On 10/02/24, Surveyor requested additional documentation related to podiatry and blood flow studies; the facility did not provide further documentation to support R6 attended these appointments.

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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** 48793 Based on observation, interview and record review, the facility did not ensure that 1 of 1 resident (R) reviewed for pressure injuries (PI) (R21) received care consistent with professional standards of practice to promote healing of PIs. R21 was at risk for PI development and has existing PIs. The facility failed to apply purple boots for off-loading heels as ordered and did not do thorough admission and weekly PI skin assessments. Findings include: R21 was admitted to the facility on [DATE] with diagnoses including in part, congestive heart failure, atherosclerotic heart disease, diabetes mellitus type 2 with underlying condition with foot ulcer, cellulitis of right and left lower limb, edema, non-ST elevation myocardial infarction, and dilated cardiomyopathy. R21 was admitted with 7 pressure injuries and facility did not identify location, sizes, or stages and is unclear determining the condition of the pressure injuries on admission. R21's Minimum Data Set (MDS) assessment, dated 05/15/24, identified R21 required substantial maximal assistance for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. MDS indicated that R21 was at risk for PIs. Surveyor reviewed R21's activities of daily living care plan initiated on 05/08/24 and revised 05/13/24, in part: -Impaired skin risk is at risk, update the nurse with any signs for skin breakdown. Lotion skin with cares initiated on 05/08/24. -Pressure relief: Roho cushion to wheelchair, purple boots to bilateral feet at all times initiated on 05/24/24 and revised on 07/12/24. -Repositioning: assist of 1-2 as needed, right and left enabler bars initiated on 05/08/24 and revised on 07/12/24. Surveyor reviewed R21's pressure ulcer care plan initiated on 05/08/24 and revised 09/30/24, in part: -Administer treatments as ordered and monitor for effectiveness initiated on 05/30/24. -Followed by wound clinic initiated on 06/27/24. -Purple heel protector boots on at all times initiated on 05/30/24 and revised on 07/09/24. -Resident needs to turn/reposition at least every 2 hours, more often as needed, or requested initiated on 05/30/24 and revised on 06/27/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed physician orders include: .-On 08/12/24, Complete skin only evaluation /assessment weekly every shift every Monday for weekly skin check . Surveyor reviewed Wound Care Clinic notes and nurse progress notes. On 05/08/24, admission skin assessment documented 2 ulcers to left leg dressings dry and intact wound care to follow in am, left heel ulcer dressings dry and intact wound care to follow in am, right foot ulcer dressings dry and intact wound care to follow in am. No PI documentation of measurements or description of condition was noted by the wound clinic to determine the exact location or stages to determine deterioration of each PI. On 05/08/24, a Braden assessment completed. Resident scored 13 at moderate risk for pressure injuries. Wound clinics note stated: in part: On 05/09/24 indicated that R21 had: -posterior right heel wound measures 3.2x2.3x0.4cm. -left posterior heel wound no measurements noted. -Right lateral foot measuring 4x2.3x0cm. Wound clinic ordered: -Nursing staff to change dressing for soilage, saturation or rolling of edges. - Nursing staff to provide continuous pressure relief to heels, coccyx, and other bony prominences. -Avoid pressure to the heel by applying heel suspension boots. Nurse progress note stated: in part: On 05/09/24, indicated R21's right lateral foot, dressings to remain in place, change only of soilage, saturation, or rolling of edges (Hydrofera blue and silicone foam). On 05/16/24, skin assessment completed for PIs that does not include a thorough assessment including documentation of location of PI, PI measurements, or description of condition of PIs noted. Wound clinics note stated, in part: On 05/20/24, wound clinic diagnoses stated, in part: 6. pressure injury of the right foot stage 2. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careview Health and Rehab of Minocqua	9969 Old Hwy 70 Rd Minocqua, WI 54548

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Diabetic ulcer of right heel. Recommendations from wound clinic is as followed: R21 should continue always wearing heel suspension boots when in bed and or chair to prevent further breakdown. Follow up with wound clinic twice weekly. Wound clinics note stated, in part: On 05/30/24, wound clinic recommends: -Nursing staff may change dressings at facility once weekly and visit wound clinic once weekly for evaluation and dressing change. . 5. Apply tubi grip F from base of toes to just below the knees. Continue pressure relief to heels and apply heel suspension boots continuously when patient is in bed. No thorough assessment including documentation of location of PI, PI measurements, or description of condition of PIs noted at this time. Wound clinics note stated, in part: On 06/26/24, No thorough assessment including documentation of location of PI, PI measurements, or description of condition of PIs noted. R21 was hospitalized ,d+[DATE]-[DATE] for surgery of metatarsal 5th toe and antibiotic therapy. Surveyor unable to determine if one of the 7 PIs R21 was admitted with progressed to stage 4 or if R21 was admitted with unstageable PIs that were already stage 3 or 4; that could not be assessed as wound clinic did not number the PIs and specify exact location on the right foot. The facility did not assess or stage PIs from admission to 7/1/24. PI assessment not completed on 07/03/24 when resident was readmitted back to nursing home. Wound clinics note stated, in part: On 07/09/24-Right heel has eschar, contacted nursing at nursing home to reinforce the importance of always keeping purple boots on to offload pressure to the heels. Surveyor unable to determine which PI progressed to eschar or if it had existing eschar, as wound clinic did not number the PIs and specify exact location on the right heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No thorough PI assessment including documentation of location of PI, PI measurements, or description of condition of PIs was completed by the facility. Wound clinics note stated, in part: On 07/12/24- wound clinic diagnoses R21 with pressure injury to the right heel stage 3. Right lateral heel wound cleansed. Strongly encouraged compliance with heel suspension boots. Surveyor unable to determine which PI progressed to stage 3 or if this is an existing stage 3 PI from admission as wound clinic did not number the PIs and specify exact location on the right foot/heel nor did the facility. Wound clinics note stated, in part: On 07/16/24 Wound clinic ordered: -Posterior right heel wound is friable at one edge, increased drainage. Reinforced need to for purple heel offloading boots at all other times, both in bed and in wheelchair. Wound clinics note stated, in part: On 07/19/24 Posterior right heel measures 1.7x1.5x0.3cm, unattached edges. -Posterior right heel wound is friable at one edge, unchanged drainage. Reinforced need to for purple heel offloading boots at all other times, both in bed and in wheelchair. No thorough PI assessment including documentation of location of PI, PI measurements, or description of condition of PIs noted. Wound clinics note stated, in part: R21 hospitalized ,d+[DATE]-[DATE] for SOB acute hypoxia and had wound care during stay. Nurse progress note indicates, R21 admitted back to nursing home on 07/29/24. Nurse progress notes indicate PI assessment was not completed until 07/31/24 after resident was readmitted . Wound clinics note stated, in part: On 08/02/24- Right posterior heel- measures 1.2cmx1.8cmx0.4cm. Wound clinics note stated, in part: On 08/06/24-Right posterior heel- measures 1.5cmx1.8cmx0.4cm. Surveyor unable to determine which PI is being measured as the wound clinic did not number the PIs and specify exact location on the right foot/heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin assessment missed on 08/07/24. Wound clinics note stated, in part: On 08/09/24- Right posterior heel- measures 1cmx1.5cmx0.4cm. Wound clinic notes STRONGLY encouraged compliance with heel suspension boots. She is wearing heel suspension boots but not consistently. Wound clinic ordered: - Follow up on 08/13/24. Wound clinics note stated, in part: On 08/13/24- Right posterior heel- measures 1.5cmx1.7cmx0.6cm. Right lateral foot stage 1 begins no measurements documented. Wound clinic ordered: - Reinforced need to for purple heel offloading boots at all other times unless transferring or walking with PT. Gave post op boot shoes to wear PT as she doesn't have shoes in the facility. -Follow up on 08/16/24. Wound clinics note stated, in part: On 08/16/24-Right posterior heel- measures 1.8cmx1.6cmx0.5cm. Right lateral foot stage 1 measures 0.5cmx0.3cmx0.1cm. No wound clinic follow-up orders. No thorough PI assessment including assessment completed by facility of location of PI, PI measurements, or description of condition of PIs noted. Wound clinics note stated, in part: On 08/23/24- Right posterior heel- measures 1.2cmx1.4cmx1.4cm. Undermining begins at 6 and 7 o clock. (worsens) Right lateral foot stage 1 no measurements documented. Wound clinic ordered: -Follow up on 08/27/24. -Adhered to recommendations of patient wearing heel protectors daily, but staff report resident refuses sometimes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor unable to determine which PI progressed with undermining, or if this was from an unstageable on admission that had undermining that was not visible at that time as wound clinic did not number the PIs and specify exact location on the right foot/heel. Facility had no PI assessment including documentation of location of PI, PI measurements, or description of condition of PIs noted. Wound clinics note stated, in part: On 08/30/24- Right posterior heel- measures 1.1cmx1.4cmx0.4cm. Right lateral foot stage 1 no measurements documented. Skin assessment missed on 09/02/24 and on 09/06/24 no thorough PI assessment of existing pressure injuries noted. Wound clinics note stated, in part: On 09/17/24- Right posterior heel- measures 0.8cmx0.8cmx0.4cm, with undermining at 12,1,2,3,4,5,6,7 o clock, with depth of 0.3cm. Surveyor unable to determine which PI progressed with undermining as wound clinic did not number the PIs and specify exact location on the right foot/heel. Wound clinic visit missed 09/20/24. Wound clinics note stated, in part: On 09/24/24- Right posterior heel- measures 0.8cmx1cmx0.4cm, with undermining at 1,2,3,4,5,6,7 o clock, with depth of 0.7cm. Surveyor unable to determine which PI progressed with undermining as wound clinic did not number the PIs and specify exact location on the right foot/heel. Observations: On 09/30/24 at 10:25 AM, Surveyor observed R21 sitting in wheelchair with feet sitting on wheelchair pedals watching TV. R21 was not observed to be wearing foot protectors as ordered. Purple boots sitting on chair across the room. On 09/30/24 at 11:35 AM, Surveyor observed R21 sitting in wheelchair with feet sitting on wheelchair pedals watching TV. R21 was not observed to be wearing foot protectors as ordered. Purple boots sitting on chair across the room. On 09/30/24 at 1:40 PM, Surveyor observed R21 sitting in wheelchair with feet sitting on wheelchair pedals watching TV. R21 was not observed to be wearing foot protectors as ordered. Purple boots sitting on chair across the room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/24 at 3:22 PM, Surveyor observed R21 sitting in wheelchair with feet sitting on wheelchair pedals. R21 was not observed to be wearing foot protectors as ordered. Purple boots sitting on chair across the room. On 09/30/24 at 4:01 PM, Surveyor observed R21 sitting in wheelchair with feet sitting on wheelchair pedals. R21 was not observed to be wearing foot protectors as ordered. Purple boots sitting on chair across the room. Facility did not apply purple boots on 09/30/24 to offload R21's heels as care planned. Surveyor reviewed treatment documentation that noted R21 only refused twice in the month of September and staff were not documenting consistently that staff applied purple boots. Facility has missing documentation that the treatment to apply purple boots was completed on most days in the month of September. Interviews: On 10/02/24 at 1:35 PM, Surveyor interviewed Director of Nursing (DON) B and asked about comprehensive PI assessments. DON B indicated that comprehensive skin assessments should be completed within 24 hours of admission. The expectation is that assessments be comprehensive and include measurements, description, location, unless the resident has an order not to remove a dressing, as in R21's case. R21 was admitted on [DATE] with an order to remove dressing at follow up wound clinic appointment. Follow up wound clinic appointment was on 05/09/24, when measurements were obtained from wound clinic. Surveyor asked if R21 refuses purple boots for off-loading. DON B indicated R21 does sometimes, but expectation is staff document this and to reapproach R21 as much as possible to apply purple boots. Surveyor asked DON B about September treatment orders and missing documentation of applying purple boots to R21. DON B indicated that staff have not been consistent with applying purple boots to off-load. On 10/02/24 2:01 PM, Surveyor interviewed Certified Nurse Assistant (CNA) G and asked why R21 did not have purple offloading boots on while up in wheelchair from 10:25 AM-4:01 PM on 09/30/24. CNA G indicated that R21 refused to put the purple boots on the morning of 09/30/24. Surveyor asked if CNA G re-offered or tried to encourage R21 to place the purple boots on. CNA G indicated that CNA G did not go back in to offer to apply the purple boots to R21. Surveyor asked if R21 refuses sometimes and if CNA G documented the refusals. CNA G indicated that CNA G did chart at 2:55 PM on 09/30/24 that R21 refused but CNA G indicated that R21 use to refuse a lot before she went into hospital in July but hasn't in a while. On 10/02/24 at 2:15 PM, Surveyor interviewed Registered Nurse (RN) F and asked if R21 refuses R21's purple off loading boots and what is expectation of wearing R21's purple boots. RN F indicated that R21 should always wear the purple boots. RN F indicated that R21 has a history of refusing boots but since had surgery on R21's foot back in July that R21 has been more accepting of staff to place on heels so R21 can get home instead of being in nursing home for so long. On 10/02/24 at 2:25 PM, Surveyor interviewed RN I and asked if pressure injuries could have been avoidable for R21. RN I indicated with all of R21's comorbidities like diabetes mellitus and venous insufficiency, all the PIs are unavoidable.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 30570 Based on observation, record review and interview, the facility did not provide the needed services in attempt to maintain R10's mobility. The facility practice has the potential to affect 1 of 3 residents (R), R10, reviewed for limited range of motion and mobility. This is evidenced by: Surveyor requested the facility policy regarding restorative or maintenance programs at the facility. Director of Nursing (DON) B informed surveyor the facility does not have a maintenance or restorative program at the facility and has not for some time due to various reasons. The facility does not have a policy specific to maintenance or restorative programing. Surveyor reviewed R10's most recent Minimum Data Set (MDS) which was a quarterly (MDS) completed on 8/22/24. The MDS notes R10 understands and is understood. R10 does not reject care. R10 has no range of motion impairments and requires supervision with transfers. Ambulation noted as has not been attempted. Surveyor reviewed R10's program that read: Restorative Carryover Recommendations Program Requested: Ambulation Instructions: Walk to and from meals as able in in hallway distance as tolerated with FWW (Front wheeled walker), contact guard with gait belt For the goal of: maintain current level of function (CLOF) and minimize fall risk Dated: 8/01/23 Therapist: PT Surveyor reviewed R10's care plan and noted: Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) frontotemporal dementia with agitation, COPD (chronic obstructive pulmonary disease), anemia, depression with anxiety, CHF (congestive heart failure), tremors, subarachnoid hemorrhage, seizures and incontinence. Goal: The resident will maintain current level and/or improve based on therapy goal of function through the review date. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revised on: 6/11/24 Target Date: 11/14/24 Intervention: Walking: assist of 1 with walker to and from meals with gait belt and walker, w/c (wheelchair) to follow. Surveyor reviewed R10's Kardex: (Certified Nursing Assistant) care guide and noted: Mobility: Walking; assist of 1 with walker to and from meals with gait belt and walker. w/c (wheelchair) to follow. On 9/30/24 at 11:32 AM, Surveyor observed staff propel R10 to the dining room in her wheelchair with no offer by staff to ambulate to the dining room. On 9/30/24 at 12:28 PM, Surveyor observed staff take R10 to the dayroom after lunch from the dining room with no offer to ambulate. On 10/01/24 at 6:58 AM, R10 was again taken to the dining room by staff with no offer by staff to ambulate to the dining room. On 10/01/24 at 8:41 AM, R10 was taken from the dining room to the therapy gym where staff placed a gait belt around her waist, assisted her to stand with walker to ambulate. Surveyor reviewed R10's record for evidence R10's maintenance walking program was conducted by staff. No evidence was located in R10's chart. On 10/01/24 at 10:34 AM, Surveyor spoke with Director of Nursing (DON) B requesting evidence of R10's walking program being offered and implemented by staff. DON B provided documentation that showed R10 was not offered her ambulation program from 7/01/24 to present. On 10/01/24 at 9:44 AM, Surveyor spoke with DON B regarding R10's walking program. DON B expressed R10 is being followed in physical therapy with expectation for staff to walk her to and from meals 3 x a day. The program is a maintenance program for R10 to maintain her ambulation status. DON B further expressed she would expect staff to offer R10 her walking program to and from every meal. Surveyor requested R10's Maintenance Program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 1:55 PM, Surveyor spoke with Certified Nursing Assistant (CNA) E regarding R10's ambulation program to and from meals. CNA E indicated she has been on the day shift for the past 5 months and works 2-3 days a week and routinely cares for R10. CNA E further expressed in the morning when R10 first gets up she is a little off balance. CNA E expressed she does her morning care and transfers R10 to her wheelchair and places R10 in the hallway. R10 is taken from the hallway to the dining room. After breakfast R10 often propels herself from the dining room. Before lunch R10 is usually in activities in the dining room and stays there for lunch thus walking is not done. Surveyor asked CNA E if she has spoken with nursing or therapy staff regarding R10's program. CNA E responded she had not talked with anyone about R10's program and the program is important because If you don't use it; you lose it.

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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** 44863 Based on record review and interview, the facility did not ensure a resident with an indwelling catheter was assessed for removal of the catheter as soon as possible for 1 of 1 resident (R) R19, reviewed with indwelling catheters. Findings: The facility policy titled, Indwelling Urinary Catheters, read in part .A resident who enters the facility with an indwelling urinary catheter is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that the catheter was necessary. 1. If the resident has an indwelling urinary catheter, complete the assessment upon admission, quarterly, and with change. 2. Document the reason the catheter is being utilized based on the following: a. Resident has an acute urinary retention or bladder outlet obstruction. 1. Changing indwelling catheters at routine, fixed intervals are not recommended. Rather, it is suggested to change catheters based on clinical indications such as infection, obstruction, or when the closed system is compromised. R19 was admitted to the facility on [DATE]; diagnoses included benign prostatic hyperplasia without lower urinary tract symptoms, urinary tract infection (UTI), and overactive bladder. R19 was admitted with an indwelling catheter. R19's most recent Minimum Data Set (MDS) assessment completed on 08/21/24, confirmed R19 had an indwelling catheter, a urinary toileting program had not been tried, and urinary continence had not been assessed due to R19 having an indwelling catheter. R19's physician orders included an order to: Change catheter every four weeks and as needed for occlusion or malfunction. R19's care plan included: -The resident has a foley catheter: Neurogenic bladder, (of note, documentation does not support this diagnosis). -Change every four weeks and as needed. On 08/12/24, R19 was admitted to the hospital for UTI with sepsis. R19 was readmitted to the facility on [DATE], with an indwelling catheter and antibiotic treatment. On 10/02/24, Surveyor reviewed R19's history and physical (H&P) completed on 07/26/24, as part of the pre-admission process. Summary of present illness included, in part, His urinary incontinence issues are resolved with the chronic indwelling catheter; they are very pleased with this. R19's plan included chronic indwelling catheter will be changed monthly. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 1:35 PM, Surveyor interviewed Director of Nursing (DON) B. DON B indicated the facility's medical director agreed with routinely changing indwelling catheters unless a urologist ordered a specific schedule. This decision does not align with current standards of practice, as routine or fixed changes are not recommended and catheters should be changed based on clinical indications, such as infection, obstruction, or when the system is compromised. DON B agreed routine changing of catheters does not align with the facility policy or the regulatory requirements. DON B stated R19's diagnoses did not meet the criteria for an indwelling catheter. Surveyor requested additional supporting documentation, such as urology visit or orders. The facility did not provide any additional documentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on observation, interview and record review, the facility did not ensure proper sanitization and food handling practices to prevent the outbreak of foodborne illness for all 28 residents (R). Serving utensil was left in thickener powder. Cooks were observed grabbing ready to eat food with gloved hands, after touching non-sanitized food surfaces, and placing the ready to eat food on plates for residents to eat. Cooks were observed not changing gloves and washing hands after touching non-sanitized food surfaces. Cooks did not perform hand hygiene between glove changes during food service. Cook did not wear hair restraint and/or correctly when entering kitchen, preparing, or serving food. Food (milk) placed in kitchen refrigerator had been opened but was not labeled with an opened date, resulting in the potential for foodborne illnesses to spread. Food items for resident consumption were not labeled with open or discard date. Findings include: Facility policy entitled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices F812, effective ,d+[DATE], states Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Under section entitled Guidelines states in part: 6. Employees must wash their hands . d. Before coming in contact with any food services. f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. h. After engaging in other activities that contaminate the hands. i. before putting gloves on and after removing gloves. j. Before distributing meals to residents. 10. Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing. 13. Hair nets and/or chef caps and/or beard restraints must be worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens. According to the FDA Food Code 2022 documents at ,d+[DATE].11 Hair restraints: Effectiveness. (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens and unwrapped single service and single use articles. The facility policy entitled Refrigerators and Freezers F812 effective ,d+[DATE] states, The facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Under section entitled Guidelines, the policy states in part: 6. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. 8. The food shall be labeled and clearly marked to indicate the date or day by which the food shall be consumed or discarded. 9. The discard day or date may not exceed the manufacturer's use-by-date or four days, whichever is earliest. The date of opening or preparation counts as day 1. 10. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. 12. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. The facility policy entitled Foods Brought by Family/Visitors F813 states, Staff must be aware of, and approve, food(s) brought to a resident by family/visitors. Under the section Guidelines, the policy states in part: 6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date. 7. The food service staff and nursing staff is responsible for discarding perishable foods on or before the use by date. 8. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs or potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). (continued on next page)

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	525678	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careview Health and Rehab of Minocqua	9969 Old Hwy 70 Rd Minocqua, WI 54548

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:46 PM, Surveyor observed [NAME] C begin tray line after washing hands and putting on gloves, pick up a plate, and using gloved hands, touched serving utensil to dish up food onto plate. [NAME] C then, using contaminated gloved hand, touched green beans to make room for dishing potatoes and proceeded to dish up service line plates. On [DATE] at 11:55 AM, Surveyor observed [NAME] C dish up a plate and determined food needed to be placed on a divided plate. Using contaminated gloved hands, [NAME] C picked up divided plate serving utensil and scraped the food into the divided plate. [NAME] C proceeded with gloved hands, picked up corn and potatoes from regular plate and placed onto the divided plate. On [DATE] at 11:57 AM, Surveyor observed [NAME] C while waiting to begin room tray service. [NAME] C, with same contaminated gloves, proceeded to touch uniform, opened oven door to remove clean plates for service, retouched uniform, picked up a vegetable spray container and placed back on shelf, turned dial on prep table, touched a clipboard to read notes, and touched a center of a clean plate to check warmth. On [DATE] at 12:15 PM, Surveyor observed [NAME] C, without conducting hand hygiene or glove change, proceed to dish resident room trays. On [DATE] at 12:16 PM, Surveyor observed [NAME] C wipe gloved hands during room tray plate service on a wet cloth and continued to dish up remaining resident room tray. On [DATE] at 7:12 AM, Surveyor observed Registered Nurse (RN) F, walk into kitchen without a hair net two times to get coffee and then chocolate milk. RN F confirmed expectation of facility is to wear a hair net when entering kitchen. On [DATE] at 8:05 AM, Surveyor entered kitchen and observed [NAME] D wearing a hair net and beard net that were not fully covering hair down side of face and around neck area, blending pureed food with gloved hands. During process, [NAME] D, with contaminated gloved hands, scooped thickener powder with metal scoop lying inside container and placed in blender, proceeded to place blender container in steam table, moved dirty cutting board to sink area, and proceeded to dish resident meal plates picking up individually cut coffee cake pieces or slices of buttered toast and placing on residents' plates. On [DATE] at 8:10 AM, Surveyor observed and interviewed CNA E, who walked into kitchen during tray service without wearing hair net. CNA E stated expectation of facility would be to wear a hair net when entering kitchen. On [DATE] at 8:12 AM, Surveyor observed [NAME] D, after conducting hand hygiene and putting on clean gloves, enter storage room and bring out a plastic bagged loaf of bread. With contaminated gloves, [NAME] D took out 2 slices of bread and placed in toaster. [NAME] D proceeded with same contaminated gloves picking up individual coffee cake slices, cracked 2 eggs, wiped gloved hand on a wet cloth, served up more coffee cake, flipped eggs, grabbed vegetable spray for griddle, cracked 2 more eggs which were dripping egg white on gloves, wiped gloved hands on wet cloth, grabbed toast from toaster, removed gloves and without hand hygiene put on clean pair of gloves. [NAME] D flipped eggs and placed on plate, wiped hand with wet cloth and sprayed griddle with vegetable spray. No hand hygiene or glove changes were observed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:11 PM, Surveyor observed [NAME] D begin to serve food with contaminated gloves. Surveyor did not observe [NAME] D doff contaminated gloves and perform hand hygiene before serving with contaminated gloves. On [DATE] at 8:20 AM, Surveyor observed [NAME] D with same contaminated gloves, begin serving room trays picking up coffee cake or toast. [NAME] D then picked up contaminated blender cup and brought it to 3 compartment sink, removed gloves and without hand hygiene put on a clean pair of gloves. [NAME] D proceeded to open freezer door, walked out with 1 slice of frozen French toast in contaminated gloved hand, opened oven door and placed French toast inside. [NAME] D proceeded to serve breakfast plates and picked up coffee cake or toast with contaminated gloves. [NAME] D opened oven door, and with contaminated gloves, took out warmed French toast, placed on a cutting board holding the French Toast with contaminated gloved hands and with knife cut into small pieces and placed on a resident plate. [NAME] D wiped gloved hands on wet cloth, cracked 4 eggs picking out pieces of broken shell from cracked eggs, removed gloves, and without conducting hand hygiene, put on a new pair of gloves and continued resident meal tray service. On [DATE] at 12:31 PM, Surveyor interviewed [NAME] C regarding use of a wet cloth during meal service to wipe off gloves. [NAME] C indicated the wet cloth was from the quaternary sanitation bucket and stated the expectation was to remove gloves and conduct hand hygiene anytime gloves become contaminated. On [DATE] at 12:31 PM, Surveyor interviewed [NAME] C regarding observations during meal services on [DATE]. [NAME] C was unaware of contaminating gloves with examples provided during observation. On [DATE] at 12:55 PM, Surveyor interviewed [NAME] D regarding observation during meal service of not wearing beard nets appropriately, touching contaminated items with gloved hands and picking up food, use of sanitization bucket sanitizer cloth to wipe off glove in place of hand hygiene, observations of no hand hygiene prior to and between glove changes. [NAME] D stated that expectation is to remove gloves when contaminated, conduct hand hygiene, and change gloves. [NAME] D stated that the beard nets do not cover full beard. On [DATE] at 9:01 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding expectation of staff entering kitchen. NHA A stated expectation would be to either wait at kitchen door for assistance from dietary staff or put on a hair net before walking into kitchen. On [DATE] at 10:50 AM, Surveyor observed the facility unit refrigerator and freezer which contained the following items: -Black plastic garbage bag with Texas Roadhouse leftovers unlabeled or dated. -Walmart bag with leftover container of raspberries unlabeled or dated. -Domino's pizza box with three slices of left over pizza unlabeled or dated. -Bag with several size containers labeled with a resident name and undated. -Open liter of Diet Mountain Dew unlabeled or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Open jar of Hellman's mayonnaise opened labeled with resident name and undated. -Box of opened mini corn dogs unlabeled or dated. Surveyor observed a sign taped to outside of fridge/freezer, dated [DATE], stating, This refrigerator is for resident use only. All items must be labeled with the resident's name and dated. All outdated (3 days) and unlabeled items will be discarded by dietary. Any employee items will be discarded. Employees may keep items in the refrigerator in the employee's breakroom. they must also be labeled and dated. Thank you Dietary Manager. On [DATE] at 11:15 AM, Surveyor interviewed RN F regarding responsibility of maintaining nursing unit fridge/freezer. RN F stated any staff who place leftovers into fridge should label and date and believes kitchen staff checks/logs temperature and cleans out item. RN F also stated anyone who goes in fridge should discard things as needed. On [DATE] at 11:17 AM, Surveyor interviewed NHA A regarding nursing unit fridge/freezer upon survey entrance on [DATE]. NHA A stated expectation would be anyone who puts items in the fridge/freezer should label and date and kitchen staff are responsible for routine monitoring and discarding anything undated/past dated. On [DATE] at 9:40 AM, Surveyor interviewed Director of Nursing (DON) B regarding observation during kitchen survey. DON B confirmed expectation would be to follow facility policies for infection control.

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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) (R17 and R25). Example 1 The facility policy entitled F880 Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) last revised on 3/2024, states under definition of EBP, 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. On 10/01/24 at 7:46 AM, Surveyor observed during med pass with Registered Nurse (RN) J, an Enhanced Barrier Precaution (EBP) sign on R17's room door directing staff to wear Personal Protective Equipment (PPE) of gown and gloves. Surveyor asked RN J reason for EBP signage. RN J stated R17 has an indwelling catheter and Certified Nursing Assistant (CNA) E is changing catheter to a leg bag. Surveyor observed CNA E come out of bathroom to grab additional supplies and noted CNA E was not wearing a protective gown. Surveyor asked RN J if CNA E should be wearing a gown. RN J stated yes confirming EBP signage on door. On 10/01/24 at 7:50 AM, Surveyor interviewed CNA E after coming out of bathroom with R17. CNA E confirmed expectation of need to wear appropriate PPE and stated was just doing task quickly to get R17 to breakfast. On 10/02/24 at 9:40 AM, Surveyor interviewed Director of Nursing (DON) B and notified of observations of CNA E not following EBP. DON B confirmed staff would be expected to follow policies of facility to prevent infections. 48793 Example 2 Surveyor reviewed R25's physician orders which include: .-On 09/29/24 COVID-19 precautions . Surveyor reviewed progress notes: .-On 09/29/24 at 11:37 AM, Resident tested positive today for COVID routine testing. Asymptomatic. MD updated. -On 09/30/24 at 4:42 PM, Covid positive resident remains in isolation and is compliant with same . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations: On 09/30/24 at 10:50 AM, Surveyor observed R25 have a precaution PPE cart outside room, and no signage on the door. On the PPE cart there was an EBP sign upside down underneath a box of gloves. On 09/30/24 at 10:53 AM, Surveyor interviewed CNA G and asked why R25 was on EBP with PPE cart outside R25's room. CNA G indicated that CNA G did not know and had to go ask RN F. RN F indicated that R25 was on droplet precautions for COVID-19. Surveyor asked RN F about the signage not on the door and an EBP sign lying upside down on PPE cart outside R25's room. RN F indicated that R25 has COVID-19 and there is supposed to be a droplet precaution sign on R25's door, so that everyone knows before entering what PPE to utilize when caring for R25. On 09/30/24 at 10:55 AM, Surveyor observed RN F walk down the hallway and grabbed EBP sign off R25's PPE cart outside the door and continued down the hallway to the nurse's station. On 09/30/24 at 10:56 AM, Surveyor observed RN F apply a droplet precaution sign to R25's door. Surveyor asked RN F when R25 became positive with COVID-19. RN F indicated that R25 tested positive yesterday on 09/29/24. RN F indicated that the day nurse charted on 09/29/24 at 11:38 AM that R25 was positive with COVID-19. Surveyor asked RN F if staff have been going in and out without proper PPE. RN F stated, I will be perfectly honest with you, since there was no sign on the door, I am sure from yesterday 09/29/24 on day shift until just now on 09/30/24 at 10:56 AM, no one has been wearing appropriate PPE to protect themselves from spreading COVID-19.