STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525702	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Country Health Services	2195 North Summit Village Way Oconomowoc, WI 53066

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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** 20483 Based on interview and record review the facility did not ensure 1 (R2) of 1 resident's resident representative was notified when there was a need to alter medical treatment. R2's POA (Power of Attorney) was not notified when there was a change in R2's pain medication. Findings include: The facility's policy titled, Change in Condition of the Resident and reviewed/revised 9/20/2022 under Policy documents A facility should immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). 1.) R2 was admitted to the facility with a diagnoses includes chronic kidney disease, chronic obstructive pulmonary disease, diabetes mellitus, and dementia. R2's POA (power of attorney) for healthcare was activated on 11/12/21. On 10/21/24, at 2:15 p.m., Surveyor spoke with R2's POA on the telephone. During this conversation R2's POA informed Surveyor they were not informed when R2's pain medication was changed. R2's POA informed Surveyor it's in R2's record if there are any medication changes they are to be notified. R2's nurses note dated 9/25/24, at 13:17 (1:17 p.m.), documents Spoke with [Name] at pain clinic regarding noticeable behavior and confusion issues with resident since recent med (medication) change to Hydromorphone. Waiting on call back from clinic for update on how to proceed forward. This nurses note was written by LPN (Licensed Practical Nurse)-Z. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note dated 9/30/24, at 11:45 a.m., under Subjective documents Patient is seen in her room during visit currently resting in bed. She has now completed antibiotics for UTI (urinary tract infection) without any further urinary concerns reported. Recently updated by nursing staff that patient had worsening behaviors with confusion that had been noted upon starting Dilaudid. Pain clinic was updated and gave order to discontinue Dilaudid and start Norco instead, which patient has been tolerating without adverse effect. She does note ongoing back pain at baseline and is reminded to let nursing staff know when she has pain, with goal to optimize her pain control. Patient has no other complaints today. No shortness of breath or chest pain. Mentation appears at baseline currently. Nursing staff to continue to monitor pain control as well with no other new concerns reported today. Under Assessment and Plan documents M54.50 - Low back pain, unspecified*: Chronic R (right) sided; w/ (with) lumbar radiculopathy. Per outpt (outpatient) specialist [Physician's name] - Dilaudid dc'ed (discontinued), Norco resumed instead given concern of worsening behaviors/confusion on Dilaudid. Tolerating Norco so far w/o (without) AE (adverse event), and appreciate ongoing specialists recs (recommendations). This progress note was written by PA (Physician Assistant)-AA. R2's physician orders with an order date 9/8/24 documents Hydromorphone HCL (Diaudid) oral tablet 2 mg (milligram). Give 1 tablet by mouth one time a day every Mon (Monday) for pain after dialysis and Give 1 tablet by mouth one time a day every Wed (Wednesday) for pain after dialysis and Give 1 tablet by mouth one time a day every Fri (Friday) for pain after dialysis and give 1 tablet by mouth every 8 hours as needed for severe pain. This order was discontinued on 9/26/24. R2's physician orders with an order & start date 9/26/24 documents Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligram) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours as needed for pain. R2's physician orders with an order date of 9/26/24 & start date of 9/27/24 documents Hydrocodone-acetaminophen Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) for pain post dialysis. During R2's record review, Surveyor was unable to locate R2's POA was notified of the change in pain medication. On 10/23/24, at 10:30 a.m., Surveyor asked ADON (Assistant Director of Nursing)-X if a resident is on a pain medication and changed to another pain medication would you notify the resident's representative of this change. ADON-X replied yes. Surveyor informed ADON-X on 9/26/24 R2's Diaudid 2 mg was discontinued and Hydrocodone-acetaminophen 5-325 mg was ordered. Surveyor informed ADON-X Surveyor was unable to locate R2's POA was notified of this change. ADON-X reviewed R2's electronic medical record and stated to Surveyor I do not see anything either. On 10/23/24, at 11:12 a.m., Surveyor informed DON (Director of Nursing)-B R2's POA was not notified when there was a change in pain medication on 9/26/24. No information was provided to Surveyor as to why R2's POA was not notified of the change of pain medication on 9/26/24.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on observation, interviews, and record review the facility did not address and resolve grievances conveyed on behalf of 2 (R9 and R12) of 5 residents reviewed for grievances. * On 10/18/2024, a grievance was initiated for R9 related to R9 having concerns with not being checked on night and being double briefed on night shift. Surveyor noted the grievance form documented the grievance was resolved, but R9 continued to express concern to Surveyor of on-going issue and Surveyor observed R9 saturated in urine in the morning on 10/23/2024. * R12 informed Surveyor of concerns that R12 is not getting up before 06:00 AM, as care planned, and has not been updated on a concern R12 voiced regarding a room change discussed with the Facility. Findings include: The Facility's policy, titled Grievance Policy, with a last reviewed date of 07/2022, documents in part, POLICY the facility will seek to resolve concerns, complaints or grievances and provide residents, reasonable parties, staff and others feedback and resolution in a timely manner . . Residents, residents' families and responsible parties, facility staff and facility contractors will be in-serviced on the Grievance procedure, how to initiate a grievance, who the Grievance Officer is and how resolutions will be communicated. The Department Head that is assigned the concern form is responsible for investigating the issue and following up to provide a resolution to the issue within 72 hours of being assigned the grievance. The Grievance Officer will ensure that: . Written grievance resolution decisions include the date when the original concern was received, a summary statement of the concern, steps taken to investigate, a summary or findings or conclusions regarding the concern, whether the concern was confirmed or not, any corrective action taken and the date the written decision was issued. 1.) R9 was admitted to the facility on [DATE] with diagnoses which includes, muscle weakness, heart failure, morbid obesity, and muscle wasting. R9's Quarterly Minimum Data Set (MDS), dated [DATE], documents R9 has a Brief Interview of Mental Status (BIMS) of 15, indicating R9 is cognitively intact. R9's Quarterly MDS, dated [DATE], is the most recent MDS indicating R9's self-care performance, and documents, R9 requires substantial/maximal assistance with toileting hygiene and rolling left and right. On 10/21/2024 at 09:25 AM, Surveyor interviewed R9. R9 informed surveyor of concerns R9 has with third shift staff not changing or check on R9, double briefing R9 and R9 wakes up in the morning in a puddle of urine. R9 informed Surveyor that R9 has voiced concerns of these issues to Nurses and Certified Nursing Assistants (CNA) on first shift. R9 informed Surveyor that R9 has told staff R9 does not want to be double briefed. R9 informed Surveyor that R9 was not double briefed last night, but woke up this morning and urine leaked through R9's brief but was changed this morning. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/2024 at 7:05 AM, Surveyor observed R9 in bed, and smelled of urine. R9 informed Surveyor that the CNA came in a little bit ago and said they would change R9 after breakfast. On 10/22/2024 at 09:35 AM, Surveyor interviewed NHA-A. NHA-A informed Surveyor that NHA-A is the Grievance Official. NHA-A indicated NHA-A follows up on grievances and talk about the grievances in daily stand-up meetings. NHA-A informed Surveyor that any staff member can fill out a grievance form and put in under NHA-A's door. NHA-A informed Surveyor that Department Heads will round daily with residents. NHA-A informed Surveyor they will ask residents if they want to file a formal complaint or not, but all abuse is to be reported. NHA-A indicated that if a resident voices concerns, the resident should be asked if they would like to file a formal complaint, if family voices concerns, then it should be a formal grievance. On 10/22/2024 at 10:13 AM, Surveyor observed that R9 was clean and changed. On 10/22/2024 at 12:46 PM, Surveyor interviewed CNA-D regarding grievance procedure. CNA-D informed Surveyor that and concerns should be brought to a supervisor, or the DON and they would follow up with it. On 10/22/2024 at 12:47 PM, Surveyor interviewed RN-E regarding the grievance process. RN-E informed Surveyor that RN-E would fill out a grievance form and give to the Executive Director or DON, and if the concern was involving abuse RN-E would call right away. RN-E informed Surveyor that not everything is written on a grievance form, most things are verbally relayed to Executive Director or DON and they will determine if a grievance form is filled out or not. On 10/23/2024 at 08:05 AM, Surveyor observed CNA-MM providing cares for R9. Surveyor observed R9 to have saturated urine in R9's brief, as well as bed sheets. Surveyor noted a strong smell of urine. R9 indicated R9 had not been checked or changed through the night. Surveyor reviewed the Facility's Grievance Log but did not locate a grievance for R9. On 10/23/2024 at 07:44 AM, Surveyor interviewed DON-B. DON-B informed Surveyor that the expectation for grievances is staff should see if the concern can be immediately resolved, and if not, a grievance form should be completed and resolved within 7 days. DON-B informed Surveyor that if concerns were brought to staff, staff would report to the Nurse or DON and rule out abuse and/or address the problem. DON-B indicated that any staff member can fill out a grievance form. Surveyor asked DON-B about R9's concerns, DON-B indicated DON-B addressed R9's grievance on Monday 10/21/2024 and indicated DON-B is still working to resolve the concern but does have the grievance form and would provide that to Surveyor. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the document titled, GRIEVANCE/COMPLAINT REPORT, with a received date of 10/18/2024 and documents in part, . Describe grievance/complaint using factual terms: Resident was Double briefed on night shift and not checked on . DOCUMENTATION OF FACILITY FOLLOW UP, Surveyor noted DON-B name is documented as the individual designated to this concern. Date assigned: 10/18/24 Time: 12:56 Date to resolved by: 10/21/2024 Was a group meeting held?, Surveyor noted Yes is marked, identify all individuals in attendance: Surveyor noted this section is blank. What other actions(s) was/were taken to resolve grievance/complaint (be specific)? Surveyor noted CNA was spoken with to ensure no double briefings. RESOLUTION OF GRIEVANCE/COMPLAINT Was grievance/complaint resolved? Surveyor noted, Yes, describe resolution is marked, but no description is given. Surveyor noted document was signed by DON-B on 10/18/2024. No additional information was provided. 2.) R12 was admitted to the facility on [DATE] with diagnoses that includes Multiple Sclerosis, dysphagia, and neuromuscular dysfunction of bladder. R12's most recent Quarterly MDS, dated [DATE], documents R9 BIMS score of 09, indicating R9 has moderately impaired cognition. On 10/21/2024 at 09:35 AM, Surveyor interviewed R12. R12 informed Surveyor that she does not currently like the room she is in and has requested to change rooms but has not heard anything back. R12 informed Surveyor that R12 has been getting self out of bed the last 4 days and indicated R12 has brought self to the bathroom and dressed self. R12 informed Surveyor that R12 likes to get up early in the morning and staff is aware of this. R12 informed Surveyor that staff will come in to empty her catheter bag, but R12 waits about an hour for call light to be answered. Surveyor reviewed R12's care plan and noted under ADL self-care deficit f/t: MS, physical limitations, documents, Resident's preference is to get up before 0600 am daily On Sunday please assist her in getting the church service on television, with an initiation date of 10/16/2023. Transfer: 1 assist w/2ww for transfers, with an initiation date of 03/13/2024. Surveyor noted a progress note, dated 09/16/2024 indicating R12 had a fall trying to self-transfer from bed to wheelchair, no injuries noted. On 10/22/2024 at 07:34 AM, Surveyor observed CNA (Certified Nursing Assistant)-K assisting R12 out of bed. On 10/22/2024 at 10:15 AM, R12 informed Surveyor that R12 feels that Social Services Coordinator-F is avoiding R12 regarding the room change. On 10/22/2024 at 01:08 PM, Surveyor spoke with Social Services Coordinator-F. Social Services Coordinator-F informed Surveyor Social Services Coordinator-F is aware of R12 requesting a room change, and Social Services Coordinator-F informed R12 that they would discuss it when a room became available. Social Services Coordinator-F informed Surveyor that Social Services Coordinator-F and R12 only had a verbal discussion about 1.5 months ago regarding the room change and there is no formal documentation regarding the room change request. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/2024 at 07:14 AM, Surveyor observed R12 in bed, R12 informed Surveyor R12 has been up just laying in bed for hours and would like to get out of bed. R12 informed Surveyor that R12 does not want to fall, so R12 was waiting for someone to come help R12 out of bed. R12 informed Surveyor that Social Services Coordinator-F came this morning to talk with R12 regarding room change. On 10/23/2024 at 08:05 AM, Surveyor interviewed CNA-MM. CNA-MM informed Surveyor that R12 like to get out of bed around 06:30-06:45 AM and that information regarding specifics on resident preferences can be found in Point Click Care. On 10/23/2024 at 08:54 AM, Surveyor interviewed DON-B. DON-B informed Surveyor that R12 is up for breakfast and has never voiced concerns regarding the time R12 gets out of bed. Surveyor informed DON-B that the time R12 likes to get out of bed is already documented in R12's care plan. Surveyor informed NHA-A and DON-B of above findings. No additional information was provided as to why the facility did not address and resolve grievances conveyed on behalf of R12.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and interviews, the facility did not ensure that 1 out of 1 resident (R1) reviewed for abuse allegations was free from exploitation, abuse of power, and mental abuse. A facility Certified Nursing Assistant (CNA-C) and R1 exchanged phone numbers and began a friendship which included several text messages between the two individuals over several months. CNA-C and R1 continued with the relationship to the point that R1 believed CNA-C was his girlfriend and that he would eventually leave the facility and they would live together. CNA-C often visited R1 in his room while she was working and assigned to other units. CNA-C and R1 did become intimate, often talking sexually in text messages, sharing several kisses, laying under covers with one another, and touching in a sexual manner. CNA-C purchased gifts for R1 and would visit even when she was not working. Ultimately the relationship ended, and CNA-C became very adamant the relationship was never real and she wanted no further contact. CNA-C texted R1 comments that were humiliating, degrading, and ridiculing. R1 expressed experiencing disappointment, sadness, and loneliness because of the relationship ending. Facility staff were aware R1 and the alleged perpetrator had been texting and that she would often visit R1 in his room when not assigned to care for him. Facility staff knew R1 received gifts from CNA-C and staff even witnessed love notes being left in R1's room from CNA-C. When Administration became aware R1 and CNA-C had exchanged phone numbers, they did not further investigate the possibility that exploitation and/or possible sexual abuse may be occurring. The facility failed to prevent abuse and exploitation by staff failure to report the relationship between CNA-C and R1 to administration timely and by the failure of administration to intervene and complete a thorough investigation into the relationship, which allowed CNA-C ongoing access to R1. This created a finding of immediate jeopardy that began on 7/7/24. Surveyor notified Nursing Home Administrator-A, Director of Nursing-B, and VP of Success-G of the immediate jeopardy on 10/23/24 at 3:02 p.m. The immediate jeopardy was removed on 10/24/24, however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: Policy Review: Abuse, Neglect and Exploitation. Date implemented 3/2018. Date Reviewed/revised 7/15/2022. Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. V. Investigation of Alleged Abuse, Neglect and Exploitation (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s). VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. F. Providing emotional support and counseling to the resident during and after the investigation, as needed. R1 was originally admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, chronic kidney disease Stage #3, retention of urine, speech and language deficits, depression, and alcohol use. R1 is responsible for himself in all decision making. A review of the most recent quarterly MDS (Minimum Data Set) dated 7/20/24 shows R1 has a BIMS (Brief Interview for Mental Status) score of 13 indicating intact cognition for daily decision making. Surveyor became aware R1 was in a relationship with Certified Nursing Assistant (CNA)-C was employed at the facility until 9/4/2024 and worked various shifts on various units throughout the facility. On 10/21/24, at 9:30 a.m., Surveyor began a review of the facility's self-reported incident which documents there was an allegation of an inappropriate relationship between a former staff member (CNA-C) and a resident (R1) with the staff member overstepping boundaries and the allegation may or may not involve exploitation (taking advantage of a resident for personal gain). The date discovered is documented as 10/2/24. Date occurred is 10/2/24, at 2:15 p.m. The occurred date and time are estimated. The timeline included in the facility's investigation stated on 10/1/24, an employee made Nursing Home Administrator-A aware of text messages between R1 and CNA-C. On 10/1/24, Nursing Home Administrator-A spoke to R1 and asked about R1's relationship with CNA-C and the employee using his (R1's) credit card. R1 denied the employee used his card. R1 stated the relationship was not an intimate relationship, they were just friends. R1 denied any text messages and did not want to be questioned about the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/2/24, Nursing Home Administrator-A interviewed R1 again and asked if she could read their (CNA-C and R1) text messages. R1 allowed Nursing Home Administrator-A to read through the text messages on his (R1's) cell phone. The text messages date back to 7/6/24. Text messages include, I love you, I cant [sic] wait for us to be together, I miss you, I want to kiss you from head to toe, I cant [sic] wait to lay with you, lets be alone, I only belong to you. The text messages also included jealous statements about other caregivers and there were text messages that talked about R1's penis and being inappropriate. R1 stated to NHA-A that he always denied the relationship because he loved her (CNA-C) and did not want to get her in trouble. R1 thought they were going to be together. R1 apologized for not telling the truth earlier. Surveyor conducted a review of the actual text messages that were sent between R1 and CNA-C between 7/7/24 and 9/29/24. The messages establish a relationship building between R1 and CNA-C with each calling each other pet names like crush, love,. boyfriend, and girlfriend. The text messages reveal that R1 and CNA-C thought of each other throughout the day and night and sometimes in a sexually explicit manner. The text messages show CNA-C would visit R1 while at work and assigned to different units. The text messages show R1 was in belief that CNA-C was his girlfriend and hoped that the two of them would be together forever and he would be able to leave the nursing home. On 9/13/24 CNA-C texted R1 saying: What part of LEAVE ME ALONE do you not understand? YOU GOT MY ASS FIRED !!!! I am grateful to be working elsewhere the drama and bullshit at [name of facility] is crazy ! DO NOT CALL TEXT ME AGAIN WE WERE NEVER GOING TO BE ANYTHING YOU WILL BE STUCK IN A NURSING HOME THE REST OF YOUR LIFE! I DON'T WANT TO BE WITH SOMEONE WHO IS STUCK IN A WHEELCHAIR AT A NURSING HOME. [NAME] I GOOD! LEAVE ME ALONE IM NOT KIDDING OTHERWISE I WILL MAKE A PHONE CALL AND IT WONT TURN OUT SO GOOD FOR YOU . On 9/29/24 CNA-C texted R1 for the last time .I HOPE YOUR ASS GETS KICKED OUT! GO LIVE WITH YOUR [NAME]! DON'T THINK I WAS SERIOUS ABOUT YOU I WAS PLAYING YOU. YOU REALLY DON'T THINK SOMEONE LIKE ME WOULD WANT TO BE WITH A MAN WHO HAS TO PISS IN A BAG AND SIT IN A WHEELCHAIR AND SHITS HIMSELF. LOL . BEING NICE TO SOMEONE DOESN'T EQUAL ROMANCE LOL LATER GATOR. Surveyor continued to review the facility's investigation and noted on 10/2/24 the facility did notify the local Police Department. Surveyor was able to review the police report. The report includes details included in the text messages as well as R1 stating he touched CNA-C's breasts under her shirt and the two of them kissed on multiple occasions. The facility's investigation included statements from staff members. The following was noted: On 10/5/24, CNA-H answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-H wrote, No, I have not first person, but I have heard about it from several residents. Question #2-are you aware of staff giving residents gifts? CNA-H wrote yes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/4/24, CNA-I answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-I wrote, I haven't witnessed any myself, but I did hear rumors about something from residents and a CNA about a month or two ago. On 10/4/24, CNA-J answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-J wrote, No I have not witnessed any inappropriate relationships between staff and residents, I've only heard about something of the sort through whispers. On 10/4/24, CNA-K answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-K wrote, I've heard about it threw staff and I have seen sweet/sexual notes from staff to resident. Question #2-are you aware of staff giving residents gifts? CNA-K wrote yes. On 10/7/24, CNA-L wrote a witness statement that documented the following: I witnessed an inappropriate relationship between a resident and a coworker. I am aware of the coworker giving the resident new clothes such as T-shirts. My resident showed me text messages between them. I then reported it to Social Services and Human Resources. My resident had confided in me and told me they were dating, which I reported. A note from the coworker was left pinned up to the resident's bulletin board. It was found in the morning after she was scheduled as a CNA for night shift on unit 200. On 10/21/24 at 12:50 p.m., Surveyor interviewed CNA-D regarding R1. CNA-D stated she was aware of the situation involving R1 and CNA-C and had heard other staff talk about inappropriate texts and letters and that the staff member bought things for R1. CNA-D stated she didn't report it because it was all hearsay. CNA-D stated that talk started bussing around April/May about R1 and CNA-C and then in July it was an everyday topic between staff. Staff would see CNA-C make her way around the facility and out of her way to go see R1. All the staff just wondered why. CNA-D stated she was aware several people reported it to their supervisors. CNA-D stated it wasn't until R1 brought it to upper management that an investigation was really done. On 10/22/24 at 8:10 a.m., Surveyor interviewed Registered Nurse (RN)-E regarding R1 and CNA-C. RN-E stated that sometime between August 5-9th 2024 a night CNA came to her and reported she felt there was some inappropriate contact between R1 and CNA-C. RN-E stated she reported it to the Director of Nursing (previous) and Administrator (previous). RN-E then stated that sometime between August 20-23rd, 2024, while at the 200 Unit nursing station, she heard a CNA talking about the relationship between R1 and CNA-C and that she had bought items for R1. RN-E stated that she then reported this to former Administrator/VP of Success-G and he said he would take it from there. RN-E stated that R1 would make comments about text messages and other staff would see CNA-C going into R1's room when she would be assigned to work on a different unit. RN-E stated that even R1's roommate would say that R1's girlfriend was here again last night. (continued on next page)

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	525702	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/22/24 at 11:20 a.m., Surveyor interviewed Social Services Coordinator (SSC)-F. SSC-F stated that he was not aware of the relationship between R1 and CNA-C until he was asked to go interview R1 with the other Social Services Coordinator. SSC-F was unable to give a date of the interview, but it was about 2 months ago. R1 was asked about text messages between himself and a staff member. R1 stated why, am I going to get this person in trouble. R1 didn't want to answer questions so SSC-F stated they left the room and were not involved with R1 after that. SSC-F stated that he was told by VP of Success (VPS)-G to just leave it be and wait for further instructions. No follow-up was ever done by SSC-F after that. SSC-F stated he had never heard anything about R1 and a staff person in a relationship prior to that. SSC-F stated in the beginning of October 2024 he was asked to write a care plan for R1 regarding trauma informed care. Social Service progress note dated 10/3/24 at 12:29 p.m., documents; Late Entry: Writer spoke with R1 regarding incident that had happened. R1 stated he was fine and that he had no hard feelings. Writer asked if he felt it would be beneficial for him to see someone for talk therapy. R1 stated no he did not feel it was necessary and that he has a good friend who he visits with on a regular basis who he confides in without judgement. After our talk resident went back to spending time outside with peers. Surveyor reviewed R1's individual plan of care that documents R1 is at risk for retraumatization of past event or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress. Date initiated: 10/4/24. Interventions included to provide a safe environment, monitor for increased withdrawal, anger or depressive behaviors and explore opportunities to avoid. R1 was offered a referral to Psychology as an additional intervention but declined. On 10/22/24 at 12:50 p.m., Surveyor interviewed VPS-G regarding R1. VPS-G stated he was the interim Nursing Home Administrator from 8/9/24 to 9/23/24. VPS-G stated all he was initially aware of is that R1 and CNA-C had exchanged phone numbers. He stated that going forward a whole different picture has been painted. VPS-G stated staff had started to talk about CNA-C having R1's phone number and they were texting one another. VPS-G said he went to talk with R1 and R1 denied anything was going on. CNA-C was also asked about having R1's phone number and she denied it as well. CNA-C stated she felt bad for R1 and just wanted to be there for him. Other facility staff did not say anything moving forward and I just thought there was nothing out of the ordinary going on. VPS-G stated then there was a text that came through to R1 and CNA-C was breaking things off. It was then brought to our attention again and we asked R1 about their relationship. R1 then became cooperative and shared all of the text messages between himself and CNA-C. VPS- G stated once we started to ask CNA-C questions about her having R1's phone number she was educated on this not being appropriate. CNA-C then resigned 9/4/24. Surveyor asked why VPS-G didn't start an investigation when he was made aware that R1 and CNA-C were texting one another. VPS-G stated he didn't think anything was going on and no one else came forward with any information. VPS-G stated he did not go and ask staff if they knew anything about R1 and CNA-C and that he did not ask R1 to see the text messages. VPS-G stated he did not interview R1's roommate nor did he ask any other residents about relationships with staff. VPS-G stated he was not aware R1 received gifts from CNA-C and looking back he should have asked more about the situation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/22/24 at 2:10 p.m., Surveyor interviewed Nursing Home Administrator-A regarding the facility's investigation into the relationship between R1 and CNA-C. Nursing Home Administrator-A stated that on 10/2/24, a staff member had come to her and had a concern about a text message she saw on R1's phone from CNA-C about calling the police on R1. Nursing Home Administrator-A stated she then went to talk with R1, and he denied it at first and said he was just friends with CNA-C. Nursing Home Administrator-A stated after talking with R1 a bit longer he agreed to share the text messages with her. Nursing Home Administrator-A stated she read through all of the messages, and they went back to July. R1 then let Nursing Home Administrator-A take pictures, with a facility cell phone, of the text messages. Nursing Home Administrator-A then said she had asked VPS-G if he had any knowledge of R1 and CNA-C being in a relationship. VPS-G stated he was aware they had exchanged phone numbers but they both stated they were just friends. Nursing Home Administrator-A stated on 9/4/24, she wanted to bring in CNA-C to talk about her about exchanging phone numbers with R1 and the purchase of t-shirts for him. CNA-C then resigned her position before we could get any further statement from her. Nursing Home Administrator-A stated there were a lot of rumors floating around about the relationship, but nobody actually said they saw anything. Nursing Home Administrator-A stated she would have expected staff to report rumors as suspected allegations. Nursing Home Administrator-A stated R1 initially denied anything was going on with CNA-C because he didn't want her to get into trouble. Nursing note dated 10/4/24 at 1:01 p.m., is documented by Nursing Home Administrator-A; Writer spoke to R1 about incident that occurred with former staff member. Writer encouraged resident to monitor his banking information. R1 stated he has had no discrepancies in his bank statements. He stated he will not be canceling his bank card. Writer educated R1 about proper relationships with staff members. R1 understands the expectations of relationships with staff members. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/23/24 at 9:05 a.m., Surveyor interviewed R1 in the privacy of his room. Surveyor explained that she had reviewed the facility's investigation regarding the relationship with CNA-C. Surveyor also stated that she was able to review the police report from the Police Department from when they came to speak with R1. Surveyor stated to R1 that she is aware that it must be a sensitive and difficult situation to talk about and that the purpose of the interview is to gain an understanding of how this situation affected R1. R1 stated CNA-C initially asked R1 for his phone number which he stated he gladly gave to her. R1 stated CNA-C was his caregiver and they had developed a friendship. R1 stated he was very comfortable with CNA-C. R1 said he really misses the relationship because he is just a lonely old guy. R1 said CNA-C would often visit him and he was always ok with that. R1 said he had given CNA-C a Visa debit card to purchase some items for him at Kwik Trip. CNA-C did accept it but didn't feel comfortable using it so she returned it to him. R1 said CNA-C did buy him t-shirts with her own money. R1 said CNA-C did want to stop the relationship and said that her job was more important. R1 said he always told CNA-C to not get in trouble because of him. R1 said then he felt like CNA-C knew something wasn't kosher and she told me I got her fired. R1 said CNA-C wouldn't talk to him after that. R1 said he felt really sad about this and asked Nursing Home Administrator-A if it was true that he got her fired. R1 said he never felt threatened by CNA-C only disappointed and sad. Surveyor asked R1 if he could talk a bit more about that. R1 said all I wanted to do is get out of this place and be with her. I don't want to be in a nursing home anymore. I thought we were going to be together forever. R1 said then CNA-C said that I was harassing her because I did text her a few times after she left. I was worried about her. R1 said CNA-C was going to call the police on him and that she and her husband would be filing the report. R1 said the whole situation has made him upset, the kind of upset you feel when you experience a bad break-up. R1 said some of the things CNA-C said to him in the end really broke his heart in two. R1 said he has been able to move on and has a few good friends at the facility he can talk to.R1 said he was offered to talk to a counselor, but he declined. R1 said he didn't think other staff members knew about him and CNA-C, but somehow things got around and there were a lot of rumors that they had sex. R1 said that was not true and, I always knew this place had ears. According to rightuseofpower.org, There is a power inequality whenever you take on a role that gives you authority over another or creates a perception that you have authority. Because of this inequality, residents can be manipulated, exploited, and/or abused by a caregiver who is allowed to begin a relationship with a resident. Therefore, the failure of facility staff to report the relationship between CNA-C and R1 to administration timely and the failure of administration to intervene and complete a thorough investigation into the relationship created a reasonable likelihood for serious harm, thus leading to a finding of Immediate Jeopardy. The facility removed the jeopardy on 10/23/24 when it completed the following: * Facility completed interviews of residents and staff on 10/9/24 by Executive Director or designee to determine any further concerns of actual or suspected abuse. * Facility staff reeducated by Executive Director or designee on Abuse, Neglect, and Exploitation policy starting 10/23/24 and will be completed prior to next scheduled shift. This reeducation included information on types of abuse, obligation to report abuse, abuse of power, and need to safeguard residents. This education included how abuse can affect a staff members licensure or ability to be employed in facility. * On 10/23/24 Director of Nursing Executive Director and [NAME] President of Success reviewed established Abuse, Neglect and Exploitation policy. No changes were necessary to this policy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Executive Director or Designee will interview a sampling of no less than 3 staff and 3 residents daily including review of grievances to ensure proper recognition, reporting, and notification of suspected/potential or actual abuse. These audits will be completed daily for 2 weeks, then 5 days per week for 10 weeks or until substantial compliance is maintained. Results of these audits will be brought to QAPI (quality assurance performance improvement) for review and recommendation. * ADHOC QAPI review of this plan was completed 10/23/24 with Medical Director, VP (Vice President) of Success, Director of Nursing, and Executive Director.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 16584 Based on record review and staff interviews, the facility did not always ensure that they reported allegations of sexual abuse and exploitation to Nursing Home Administrator (NHA)-A and to the State Survey Agency. This occurred for 1 of 1 resident reviewed (R1). Facility staff became aware of a relationship between R1 and CNA (Certified Nursing Assistant)-C that included months of communication via phone calls, text messages, and in-person visits to the resident's room. CNA-C would often visit R1 while working at the facility when she was not assigned to his unit. By the staff not reporting to Administration what they had heard and observed, it allowed the alleged perpetrator (CNA-C) continued access to R1. In addition, the facility failed to submit to the State Survey Agency within the required timeframes, the allegation of sexual abuse and exploitation when they were finally made aware in August 2024. CNA-C worked various shifts, on multiple units of the facility. This had the potential to effect the entire census of 69 residents. Findings include: The facility's policy dated as reviewed 7/15/2022 and titled, Abuse, Neglect and Exploitation documents: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. VII. Reporting/ Responses 1. Reporting of alleged violations to the NHA, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily harm. 1.) Surveyor became aware that R1 was in a relationship with Certified Nursing Assistant (CNA)-C which began in July 2024. CNA-C was employed at the facility until 9/4/2024 and worked various shifts on various units throughout the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/21/24 at 9:30 a.m., Surveyor began a review of the facility's reported incident which documents there was an allegation of an inappropriate relationship with former staff member (CNA-C) overstepping boundaries and may or may not involve exploitation (taking advantage of a resident for personal gain.) The date discovered is documented as 10/2/24. The date of occurrence is 10/2/24 at 2:15 p.m. The occurred date and time are estimated. The timeline included in the facility's investigation states that on 10/1/24, an employee made NHA-A aware of text messages between R1 and CNA-C. On 10/1/24, NHA-A spoke to R1 and asked about R1's relationship with CNA-C and the employee using his credit card. R1 denied the employee used his card. R1 stated that the relationship was not an intimate relationship, they were just friends. R1 denied any text messages and did not want to be questioned about the incident. On 10/2/24, NHA-A interviewed R1 again and asked if she can read their (CNA-C and R1) text messages. R1 allowed NHA-A to read through the text messages on his cell phone. The text messages date back to 7/6/24. Text messages include, I love you, I cant wait for us to be together, I miss you, I want to kiss you from head to toe, I can't wait to lay with you, let's be alone, I only belong to you, jealous statements about other caregivers; there were text messages that talked about R1's penis and being inappropriate with R1. Surveyor continued to review the facility's investigation and noted that on 10/2/24, the facility notified the Summit Police Department. Surveyor was able to review the police report. The report includes details included in the text messages as well as R1 stating he touched CNA-C's breasts under her shirt and the two of them kissed on multiple occasions. The facility's investigation included statements from staff members. The statements are documented below. On 10/5/24, CNA-H answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-H wrote, No, I have not first person, but I have heard about it from several residents. Question #2-are you aware of staff giving residents gifts? CNA-H wrote yes. On 10/4/24, CNA-I answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-I wrote, I haven't witnessed any myself, but I did hear rumors about something from residents and a CNA about a month or two ago. On 10/4/24, CNA-J answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-J wrote, No I have not witnessed any inappropriate relationships between staff and residents, I've only heard about something of the sort through whispers. On 10/4/24, CNA-K answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-K wrote, I've heard about it through staff and I have seen sweet/sexual notes from staff to resident. Question #2-are you aware of staff giving residents gifts? CNA-K wrote yes. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/7/24, CNA-L wrote a witness statement that documented the following: I witnessed an inappropriate relationship between a resident and a coworker. I am aware of the coworker giving the resident new clothes such as T-shirts. My resident showed me text messages between them. I then reported it to Social Services and Human Resources. My resident had confided in me and told me they were dating, which I reported. A note from the coworker was left pinned up to the resident's bulletin board. It was found in the morning after she was scheduled as a CNA for night shift on unit 200. On 10/21/24 at 12:50 p.m., Surveyor interviewed CNA-D regarding R1. CNA-D stated she was aware of the situation involving R1 and CNA-C and had heard other staff talk about inappropriate texts and letters and that the staff member bought things for R1. CNA-D stated that she didn't report it because it was all hearsay. CNA-D stated that talk started buzzing around April/May about R1 and CNA-C and then in July it was an everyday topic between staff. Staff would see CNA-C make her way around the facility and out of her way to go see R1. All the staff just wondered why. CNA-D stated that she was aware several people reported it to their supervisors. CNA-D stated that it wasn't until R1 brought it to upper management that an investigation was really done. On 10/22/24 at 8:10 a.m., Surveyor interviewed Registered Nurse (RN)-E regarding R1 and CNA-C. RN-E stated that sometime between August 5-9th 2024 a night CNA came to her and reported that she felt there was some inappropriate contact between R1 and CNA-C. RN-E stated that she reported it to the Director of Nursing (previous) and NHA (previous). RN-E then stated that sometime between August 20-23rd, 2024, while at the 200 Unit nursing station, she heard a CNA talking about the relationship between R1 and CNA-C and that she had bought items for R1. RN-E stated that she then reported this to former NHA/VP of Success-G and he said he would take it from there. RN-E stated that R1 would make comments about text messages and other staff would see CNA-C going into R1's room when she would be assigned to work on a different unit. RN-E stated that even R1's roommate would say that R1's girlfriend was here again last night. On 10/22/24 at 12:50 p.m., Surveyor interviewed VPS-G regarding R1. VPS-G stated that he was the interim NHA from 8/9/24 to 9/23/24. VPS-G stated that all he was initially aware of is that R1 and CNA-C had exchanged phone numbers. He stated that going forward a whole different picture has been painted. VPS-G stated that staff had started to talk about CNA-C having R1's phone number and they were texting one another. VPS-G said he went to talk with R1 and R1 denied anything was going on. CNA-C was also asked about having R1's phone number and she denied it as well. CNA-C stated that she felt bad for R1 and just wanted to be there for him. Other facility staff did not say anything moving forward and I just thought there was nothing out of the ordinary going on. VPS-G stated that then there was a text that came through to R1 and CNA-C was breaking things off. It was then brought to our attention again and we asked R1 about their relationship. R1 then became cooperative and shared all of the text messages between himself and CNA-C. VPS-G stated that once we started to ask CNA-C questions about her having R1's phone number she was educated on this not being appropriate. CNA-C then resigned 9/4/24. Surveyor asked why VPS-G didn't start an investigation when he was made aware that R1 and CNA-C were texting one another. VPS-G stated that he didn't think anything was going on and no one else came forward with any information. VPS-G stated he did not go and ask staff if they knew anything about R1 and CNA-C and that he did not ask R1 to see the text messages. VPS-G stated he did not interview R1's roommate nor did he ask any other residents about relationships with staff. VPS-G stated he was not aware that R1 received gifts from CNA-C and that looking back he should have asked more about the situation. VPS-G also did not report to the state survey agency within the required timeframe, as an investigation was not conducted until 10/2/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/22/24 at 2:10 p.m., Surveyor interviewed NHA-A regarding the facility's investigation into the relationship between R1 and CNA-C. NHA-A stated that on 10/2/24, a staff member had come to her and had a concern about a text message she saw on R1's phone from CNA-C about calling the police on R1. NHA-A stated that she then went to talk with R1, and he denied it at first and said he was just friends with CNA-C. NHA-A stated that after talking with R1 a bit longer he agreed to share the text messages with her. NHA-A stated she read through all of the messages, and they went back to July. R1 then let NHA-A take pictures of the text messages with a facility cell phone. NHA-A then said she had asked VPS-G if he had any knowledge of R1 and CNA-C being in a relationship. VPS-G stated that he was aware they had exchanged phone numbers but they both stated they were just friends. NHA-A stated that on 9/4/24 she wanted to bring in CNA-C to talk about her about exchanging phone numbers with R1 and the purchase of T-shirts for him. CNA-C then resigned her position before we could get any further statement from her. NHA-A stated that there were a lot of rumors floating around about the relationship, but nobody actually said they saw anything. NHA-A stated that she would have expected staff to report rumors as suspected allegations. As of the time of survey exit on 10/23/24, the facility did not provide any additional information as to why facility staff did not report suspected abuse/exploitation happening between R1 and CNA-C immediately and also why the facility Administration did not report the allegation to the state survey agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not always ensure allegations of abuse/exploitation were thoroughly investigated for 2 out of 2 residents reviewed (R1, R6). * Facility staff became aware of a relationship between R1 and CNA (Certified Nursing Assistant)-C that included months of communication via phone calls, text messages, and in-person visits to the resident's room. CNA-C would often visit R1 while working at the facility when she was not assigned to his unit. By the staff not reporting to Nursing Home Administrator (NHA) what they had heard and observed, it allowed the alleged perpetrator (CNA-C) continued access to R1. When NHA did become aware that R1 and CNA-C had exchanged phone numbers, they failed to thoroughly investigate the situation by talking with staff who may have knowledge of the incident. CNA-C worked various shifts on multiple units of the facility. This had the potential to effect the entire census of 69 residents. *R6's family member expressed a concern to the facility regarding R6 expressing a Certified Nursing Assistant (CNA) was rough with cares. The facility did not investigate the allegation of abuse/mistreatment and the facility has no documentation of this incident. Findings include: The facility's policy dated as reviewed 7/15/2022 and titled, Abuse, Neglect and Exploitation documents: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s). VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. (continued on next page)

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Lake Country Health Services	2195 North Summit Village Way Oconomowoc, WI 53066

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. Providing emotional support and counseling to the resident during and after the investigation, as needed. Surveyor became aware that R1 was in a relationship with Certified Nursing Assistant (CNA)-C which began in July 2024. CNA-C was employed at the facility until 9/4/2024 and worked various shifts on various units throughout the facility. On 10/21/24 at 9:30 a.m., Surveyor began a review of the facility's reported incident which documents there was an allegation of an inappropriate relationship with former staff member (CNA-C) overstepping boundaries and may or may not involve exploitation (taking advantage of a resident for personal gain). The date discovered is documented as 10/2/24. The date of occurrence is 10/2/24 at 2:15 p.m. The occurred date and time are estimated. The timeline included in the facility's investigation stated that on 10/1/24 an employee made Administrator-A aware of text messages between R1 and CNA-C. On 10/1/24, Administrator-A spoke to R1 and asked about R1's relationship with CNA-C and the employee using his credit card. R1 denied the employee used his card; R1 stated the relationship was not an intimate relationship, they were just friends. R1 denied any text messages and did not want to be questioned about the incident. On 10/2/24, Administrator-A interviewed R1 again and asked if she can read their (CNA-C and R1) text messages. R1 allowed Administrator-A to read through the text messages on his cell phone. The text messages date back to 7/6/24. Text messages include, I love you, I cant wait for us to be together, I miss you, I want to kiss you from head to toe, I can't wait to lay with you, let's be alone, I only belong to you, and jealous statements about other caregivers; there were text messages that talked about R1's penis and being inappropriate. The facility's investigation included statements from staff members. The following statements documented: On 10/5/24, CNA-H answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-H wrote, No, I have not first person, but I have heard about it from several residents. Question #2-are you aware of staff giving residents gifts? CNA-H wrote yes. On 10/4/24, CNA-I answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-I wrote, I haven't witnessed any myself, but I did hear rumors about something from residents and a CNA about a month or two ago. On 10/4/24, CNA-J answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-J wrote, No I have not witnessed any inappropriate relationships between staff and residents, I've only heard about something of the sort through whispers. On 10/4/24, CNA-K answered the following question: Have you ever witnessed any inappropriate relationships between staff and residents? CNA-K wrote, I've heard about it through staff and I have seen sweet/sexual notes from staff to resident. Question #2-are you aware of staff giving residents gifts? CNA-K wrote yes. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/7/24, CNA-L wrote a witness statement that documented the following: I witnessed an inappropriate relationship between a resident and a coworker. I am aware of the coworker giving the resident new clothes such as T-shirts. My resident showed me text messages between them. I then reported it to Social Services and Human Resources. My resident had confided in me and told me they were dating, which I reported. A note from the coworker was left pinned up to the resident's bulletin board. It was found in the morning after she was scheduled as a CNA for night shift on unit 200. On 10/21/24 at 12:50 p.m., Surveyor interviewed CNA-D regarding R1. CNA-D stated she was aware of the situation involving R1 and CNA-C and had heard other staff talk about inappropriate texts and letters and that the staff member bought things for R1. CNA-D stated that she didn't report it because it was all hearsay. CNA-D stated that talk started buzzing around April/May about R1 and CNA-C and then in July it was an everyday topic between staff. Staff would see CNA-C make her way around the facility and out of her way to go see R1. All the staff just wondered why. CNA-D stated that she was aware several people reported it to their supervisors. CNA-D stated that it wasn't until R1 brought it to upper management that an investigation was really done. On 10/22/24 at 8:10 a.m., Surveyor interviewed Registered Nurse (RN)-E regarding R1 and CNA-C. RN-E stated that sometime between August 5-9th 2024 a night CNA came to her and reported that she felt there was some inappropriate contact between R1 and CNA-C. RN-E stated that she reported it to the Director of Nursing (previous) and Administrator (previous). RN-E then stated that sometime between August 20-23rd, 2024, while at the 200 Unit nursing station, she heard a CNA talking about the relationship between R1 and CNA-C and that she had bought items for R1. RN-E stated that she then reported this to former Administrator/VP of Success-G and he said he would take it from there. RN-E stated that R1 would make comments about text messages and other staff would see CNA-C going into R1's room when she would be assigned to work on a different unit. RN-E stated that even R1's roommate would say that R1's girlfriend was here again last night. On 10/22/24 at 12:50 p.m., Surveyor interviewed VPS-G regarding R1. VPS-G stated that he was the interim Administrator from 8/9/24 to 9/23/24. VPS-G stated that all he was initially aware of is that R1 and CNA-C had exchanged phone numbers. He stated that going forward a whole different picture has been painted. VPS-G stated that staff had started to talk about CNA-C having R1's phone number and they were texting one another. VPS-G said he went to talk with R1 and R1 denied anything was going on. CNA-C was also asked about having R1's phone number and she denied it as well. CNA-C stated that she felt bad for R1 and just wanted to be there for him. Other facility staff did not say anything moving forward and I just thought there was nothing out of the ordinary going on. VPS-G stated that then there was a text that came through to R1 and CNA-C was breaking things off. It was then brought to our attention again and we asked R1 about their relationship. R1 then became cooperative and shared all of the text messages between himself and CNA-C. VPS-G stated that once we started to ask CNA-C questions about her having R1's phone number, she was educated on this not being appropriate. CNA-C then resigned 9/4/24. Surveyor asked why VPS-G didn't start an investigation when he was made aware that R1 and CNA-C were texting one another. VPS-G stated that he didn't think anything was going on and no one else came forward with any information. VPS-G stated he did not go and ask staff if they knew anything about R1 and CNA-C and that he did not ask R1 to see the text messages. VPS-G stated he did not interview R1's roommate nor did he ask any other residents about relationships with staff. VPS-G stated he was not aware that R1 received gifts from CNA-C and that looking back he should have asked more about the situation. VPS-G also did not report to the state survey agency within the required timeframes, as an investigation was not conducted until 10/2/24. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review, the facility did not ensure their admissions policy was followed for 1 resident (R16) of 1 residents reviewed. * R16 was admitted on [DATE] and did not sign the admission agreement within 48 hours which includes but not limited to: consent to treat, financial agreement, and resident rights. Findings Include: The facility's Admission Policy implemented 10/1/18 and last revised on 11/1/23 documents: Policy : All facilities must follow the policy and procedures for all admissions to mitigate bad debt risk. The admission process sets the precedent for all the billing and collection process. The Executive Director will delegate the admission process to the appropriate individual(based on staffing pattern of the facility). This individual must ensure that both clinical and financial assessments are completed before any admission decision. Policy Explanation and Compliance Guidelines Admission Agreement The Admissions Designee, will ensure the admission agreement and Alternative Dispute Resolution(ADR) is completed in Carefeed on day of admission, with proper signatures in place. The entire admission packet should be completed in Carefeed within 48 hours of admission. Note, the patient/family is NOT required to sign in agreement of the ADR. A new admission agreement is required in the following circumstances: -All first time admissions -Any admission that was discharged with no intent to return, regardless of time between discharge and return A properly signed admission agreement should include the following: -Patient's signature, unless deemed legally incompetent. In this case, the Medical Director needs to document the reason in the medical chart. In addition, two facility signatures are required. OR -Patient's x mark, if unable to sign. In this situation, two facility signatures are required as witness. -Legal representative, if applicable (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Facility representative -If signed by a Legal representative, a copy of the applicable legal documents must be provided to the facility and maintained with admission documents Financial Agreement The financial Agreement must be completed in Carefeed by the business office manager, or designee, on all admissions except short term stays that have confirmed a pay source for the entire stay. The admitting pay source should have already been confirmed prior to admission. This agreement serves as a validation of that pay source, as well as a determination of next or secondary pay source. Information should be obtained prior to admission if possible. If necessary, the agreement is to be completed on day of admission. The information is needed to ensure they receive any and all benefits that they are entitled to receive. Potential available benefits include, but are not limited to: -Insurance-Must follow specific insurance requirements regarding authorizations, documentation, etc. -Insurance may cover part of a stay based on level of care needs A business office associate should also meet with the patient/family to discuss the following: -Payment terms and expectations -Format of monthly statement -Benefits of Direct Deposit, if not signed upon admission -All other benefits available for the patient Admission File After all Signers have completed their session in Carefeed and the documents move to Completed Status, the admission agreements, along with supporting documents, are automatically, uploaded to the patient's PCC Misc tab by Carefeed. The admission file documents are maintained in PCC Misc tab. 1.) R16 was admitted to the facility on [DATE] with diagnoses of Other Specified Diseases of Liver, Muscle Weakness, Hypertensive Heart Disease with Heart Failure, Unspecified Asthma, Arthropathic Psoriasis, Immunodeficiency, Type 2 Diabetes Mellitus, and Adjustment Disorder with Muscle Weakness. R16 discharged from the facility on 10/17/24. R16's Admission Minimum Data Set(MDS) completed on 9/23/24 documents R16 has a Brief Interview for Mental Status(BIMS) score of 15, indicating R16 was cognitively intact for daily decision making at time of assessment. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 11:24 AM, Surveyor interviewed Admission Director (AD-M) in regards to the admission process. AD-M explained that all admission paperwork should be explained to the Resident and/or representative including insurance benefits. The admission paperwork should be completed timely of admission to the facility. The admission paperwork is completed electronically and AD-M always offers to provide the Resident and/or representative with a 'hard copy'. AD-M informed Surveyor that AD-M was out on medical leave during the time R16 was admitted to the facility and that Social Services Coordinator (SSC-F) was completing the admission paperwork for new Residents admitted to the facility. On 10/22/24 at 12:42 PM, Surveyor spoke to SSC-F in regards to R16 and the admission process. SSC-F confirmed that SSC-F was covering for admissions and completing the required paperwork when R16 was admitted to the facility. SSC-F believes SSC-F had R16 sign electronically on the facility's I-Pad. Surveyor requested a copy of R16's signed admission agreement including notification of R16's financial agreement. Surveyor explained to SSC-F that Surveyor is unable to locate the Admission File in R16's electronic medical record(EMR). On 10/22/24 at 2:18 PM, SSC-F informed Surveyor that R16's admission paperwork somehow got deleted and the facility is working on getting it retrieved. On 10/22/24 at 3:15 PM, Surveyor shared the above findings with Nursing Home Administrator (NHA-A) and Director of Nursing (DON-B) regarding that R16's signed admission paperwork is not available. On 10/23/24 at 9:04 AM, NHA-A informed Surveyor that R16's admission paperwork including but not limited to: consent to treat and financial agreement was not reviewed with R16 and/or representative and acknowledged with signature of understanding by R16 and/or representative. NHA-A stated the expectation is that it should have been completed with R16 and/or representative and several things fell through the cracks during that period of time. NHA-A stated he understood the concern that R16's admission paperwork was not reviewed and acknowledged by R16 and/or representative. No additional information was provided by the facility at this time.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure 1 (R16) of 16 Residents reviewed had a comprehensive care plan that was reviewed and revised by the interdisciplinary team as determined by the Resident's assessed needs. R16's care plan was not revised to accurately identify R16's at risk for pressure areas/skin impairments, the need for a toileting plan, and discharge planning interventions. Findings Include: 1.) R16's Admission Minimum Data Set(MDS) completed on 9/23/24 documents R16 has a Brief Interview for Mental Status(BIMS) score of 15, indicating R16 was cognitively intact for daily decision making. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for shower/bathing, lower dressing, personal hygiene, rolling left to right, and sit to lying. R16 required partial/moderate assistance for upper dressing. R16 was dependent for sit to stand, transferring from chair to bed, and toileting transfers. R16 was occasionally incontinent of bladder and always continent of bowel on the admission MDS. R16's MDS documents R16 desired to discharge to the community and required active discharge planning. R16's quarterly MDS completed on 10/9/24 documents R16's BIMS score to be 11, indicating R16 was demonstrating moderately impaired skills for daily decision making. R16's MDS also documents at this time that R16 is frequently incontinent of bowel and bladder. R16's Discharge MDS completed on 10/17/24 does not assess R16's cognitive skills. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for lower dressing, personal hygiene. Shower/bathing was not attempted due to medical condition. R16 required partial/moderate assistance for upper dressing, sit to lying and lying to sitting, sit to stand, chair to bed transfer, and toilet transfer. Transferring to to tub/shower was not attempted due to medical condition. R16 was supervision for rolling left to right. R16 was frequently incontinent of bladder and always incontinent of bowel. R16's comprehensive care plan documents R16 shows potential for discharge initiated 9/17/24. Goal was to discharge home when clinical and rehabilitation goals are met. Interventions included: -Arrange transportation-9/17/24 -Complete a post discharge plan. Provide copy and review with Resident and/or representative 9/17/24 -Investigate need for special equipment, home health services, lifeline, outpatient therapy, physical follow up, resources. Make referrals as needed. 9/17/24 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review progress toward discharge during scheduled meetings 9/20/24 Surveyor notes that R16's discharge focused problem was not revised during R16's stay at the facility to incorporate a person-centered approaches, knowing R16 potentially having only 30 days of stay at the facility. R16's comprehensive care plan documents R16 has urinary incontinence due to impaired mobility initiated 10/1/24. Interventions included: -Administer medication per MD orders 10/1/24 -Apply skin moistures/barrier creams as needed 10/1/24 -Place urinal/bedpan within Residents reach 10/1/24 -Provide assistance with toileting 10/1/24 -Provide incontinent care as needed 10/1/24 On 9/20/24 a grievance was filed by R16 in regards to incontinence care. A toileting plan was to be implemented at night. R16 was occasionally incontinent of bladder, always continent of bowel at admission and was frequently incontinent of bladder and always incontinent of bowel at time of discharge. R16's care plan was not revised to include person centered interventions for a toileting plan or interventions to address R16's continence decline. Surveyor notes that R16 has shearing documented on R16's admission evaluation dated 10/17/24. R16 also had blisters on bilateral arms and legs that at times would be described as weeping. R16's skin focused problem initiated 9/17/24 states the following: Actual at(specify location) due to -Administer treatment per MD orders 9/17/24 -Encourage and assist as needed to turn and reposition; use assuasive devices as needed 9/17/24 -Float heels as able 9/17/24 -Report evidence of infection such purulent drainage, [NAME], localized heat, increased pain, notify MD PRN 9/17/24 Surveyor notes that R16's skin care plan was not revised to include person centered interventions to identify the potential for skin breakdown including pressure relieving mattress, pressure relieving cushion for wheelchair, person centered intervention to float heels, and interventions to address R16's blisters on bilateral arms and legs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 11:07 AM, Surveyor interviewed Director of Nursing (DON-B). DON-B agreed that R16's comprehensive care plan was not person centered and the care plan was lacking for person centered interventions. DON-B understands that R16 did not participate in the revision of R16's care plan and R16's care plan was not revised to incorporate appropriate goals and needs of R16. DON-B understands the concern and the facility had no additional information to provide.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review, the facility did not develop and implement an effective discharge planning process focusing on resident discharge goal, preparation for transition and reduction in factors leading to preventable readmission for 1 resident (R16) of 1 residents reviewed for discharge planning. * The facility did not complete the admission process for R16 and/or representative including explaining R16's available benefits at time of admission detailing that R16 would either need to private pay as of 10/18/24, or the facility would need to assist R16 with an effective discharge plan for 10/18/24. R16 was notified at 8:45 AM on 10/17/24 the option of private pay or discharge home effective 10/18/24. R16 chose to discharge home on 10/18/24. Findings Include: The facility's Transfer and Discharge Policy implemented June 2017 and last revised on 7/15/22 documents: Anticipated Transfers or Discharges-initiated by the Resident a. Obtain physicians' orders for transfer or discharge and instructions or precautions for ongoing care. b. A member of the interdisciplinary (IDT) team completes relevant sections of the Discharge Summary. The nurse caring for the Resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: i. A recap of the Resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. ii. A final summary of the Resident's status. iii. Reconciliation of all pre-discharge medications with the Resident's post-discharge medications. iv. A post discharge plan of care that is developed with the participation of the Resident, and the Resident's representative(s) which will assist the Resident to adjust to his or her new living environment. c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the Resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. The comprehensive, person-centered care plan shall contain the Resident's goals for admission and desired outcomes and shall be in alignment with the discharge. 1.) R16 was admitted to the facility on [DATE] with diagnoses of Other Specified Diseases of Liver, Muscle Weakness, Hypertensive Heart Disease with Heart Failure, Unspecified Asthma, Arthropathic Psoriasis, Immunodeficiency, Type 2 Diabetes Mellitus, and Adjustment Disorder with Muscle Weakness. R16 discharged from the facility on 10/17/24. R16's Admission Minimum Data Set(MDS) completed on 9/23/24 documents R16 has a Brief Interview for Mental Status(BIMS) score of 15, indicating R16 was cognitively intact for daily decision making. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for shower/bathing, lower dressing, personal hygiene, rolling left to right, and sit to lying. R16 required partial/moderate assistance for upper dressing. R16 was dependent for sit to stand, transferring from chair to bed, and toileting transfers. R16 was occasionally incontinent of bladder and always continent of bowel on the admission MDS. R16's MDS documents R16 desired to discharge to the community and required active discharge planning. R16's quarterly MDS completed on 10/9/24 documents R16's BIMS score to be 11, indicating R16 was demonstrating moderately impaired skills for daily decision making. R16's Discharge MDS completed on 10/17/24 does not assess R16's cognitive skills. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for lower dressing, personal hygiene. Shower/bathing was not attempted due to medical condition. R16 required partial/moderate assistance for upper dressing, sit to lying and lying to sitting, sit to stand, chair to bed transfer, and toilet transfer. Transferring to to tub/shower was not attempted due to medical condition. R16 was supervision for rolling left to right. R16 was frequently incontinent of bladder and always incontinent of bowel. R16's comprehensive care plan documents R16 shows potential for discharge initiated 9/17/24. Goal was to discharge home when clinical and rehabilitation goals are met. Interventions included: -Arrange transportation-9/17/24 -Complete a post discharge plan. Provide copy and review with Resident and/or representative 9/17/24 -Investigate need for special equipment, home health services, lifeline, outpatient therapy, physical follow up, resources. Make referrals as needed. 9/17/24 -Review progress toward discharge during scheduled meetings 9/20/24 Surveyor notes R16's discharge care plan is not person-centered and was not updated during R16's stay at the facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, a care conference was held with Resident and family in attendance. It is documented that there may be a need for more care services in the home. If necessary upon discharge, may need electric lift. R16 is currently still very weak and requiring a lot of assistance with transfers and activities of daily living(ADLS). R16 and family concerned about how to address R16's needs at home if unable to build up a lot of strength. On 9/27/24, R16 was diagnosed with COVID, requiring isolation. R16's Occupational Therapy(OT) Discharge Summary dated 10/17/24 documents R16 had a setback during that period of time and both OT and Physical Therapy (PT) could be provided at bedside. Surveyor notes with every visit of R16, Doctor of Osteopathic Medicine (DO)-BB documents that discharge planning including discussion with therapy team, family and social worker is the goal. DO-BB also documents with every visit that durable medical equipment(DME) needs will be determined and ordered based on R16's needs at time of discharge. Discharge planning did not occur for R16 until the day before discharge and ordering of DME did not occur during R16's stay at the facility. On 10/17/24 at 8:45 AM, Social Services Coordinator (SCC)-F documents that Director of Nursing (DON)-B and SSC-F went to R16's room to discuss that R16's insurance days had been exhausted with a last covered day being 10-16-24. SSC-F and DON-B were not aware of the insurance policy of only having 30 days at the facility. SSC-F informed R16 that the options were to either discharge home or privately pay at the facility. R16 did not want to pay privately at the facility and requested discharge home. SSC-C does not document any attempts to order DME. SSC-F documents that SSC-F was informed by MDS Reimbursement (MDS)-T that R16 could not appeal. On 10/17/24 at 8:48 AM, DON-B documents that DON-B called family of R16 and informed that R16's insurance was ending and R16 wanted to proceed with discharge. On 10/17/24 at 11:51 AM, DON-B documents that R16 receives PT and OT. R16 transfers with 2 assist stand pivot in therapy, and with a sit to stand on the floor, toilets with sit to stand and dependent on peri-care, upper body dressing minimum assist, lower body dressing moderate assist, unable to ambulate and bed mobility is minimum to moderate assist. R16 will need diabetic teaching in preparation for discharge. Surveyor notes the facility obtained a discharge order from the physician including home health, PT and OT. A Recapitulation of Stay was completed, 30 day medication supply sent to R16's pharmacy of choice and a referral was made to a home health agency. No documentation that needed DME was obtained. R16 did sign the Discharge Instructions. Surveyor notes there is a diabetic teaching in preparation for discharge, document what was taught and response every shift with a start date of 10/17/24. There is no documentation in R16's electronic medical record(EMR) of diabetic teaching On 10/22/24 at 9:28 AM, Surveyor spoke with Intake Home Health (IHH)-EE who confirmed that a referral was sent on 10/17/24 by the facility. IHH-E stated that R16 was admitted back to the hospital on 10/18/24. Documentation in the system stated that R16 was unsafe at home and will need a skilled nursing facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 9:37 AM, Surveyor spoke with Registered Nurse Home Health (RNHH)-R who stated that RNHH-R was notified by R16's primary physician's office on 10/18/24 that the office called an ambulance for R16. RNHH-R was informed it took 5 people to get R16 into the home and RNHH-R had conflicting information that either R16 wanted to go home or that R16's insurance benefits had run out. On 10/22/24 at 10:22 AM, Surveyor spoke with Registered Nurse (RN)-S from R16's primary physician's office. RN-S stated the office received a very frantic phone call from R16's family about 8:30 AM on 10/18/24. RN-S stated the family could not take care of R16 and that R16 needed a sit to stand or hoyer lift but there was neither in the home. RN-S confirmed the office called an ambulance for R16. R16 was admitted back in the hospital on 10/18/24 with diagnoses of sepsis and urinary tract infection(UTI). RN-S stated that R16 had a raging UTI and a narly wound on R16's buttocks. RN-S did not receive any discharge paperwork for R16 from the facility. On 10/22/24 at 11:15 AM, Surveyor interviewed MDS-T in regards to R16's insurance benefits. MDS-T explained that R16's insurance was not medicare and R16 only had 30 days coverage. MDS-T stated that R16 could have appealed directly to the insurance company, stayed at the facility pending the results and possibly would have had to pay out of pocket if decision was not to continue coverage at the facility. The initial verification of 30 day benefit would have been circulated to the rest of the interdisciplinary team(IDT). On 10/22/24 at 11:24 AM, Surveyor interviewed Admissions Director (AD)-M in regards to R16. AD-M stated that exact insurance coverage/benefits should be explained to the Resident and/or representative at time of admission as well as explained to the IDT. AD-M informed Surveyor that AD-M was on medical leave when R16 was admitted and SSC-F was covering. On 10/22/24 at 12:42 PM, Surveyor interviewed SSC-F. SSC-F confirmed SSC-F was completing the admission process during the time R16 was admitted to the facility. SSC-F stated that Central Intake (CI)-U confirms a Resident's verification of insurance benefits and informs the facility. SSC-F denies being aware that R16 only had 30 days for rehabilitation. SSC-F stated that insurance updates did not indicate that R16 only had 30 days of benefits. SSC-F stated that therapy does a home evaluation. SSC-F stated that R16 was not offered the option to appeal directly to the insurance company. SSC-F stated that R16 was given the option to private pay for continued rehabilitation or discharge home and R16 chose to discharge home. SSC-F stated that R16's family indicated they would order a sit to stand for R16. SSC-F confirmed that R16 would have benefited from more time at the facility. On 10/22/24 at 1:42 PM, Director of Rehabilitation (DOR)-W stated that R16 was a sit to stand with assistance of 2 and all ADLS was an assist of 1. DOR-W informed Surveyor that the therapy department did not know R16 only had 30 days of benefits. DOR-W confirmed that therapy completes home evaluations. DOR-W stated that therapy did not do a home evaluation prior to discharge because it was not recommended by therapy that R16 return home. DOR-W confirmed that R16 was making minimal improvements slowly and was slowed down when R16 got COVID. DOR-W stated that R16 was not at baseline at time of discharge and that there was no sit to stand currently at home for R16. On 10/22/24 at 2:01 PM, Surveyor confirmed with MDS-T that R16 could have with the assistance of SSC-F appeal directly to the insurance company. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 9:11 AM, Surveyor interviewed Corporate Level CI-U. CI-U confirmed referrals for skilled nursing facility is handled by CI-U. CI-U verify's financials through electronic medical record which gives a quick summary. CI-U states that each facility is responsible for confirming verification of benefits of each Resident which is done by the business office. CI-U denies verifying R16's insurance benefits. On 10/23/24, at 9:37 AM, Surveyor interviewed Business Office Assistant (BOM)-Q. BOM-Q stated that verification of benefits for a Resident is completed at the Corporate Level (CI-U) and that SSC-F was covering the admission process when R16 was admitted to the facility. On 10/23/24, at 10:01 AM, DON-B does not recall what was discussed with family when DON-B made the phone call to discuss R16's discharge. On 10/23/24, at 10:13 AM, SSC-F confirmed that CI-U was helping with verification of benefits when SSC-F was helping with the admission process. SSC-F stated that CI-U would print off the verification of benefits and send with the referral for each Resident. Surveyor notes that on 9/16/24, 1 day prior to R16's admission to the facility on [DATE], the facility was notified per documentation on the verification of benefits for R16, that R16 only had 30 days of coverage at the facility. The facility did not initiate discharge planning with the intent to discharge R16 after the 30 days. The facility did not review the insurance benefits of coverage with R16 and/or representative at time of admission as the facility as no documentation that R16 and/or representative signed acknowledgement of financial benefits during the admission process. The facility did not provide R16 with the option to appeal directly to the insurance company. R16 discharged late afternoon on 10/17/24. IDT confirm R16 was not safe to discharge home and could have benefited from more skilled nursing care, which resulted in R16 being admitted to the hospital less than 24 hours from discharge. On 10/23/24 at 11:21 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that the facility waited until the last covered day to inform R16 of the issue with the 30 day insurance benefits, despite documentation that the facility knew of the R16's 30 day insurance coverage 1 day prior to R16's admission to the facility. NHA-A agreed that discharge planning was inadequate for R16 and communication with IDT hampered the discharge process for R16. No additional information was provided by the facility at this time.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on observation, interview, and record review the facility did not provide the necessary ADL (Activities of Daily Living) services for 3 (R7, R11, and R13) of 17 residents who were dependent on staff to provide ADL care. R7 is dependent for bathing and R7 did not receive showers on 9/8/24 and 9/15/24. R11 is dependent for bathing and R11 received 2 showers for the month of September 2024. R13 is dependent for continence care and did not receive continence care multiple times in July 2024. Findings include: 1.) R7 was admitted to the facility on [DATE] with a diagnosis that includes hemiplegia, anxiety, neuromuscular dysfunction of the bladder, dementia, reduced mobility, and speech deficits following cerebral infarction. R7 is dependent on staff for bathing, transferring, and toileting. Surveyor reviewed R7's medical record which documents R7 did not receive a shower on 9/8/24 and 9/15/24. Surveyor could not locate any not documentation of R7 declining a shower on 9/8/24 or 9/15/24. R11 was admitted to the facility on [DATE], with a diagnosis that includes multiple sclerosis, chronic respiratory failure, and morbid obesity. R11 is dependent on staff for bathing and toileting. Surveyor reviewed R11's medical record which documents R11 received 2 showers for the month of September 2024. Surveyor notes R11 received a shower on 9/20/24 and 9/24/24. Surveyor does not see documentation of R11 declining a shower on 9/3/24, 9/6/24, 9/10/24, 9/13/24, 9/17/24, and 9/27/24. On 10/22/24 at 10:07 am, Surveyor interviewed Director of Nursing (DON)- B who states Certified Nursing Assistant (CNA)'s provide showers to residents. CNA's are to notify the nurse if a resident declines a shower and document in the computer. Surveyor notified DON- B of shower concerns with R7 and R11. DON- B indicates R11 receives bed baths which may not be documented, but then states she is new to the facility and still learning residents. DON- B states R7 gets a lot of visitors on Sundays and staff may have offered baths on a different day. On 10/22/24 at 11:20 am, DON- B notified Surveyor she looked into R7's and R11's medical record and did not find showers documented for R7 on 9/8/24 and 9/15/24 which are Sundays and reminded Surveyor that R7 typically has many visitors on Sundays. On 10/22/24 at 12:39 pm, DON- B provided Surveyor skin assessments for R7 and R11 for the month of September and October 2024. Surveyor notes the skin assessments for R7 and R11 however, Surveyor notified DON- B that skin assessments are not documentation of showers and requested additional information on showers if available. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 3:13 pm, Surveyor notified Nursing Home Administrator (NHA)- A and DON- B of shower concerns for R7 and R11. Surveyor requested additional information if available. No additional information was provided. 20483 2.) R13 was admitted to the facility on [DATE] with diagnoses includes multiple sclerosis, hypertension and age related osteoporosis. The urinary incontinence care plan initiated 6/3/24 & revised 6/4/24 documents the following interventions: * Adjust toileting times to meet resident's needs. Initiated 6/4/24. * Administer medication per MD (medical doctor) orders. Initiated 6/4/24. * Apply skin moisturizers/barrier creams as needed. Initiated 6/4/24. * Identify voiding pattern and establish toileting program. Initiated 6/4/24. * Provide assistance with toileting. Initiated 6/4/24. * Provide incontinent care as needed. Initiated 6/4/24. * Report changes in amount, frequency, color or odor of urine. Initiated 6/4/24. * Report changes in skin integrity found during daily care. Initiated 6/4/24. * TOILETING PLAN: offer and assist with toileting q (every) 2-3 hrs (hours) while awake pending patterning. Initiated 6/4/24. * Use absorbent products as needed. Initiated 6/4/24. The functional abilities (self care & mobility) CAA (care area assessment) dated 6/13/24 under nature of problem/condition documents CAA triggered due to the resident needing a lot of assistance with ADL's (activities daily living) in the look back period. The resident was a total lift upon admission. Under care plan considerations documents The resident needs assistance with ADL's in the look back period. The staff will continue to assist the resident with ADL's. The resident is able to make their basic needs known. The staff will monitor the resident for changes in physical functioning and notify the provider for further evaluation and treatment as needed. The resident is active in the plan of care and any questions or concerns will be addressed on an on going basis. No referrals are needed at this time but will make referrals as needed in the future. The residents care plan will address the need for assistance with ADL's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS (minimum data set) with an assessment reference date of 9/12/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R13 is assessed as not having any behavior. R13 is assessed as being dependent for toileting hygiene, chair/bed to chair transfer, and toilet transfer. R13 requires partial/moderate assistance to roll left and right. R13 is assessed as being frequently incontinent of urine and bowel. On 10/21/24 at 9:33 a.m., Surveyor observed R13 dressed for the day sitting in an electric wheelchair in the room. Surveyor asked R13 back in July were there times when staff did not provide continence cares for her. R13 replied yes. R13 explained there was a time when she was on the bedpan for two hours. Surveyor asked if she reported this. R13 replied she complained to the administrator but now that administrator isn't here anymore and there is a different lady. Surveyor asked if there was a time in July when she wasn't provided continence cares from 9:00 a.m. to 4:00 p.m. R13 replied yes. R13 informed Surveyor that some times at night she isn't checked the whole night or some times just once depending who is working. R13 informed Surveyor it has been better since she moved to her current room which is on the other side of the building. On 10/22/24, from 7:35 a.m. to 7:50 a.m., Surveyor observed morning cares for R13 with CNA (Certified Nursing Assistant)-MM. No concerns were identified during this observation. On 10/22/24 Surveyor reviewed R13's bowel and bladder elimination records for July 2024 under the task tab. Surveyor noted there is no documentation R13 received continence cares on 7/2/24 during the night shift, 7/3/24 during the day & night shifts, 7/9/24 during the evening shift, 7/12/24 during the night shift, 7/14/24 during the evening shift, 7/15/24 during the day shift, 7/21/24 & 7/23/24 during the night shift, and 7/25/24 during the day shift. On 10/22/24 at 9:14 a.m., Surveyor asked CNA-NN if she took care of R13. CNA-NN replied yes actually she was recently moved. Surveyor asked CNA-NN what did they have to do for R13. CNA-NN informed Surveyor they did her cares and she was a Hoyer transfer with 2 people to get out of bed into the chair. When R13 was in the chair she would try to do a portion of getting herself dressed. Surveyor inquired when R13 was provided with incontinence cares. CNA-NN replied she would let us know if she was wet. CNA-NN explained they would change her and put her back in the chair. Surveyor asked if incontinence cares are documented. CNA-NN informed Surveyor they are suppose to document this and will stay late complete her charting. On 10/23/24 at 7:18 a.m., Surveyor again asked R13 if during July was there ever a time when staff did not change her. R13 replied yes, all the time. R13 then informed Surveyor during the 4th of July weekend there was no one here stating, who wants to be cleaning old ladies. On 10/23/24 at 8:27 a.m., Surveyor asked DON (Director of Nursing)-B what is the expectation for staff providing continence care to residents. DON-B informed Surveyor they should be following what is on the care card and care plan, there are no odors and kept clean & dry. Surveyor inquired if the CNA's document continence care. DON-B informed Surveyor if the task is activated. Surveyor informed DON-B R13 informed Surveyor there were multiple times in July when R13 did not receive continence care and there are multiple times in the task documentation for bowel and bladder when continence care is not documented. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 8:56 a.m., Surveyor informed NHA (Nursing Home Administrator)-A there were multiple times in July when R13 was not provided continence care and documentation doesn't show R13 received continence care. No additional information was provided for R13.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure residents received treatment and care consistent with the N6 Wisconsin Nurse Practice Act for 3 (R2, R16, and R5) of 16 residents reviewed. During the night shift on [DATE], R2 was yelling help me, help me, and couldn't breathe. Certified Nursing Assistant (CNA)-QQ notified Registered Nurse (RN)-PP. RN-PP observed R2 sitting on the edge of the bed, leaning over the half side rail, and not responding. RN-PP laid R2 down in bed, placed the pulse ox on R2's finger but was unable to obtain a reading, checked the oxygen tubing, and observed R2 had agonal breathing. RN-PP noted R2 was a DNR (Do Not Resuscitate) and called R2's daughter who is the 2nd Power of Attorney (POA) to inquire what she would like the facility to do. RN-PP did not complete any further assessments, did not attempt to contact the doctor, and did not call 911. RN-PP contacted the nurse on the short term unit, 100 to 200 units, and asked RN-HH to come to R2's room. Upon RN-HH's assessment, R2 was pulseless and was not breathing. The facility's failure to comprehensively assess R2, contact R2's physician, or call 911 created a finding of Immediate Jeopardy (IJ) which began on [DATE]. NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, VP (Vice President) of Success-G, and VP of Clinical-GG were notified of the immediate jeopardy on [DATE] at 3:02 p.m. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity of D (potential for harm/isolated) related to the examples involving R16 & R5 and as the facility continues to implement its action plan. * Weekly skin assessments did not address R16's weeping blisters on R16's arms. * R5 was transferred via a Hoyer lift on [DATE]. A bar from the Hoyer lift hit R5's head causing pain. An initial neurological check (neuro-check) evaluation was not documented by the facility staff. R5 was sent to the emergency room (ER) for evaluation. R5 returned to the facility with a diagnosis of a mild concussion. R5 was not placed on the facility's 24-hour board for close monitoring. R5 did not have any documented neuro-checks completed after R5 returned from the ER. Findings include: The facility's policy titled, Change in Condition of the Resident and reviewed/revised [DATE] under Policy documents: A facility should immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy Explanation and Compliance Guidelines documents: When a resident presents with a possible change of condition, after a fall or other possible injury, trauma, or noted changes in mental or physical functioning: 1. Assess the resident's need for immediate care/medical condition. Provide emergency care as needed. 2. Assess/evaluate the resident . 3. Notify resident's physician - Use INTERACT Change in Condition: when to report to the MD/NP/PA (Medical Doctor/Nurse Practitioner/Physician Assistant) as a guideline. a. Immediate notification: Immediate notification for any symptom, sign or apparent discomfort that is: 1. Acute or sudden in onset, and: ii. A marked change (i.e. more severe) in relation to usual symptoms and signs, or iii. Unrelieved by measures already prescribed requires a phone call to the provider. Do not fax for issues requiring immediate notification. If no response from provider and condition warrants, call the center medical director. If no response from the center medical director, contact the DON (Director of Nursing) for further guidance. According to the State of Wisconsin Nurse Practice Act: N 6.03 - Standards of practice for registered nurses. (1)? General nursing procedures. 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. 1.) R2 was admitted to the facility on [DATE] with diagnoses that include chronic kidney disease (receives hemodialysis three times a week), COPD (chronic obstructive pulmonary disease), DM (diabetes mellitus), dementia, anxiety disorder, and obstructive sleep apnea. R2 has an order for CPAP (Continuous Positive Airway Pressure) with 2 liters of oxygen. R2 has an activated Power of Attorney for Health Care (POAHC) and advance directives for DNR (do not resuscitate). R2 was not receiving hospice services. The annual MDS (minimum data set) with an assessment reference date of [DATE] shows R2 has a BIMS (Brief Interview for Mental Status) score of 8 which indicates moderate cognitive impairment. R2 is assessed as having verbal behaviors 1 to 3 days during the assessment period and is not assessed as refusing care. R2 is independent in eating, roll left & right, sit to stand, chair/bed to chair transfers, and toilet transfers. R2 is occasionally incontinent of urine and continent of bowel. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2 was transferred to the hospital on two occasions, [DATE] and [DATE], prior to R2's change of condition. R2 was not hospitalized during either of these transfers. The nurses note dated [DATE] at 12:15 p.m. documents: Resident c/o (complained of) feeling lightheaded and upon standing she vomited. She also stated that she felt her heart beating very fast and felt like she was going to die. Writer took vitals and pulse was 101. Resident stated she still did not feel well. Writer called on call provider which [Name] NP indicated to have her sent out to be checked over. This nurses note was written by LPN (Licensed Practical Nurse)-FF. The nurses note dated [DATE] at 1625 (4:25 p.m.) documents: Resident has come back from ER (emergency room) via stretcher. She was helped into her wheelchair and is eating dinner now. She came back with new order for Zofran 4 mg (milligram) Q (every) 8 hours PRN (as needed) for nausea. At the ER they did a cardiac monitor along with other labs which showed nothing concerning. Writer updated POA on resident before and after resident was sent out and returned. This nurses note was written by LPN (Licensed Practical Nurse)-FF. The nurses note dated [DATE] at 1751 (5:51 p.m.) documents: Writer received a call from [Name] RN (Registered Nurse) from [hospital] ER that urine test results came back post d/c (discharge) and resident has a UTI (urinary tract infection). New orders received Keflex BID (twice daily) 500 mg for 7 days. This nurses note was written by LPN (Licensed Practical Nurse)-FF. The nurses note dated [DATE] at 2123 (9:23 p.m.) documents: Resident was sent to ER from dialysis to have a new port inserted. Resident had some minor bleeding from site after returning. Call ER to report bleed per summary instructions. An order to place a compression dressing to site. If bleeding does not stop resident is to go to ER. After several minutes bleed has stopped and compression dressing is still intact. Resident is to be woke at 0500 (5:00 a.m.) on [DATE] to return to dialysis for a 0600 (6:00 a.m.) chair time. Family arranged transportation to arrive at 0540 (5:40 a.m.). This nurses note was written by LPN-Z. The progress note dated [DATE] at 11:45 a.m. under Subjective documents: Patient is seen in her room during visit currently resting in bed. She has now completed antibiotics for UTI (urinary tract infection) without any further urinary concerns reported. Recently updated by nursing staff that patient had worsening behaviors with confusion that had been noted upon starting Dilaudid. Pain clinic was updated and gave order to discontinue Dilaudid and start Norco instead, which patient has been tolerating without adverse effect. She does note ongoing back pain at baseline and is reminded to let nursing staff know when she has pain, with goal to optimize her pain control. Patient has no other complaints today. No shortness of breath or chest pain. Mentation appears at baseline currently. Nursing staff to continue to monitor pain control as well with no other new concerns reported today. The nurses note dated [DATE] at 03:26 (3:26 a.m.) documents: Resident summary: Resident A/O (alert/orientated) x (times) ,d+[DATE], able to make needs know, Denies pain and discomfort other than her base line. Resident has dialysis appoint three times a week. Resident independently hydrates and nourishes adequately. Resident independently propels her wheelchair in the facility. Needs assistance with ADL (activities of daily living). On a breathing treatment and pain meds (medication). Resident is continent of bowel and bladder. This nurses note was written by RN-OO. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 05:42 (5:42 a.m.) documents: Pt (patient) put call light on and informed staff she could not breathe. Pt sat at edge of bed. CPAP on. CNA (Certified Nursing Assistant) notified writer and writer went to room. Pt sitting at edge of bed and leaning over the side rail. Lips are blue. Pt is not responding verbally. Writer unable to get pulse ox. Fingers are cyanotic. Agonal breathing present. Pt is a DNR. Writer placed call to daughter [Name] and informed of information. [Name] stated she wanted to call her brother to see if they wanted her to go to the ER. [Name] will call facility back. This nurses note was written by RN-PP. The nurses note dated [DATE] at 05:47 (5:47 a.m.) documents: Pt has no pulse or respirations. Writer placed call to daughter [Name] and updated on death. [Name] is still trying to call her brother. [Name] unsure when they will be coming to the facility. Writer did ask [Name] about funeral home (burial or cremation). [Name] states she has the information and will update facility on funeral home information when they get her [sic] (here). This nurses note was written by RN-PP. The nurses note dated [DATE] at 05:52 (5:52 a.m.) documents: Call placed to [Name] Medical answering service and informed of death with need for call back. This nurses note was written by RN-PP. The nurses note dated [DATE] at 05:55 (5:55 a.m.) documents: Call received from [Name] Medical; [Name] NP informed of death. Permission given to release body to funeral home. This nurses note was written by RN-PP. On [DATE] at 9:34 a.m., Surveyor asked LPN-FF how R2 was during the evening shift on [DATE]. LPN-FF informed Surveyor R2 was completely normal, there were no concerns, nothing with R2's vital signs, behavior or anything. Surveyor asked LPN-FF if R2 complained of not feeling well. LPN-FF informed Surveyor she was stating she was not feeling good for two weeks and they did send her out. LPN-FF informed Surveyor R2 was not admitted and they did not find anything. (See nurses note dated [DATE] On [DATE] at 4:18 p.m., Surveyor spoke with CNA-RR who worked the evening shift on [DATE] and night shift into [DATE]. CNA-RR informed Surveyor she was in training and got to the facility about 6:00 p.m. Surveyor asked CNA-RR if she was in R2's room between 6:00 p.m. & 10:00 p.m. (evening shift). CNA-RR informed Surveyor she went into R2's room one time with the CNA she was training with and R2's call light went off she thought sometime between 8:00 p.m. & 9:00 p.m. CNA-RR explained R2 was on the toilet getting ready for bed and needed her hair put up in a bun. CNA-RR informed Surveyor she did exactly what R2 wanted. The next time R2's call light went off was around shift change and she wanted ice. CNA-RR informed Surveyor she worked the 300 unit during the night shift. CNA-RR informed Surveyor the last time she heard about R2 was between 5:00 a.m. & 6:00 a.m. when RN-PP told her you have to give me a second I have a code & took off running, want to say she passed away. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:17 a.m., Surveyor spoke with CNA-QQ on the telephone. Surveyor asked CNA-QQ to explain what occurred on [DATE] with R2. CNA-QQ informed Surveyor it was an average night. R2 got up at 4:00 a.m. and asked for water & ice for a flavor packet she had and then laid back down. CNA-QQ informed Surveyor an hour or hour and a half later R2 was yelling help me help me and she couldn't breathe. CNA-QQ informed Surveyor R2 had a mask on her face. CNA-QQ informed Surveyor she was on the 400 hall with R2 and the nurse was on the 300 hall. CNA-QQ informed Surveyor she yelled for the nurse, who was not a regular nurse, that R2 couldn't breathe. CNA-QQ informed Surveyor the nurse came in then said she needs to see if R2 is a DNR as doesn't look good. CNA-QQ informed Surveyor she went back in a few minutes later and the nurse and another nurse were in the room. She, (referring to RN-PP,) must have called the charge nurse. CNA-QQ informed Surveyor she was told to get another aide as R2 had passed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:35 a.m., Surveyor interviewed RN-PP regarding R2. Surveyor asked RN-PP if she was the nurse assigned to R2. RN-PP informed Surveyor she was the nurse on the 300 & 400 wings. Surveyor asked RN-PP if she had taken care of R2 prior to R2 having a change of condition and expiring. RN-PP informed Surveyor this was the first night with R2 alone explaining she had taken care of her one time prior when she was training with [first name], LPN. Surveyor asked RN-PP if she received report of any concerns involving R2. RN-PP informed Surveyor there were no concerns voiced to her from the PM (evening) shift. RN-PP informed Surveyor since there was COVID in the facility she had checked R2's temperature & oxygen sats and changed the nebulizer equipment. RN-PP indicated R2 was alert & verbal and aroused easily. Surveyor asked RN-PP if she remembers what time R2's change of condition was. RN-PP replied no, it's in the charting. RN-PP informed Surveyor she also administered R2 her morning medication. Surveyor asked what time these medications were given. RN-PP informed Surveyor she can give morning medication any time after 3:00 a.m. and couldn't tell Surveyor what time. RN-PP informed Surveyor she thinks there was an agency CNA working this night and the CNA sits at the 400 nurses' station and she was at the 300 nurses' station. RN-PP informed Surveyor she doesn't know what interactions the CNA had with R2 and Surveyor would have to ask the CNA what her interactions with R2 were. RN-PP informed Surveyor the CNA shouted she's not able to breathe and then said R2's first name. RN-PP informed Surveyor she went down to R2's room, R2 was sitting on the edge of the bed and was leaning over the half side rail. RN-PP indicated she could see that R2 had agonal breathing (abnormal breath that occurs when someone is not getting enough oxygen. Agonal breathing is a sign that someone is in a severe medical emergency and requires immediate action). RN-PP informed Surveyor she moved R2 into bed so she was laying down to see if there was any response. RN-PP indicated R2 was not verbal and her lips & fingers were cyanotic. RN-PP informed Surveyor she could not get a reading from the pulse ox. RN-PP informed Surveyor she placed a call to [name], who is R2's second POA. RN-PP explained to R2's daughter R2 was DNR, confirmed DNR status, and asked what their wishes were. R2's daughter informed RN-PP she was going to call her brother and would get back to the facility. Surveyor asked RN-PP after she spoke with R2's daughter what did she do. RN-PP informed Surveyor she called the nurse from the rehab side, indicating she couldn't remember if she called RN-HH first or the family, and told her she needed help in room [R2's room number]. RN-PP informed Surveyor she ran back to R2's room, RN-HH was in the room, and R2 had passed. Surveyor asked RN-PP if R2 was using her CPAP. RN-PP informed Surveyor R2 was using it with oxygen. Surveyor asked RN-PP if she remembered what the oxygen was set at. RN-PP informed Surveyor she would have to look at the orders. Surveyor asked RN-PP if she increased R2's oxygen. RN-PP replied with agonal breathing it would not have done anything so I left it the way it was. Surveyor asked RN-PP if she called the doctor. RN-PP replied yes. Surveyor asked when she contacted the doctor. RN-PP replied after she passed. RN-PP informed Surveyor she made the NP aware of R2's death and the NP was going to call the doctor. RN-PP informed Surveyor if she had called the doctor prior you get the answering service and when the doctor called back it would have been telling the doctor R2 was dead. Surveyor asked RN-PP why she didn't call 911. RN-PP replied, with her being DNR I needed to know what the family's wishes were, she's a DNR. If she had been dead they (EMS) wouldn't have transported or done CPR (Cardiopulmonary Resuscitation). RN-PP stated, I'm told we can't call 911 unless there is an MD order. Surveyor asked, you can't call 911 first? RN-PP then walked back what she said stating the DON (Director of Nursing) never told her she couldn't call 911 first. RN-PP stated, If I felt she would have made it with transport I would have sent her out. There was agonal breathing. Surveyor asked RN-PP if there is a change of condition what is she supposed to do. RN-PP informed Surveyor there is an E interact in PCC (point click care) assessment to complete, update MD, call family, and ascertain what the family's wishes. If want to go to hospital, call 911, update DON and Administrator. RN-PP informed Surveyor she hasn't had this yet. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:25 a.m., Surveyor asked RN-PP what assessments she did for R2 on [DATE]. RN-PP informed Surveyor R2 was not responding verbally. She placed a pulse ox on her finger, couldn't get any reading. That's when she made sure the oxygen was flowing and then went to go speak with [Name], (R2's daughter, 2nd POA). On [DATE] at 1:46 p.m., Surveyor spoke with RN-HH on the telephone regarding R2. RN-HH informed Surveyor she was on the ,d+[DATE] unit and the nurse the other side called her to come over. RN-HH informed Surveyor she assessed R2 and she had already expired, explaining she was pulseless and not breathing. RN-HH informed Surveyor she removed R2's CPAP so she could hear and listen for heart sounds and respirations. Surveyor asked RN-HH after R2 passed what she did. RN-HH informed Surveyor she contacted the doctor while RN-PP was on the phone with the family and made a note the doctor was called and could release the body to the funeral home. On [DATE] at 8:31 a.m., Surveyor asked DON (Director of Nursing)-B if a resident has a change in condition what is the expectation of the nurse. DON-B informed Surveyor observe or assess and follow up appropriately. Surveyor asked what is appropriately. DON-B informed Surveyor depending on concern. Use the interact change of condition guide, notification to MD and family. Surveyor asked DON-B if a resident is a DNR what does this mean. DON-B replied do not resuscitate; what to do for code status, this is in the event the heart stops. Surveyor asked DON-B if a resident is a DNR and has a change in condition what happens. DON-B informed Surveyor if a resident is a DNR or full code does not change how they respond to assessing or observing. They absolutely treat the resident the same. DON-B informed Surveyor her expectation is the MD would be notified of a change in condition. DON-B informed Surveyor with some situations with critical thinking of the nurse 911 may be called prior to the MD being notified. DON-B informed Surveyor the MD should be updated first but there are cases when we don't want to cause harm. The facility's failure to ensure R2 received appropriate care and treatment consistent with profestional standards of practice when R2 experienced a change in condition including shortness of breath and later agonal breathing created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed on [DATE] when the facility implemented the following action plan: * Director of Nursing/designee completed an audit on [DATE] of residents requiring transfer from facility to higher level of care within the last 14 days, to verify appropriate assessment and notification, including Emergency Medical Services Activation. * Facility Licensed Nursing staff to be reeducated prior to the next working shift by Director of Nursing or designee on Change of Condition of the Resident policy. This reeducation includes information on assessment/evaluation (regardless of code status), provider notification of findings, and documentation requirements. Reeducation includes use of the INTERACT 4.5 Change in Condition Guidelines for when to immediately notify the physician/provider and activate emergency medical services. * On [DATE], Director of Nursing, Executive Director, and [NAME] President of Success reviewed established Change in Condition of the Resident policy. No changes were necessary to this policy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Director of Nursing or Designee will review facility charting daily to identify resident change in condition to ensure proper documentation of assessment/evaluation and timely provider notification. These audits will be completed daily for 2 weeks, then with morning clinical 5 days per week for 10 more weeks or until substantial compliance is maintained. Results of these audits will be brought to QAPI (quality assurance performance improvement) for review and recommendation. * ADHOC QAPI review of this plan was completed [DATE] with Medical Director, VP (Vice President) of Success, Director of Nursing, and Executive Director. The deficient practice continues at a scope/severity of D (harm/isolated) as evidenced by the following examples. 38829 2) R16 was admitted to the facility on [DATE] with diagnoses of Other Specified Diseases of Liver, Muscle Weakness, Hypertensive Heart Disease with Heart Failure, Unspecified Asthma, Arthropathic Psoriasis, Immunodeficiency, Type 2 Diabetes Mellitus, and Adjustment Disorder with Muscle Weakness. R16 discharged from the facility on [DATE]. R16's Admission Minimum Data Set (MDS) completed on [DATE] documents R16 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R16 was cognitively intact for daily decision making. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating, required substantial/maximum assistance for shower/bathing, lower dressing, personal hygiene, rolling left to right, and sit to lying. R16 required partial/moderate assistance for upper dressing. R16 was dependent for sit to stand, transferring from chair to bed, and toileting transfers. R16 was occasionally incontinent of bladder and always continent of bowel. R16 is at risk for developing pressure ulcers but has none currently. R16's MDS documents R16 desired to discharge to the community and required active discharge planning. R16's quarterly MDS completed on [DATE] documents R16's BIMS score to be 11, indicating R16 was demonstrating moderately impaired skills for daily decision making. R16's MDS also documents R16 is receiving ointments to areas other than feet. R16's Discharge MDS completed on [DATE] does not assess R16's cognitive skills. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for lower dressing, personal hygiene. Shower/bathing was not attempted due to medical condition. R16 required partial/moderate assistance for upper dressing, sit to lying and lying to sitting, sit to stand, chair to bed transfer, and toilet transfer. Transferring to to tub/shower was not attempted due to medical condition. R16 was supervision for rolling left to right. R16 was frequently incontinent of bladder and always incontinent of bowel. R16's Care Area Assessment (CAA) for Pressure Ulcer/Injury documents: .Care plan will be initiated or reviewed to improve or maintain current ADL (Activities of Daily Living) status and functional ability, maintain continence status, prevent pain, and decrease pressure ulcer/fluid deficit risk. Resident has increased risk for skin impairment related to increased need for help with ADL such as bed mobility which can decrease flood flow and increase pressure leading to wounds . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor notes R16 was assessed to have shearing which was documented on R16's admission evaluation dated [DATE]. R16 also had blisters on bilateral arms and legs that at times would be documented to be weeping. R16's skin focused care plan problem initiated [DATE] states the following: -Actual at (specify location) due to . -Administer treatment per MD (Medical Doctor) orders [DATE] -Encourage and assist as needed to turn and reposition; use assistive devices as needed [DATE] -Float heels as able [DATE] -Report evidence of infection such purulent drainage, [NAME], localized heat, increased pain, notify MD PRN [DATE] Surveyor notes R16's skin care plan was not revised to include person centered interventions to identify the potential for skin breakdown including pressure relieving mattress, pressure relieving cushion for wheelchair, and interventions to address R16's blisters on bilateral arms and legs. R16's Kardex documents R16 is receiving ointments for skin issues. R16's physician orders documents: -Weekly skin review every evening shift every Monday if new skin area is identified follow protocol for SBAR (Situation, Background, Assessment and Recommendation), MD update and risk management. -May have kerlix bedside for wound drainage from bilateral arms and legs as needed for drainage. -Clobetasol Pripionate External Cream 0.05%, apply to affect area topically as needed for psoriasis. -Triamcinolone Acetonide External Cream 0.1%, apply to buttock topically one time a day for dermatitis. R16's Admission Evaluation dated [DATE] documents a score of ,d+[DATE] which means R16 is at risk for skin issues. It is documented by Registered Nurse (RN)-N that R16 has shearing on left buttock and a skin tear on right forearm with no other description for the areas. On [DATE], R16's Braden Scale for Predicting Pressure Sore Risk documents a score of 14, indicating R16 was at moderate risk. On [DATE], Physician (DR)-TT documented that R16 had fragile skin, scattered ecchymosis, weeping and blisters. Continues to have peripheral edema mostly 3rd spacing. Does have very fragile skin with multiple bruises and blistering lesions. 1 to 2 pretibial pitting bilateral lower extremity edema. Bilateral upper extremities puffy. Weeping. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor notes R16's facility weekly head to toe skin checks does not document any of the skin areas identified by DR-TT including addressing interventions on R16's care plan. R16's EMR does not have documentation from nursing addressing areas that are identified as blisters and are weeping. On [DATE], at 2:14 PM, Surveyor interviewed Registered Nurse (RN)-N regarding R16's skin issues. RN-N stated R16 consistently scratched their arms. R16 also had an issue with edema. R16 would have areas that looked like they were open. RN-N stated R16 had multiple blisters with small holes with fluid that would come out. RN-N recalls the shearing area on R16's buttocks not being open but had new skin present. On [DATE], at 10:01 AM, Director of Nursing (DON)-B stated the expectation would licensed professionals should complete skin evaluations and assessments on any area that that has bruising, blisters, or is open. DON-B agreed R16's blisters would require additional assessments to be completed. On [DATE], at 3:22 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R16's skin issues were not further evaluated with comprehensive assessments and person-centered interventions identified and documented in R16's comprehensive care plan. No further information was provided by the facility at this time. 49435 3) On [DATE] at 9:10 AM, Surveyor asked Director of Nursing (DON)-B for the faciliy's neuro-check policy. Nursing Home Administrator (NHA)-A returned to surveyor and informed surveyor that the incident involving the Hoyer lift bar hitting R5's head would be addressed in the fall policy under the neuro-checks section. NHA-A stated the facility does not have a separate neuro-check policy. The facility policy entitled, Fall Prevention and Management Guidelines with a review date of [DATE], documents, in part: . Neuro checks for any unwitnessed fall or witnessed fall, where resident hits their head: Initially, then hourly x 3, then continue neuro checks every 4 hours x 6, then continue neuro checks every 8 hours x 6 or as indicated by the physician. Alert MD (Medical Doctor) of any abnormal findings from neuro checks- do not wait until series is complete to notify MD of abnormal findings. In a document entitled, Post-Fall Assessments dated, August of 2021, The American Association of Post-Acute Care Nursing (AAPACN) documents the following about neuro checks : An assessment of neurological status, often called a neuro check, should be done when a resident hits his or her head or if it is unknown if they hit their head (unwitnessed fall). R5 was admitted to the facility on [DATE] with diagnosis that include Hemiplegia and hemiparesis following stroke, Contracture of left knee, Heart failure, Emphysema, Morbid obesity, Atrial-fibrillation, and Depression. R5's Annual Minimum Data Set Assessment (MDS) dated [DATE] documents R5 is cognitively intact. R5 is dependent on staff for bathing, toileting, lower body dressing, mobility, and transfers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5's Care Area Assessment (CAA) for Functional Abilities dated [DATE], documents, Resident requires assistance [with] most Activities of Daily Living (ADLs) d/t (due to) impaired mobility. Goal is to ensure resident is safe and needs are met. Nursing staff will continue to offer and assist [with] ADLs and ensure to meet resident's daily needs. On [DATE], at 10:03 AM, Surveyor interviewed R5. R5 informed Surveyor that during a Hoyer lift transfer a few weeks ago, R5 was hit on the top of the head. R5 stated 2 Certified Nursing Assistants (CNAs) were helping R5 get into her wheelchair. R5 stated one CNA was behind her and another one was in front of her. R5 stated the CNA's were talking back and forth to each other about the transfer. R5 stated R5 was lowered into the chair and the top bar of the Hoyer lift hit R5's head very hard. R5 stated she began to cry because the hit was hard and hurt a lot. R5 stated R5 was sent to the hospital for evaluation in the ER (emergency room). R5 stated the emergency room doctor told R5 that R5 had a mild concussion. R5 returned to the facility. R5 stated the pain lasted a few days and then resolved. R5's incident report entered by Licensed Practical Nurse (LPN)-Z, dated [DATE], at 11:35 AM, documents, [CNA-CC] informed writer [TRUNCATED]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure 2 of 2 residents (R14 & R5) received adequate supervision and assistance devices to prevent accidents. * R14 was admitted to the facility on [DATE] with a fracture of right pubis and history of falls. The facility did not develop a person centered falls care plan and this care plan did not address R14 self transferring. On 7/17/24, R14 attempted to self transfer, fell , and was transferred to the hospital. The hospital ED (emergency department) notes document a new sacral fracture. * R5 was transferred by 2 Certified Nursing Assistants (CNAs), CNA-CC and CNA-DD, via a Hoyer lift on 9/6/24. During the transfer, the bar from the Hoyer lift hit R5's head causing pain. R5 was sent to the emergency room (ER) for evaluation. R5 returned to the facility with a diagnosis of a mild concussion. CNA-CC stated that CNA-CC did not receive formal training on Hoyer lift transfers prior to transferring R5 on 9/6/24. Findings include: The facility's policy titled, Fall Prevention and Management Guidelines last reviewed/revised 7/18/22 under Policy documents: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. 1.) R14's diagnoses includes fracture of right pubis, hypertensive heart disease with heart failure, and anxiety disorder. The at risk for falls due to: recent fall with fracture, history of falls care plan initiated 7/9/24 has the following interventions: * Assess for orthostatic hypotension. Initiated 7/9/24. * Encourage to transfer and change positions slowly. Initiated 7/9/24. * Fall Risk (FYI) (for your information). Initiated 7/9/24. * Have commonly used articles within easy reach. Initiated 7/9/24. * Provide assist to transfer and ambulate as needed. Initiated 7/9/24. * Reinforce w/c (wheelchair) safety as needed such as locking brakes. Initiated 7/9/24. * Report development of pain, bruises, change in mental status, ADL (activities daily living) function, appetite, or neurological status post fall. Initiated 7/9/24. * Therapy eval and treat as ordered. Initiated 7/9/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The ADL self care deficit care plan initiated 7/9/24 includes interventions of: TOILETING: Assist of 2. Initiated 7/9/24 and TRANSFER: Assist of 2. Initiated 7/9/24. The admission evaluation dated 7/9/24 under section L Mobility/Fall Risk is checked yes for resident is at risk for falls. The nurses note dated 7/10/24 at 02:49 (2:49 a.m.) documents: Resident is on follow up for: F/U (follow up) new admission. The current status is PAC (post acute care) #2 after recent hospitalization with pubic fx (fracture) r/t (related to) fall. Resident is alert and orientated with pleasant affect. No complaints of pain or discomfort noted. Lungs clear, no sob (shortness of breath) or cough noted. Abdomen soft and non=tender, bowel sounds + (positive) times 4. No edema noted to BLEs (bilateral lower extremities). Resident up to bathroom with assist of 1, incontinent of urine. Peri care completed and barrier cream applied. Safety reminders given, call light in reach. Will continue to monitor. This nurses note was written by RN (Registered Nurse)-HH. The Admission MDS (minimum data set) with an assessment reference date of 7/16/24 has a BIMS (Brief Interview for Mental Status) score of 10 which indicates moderate cognitive impairment. R14 is assessed as not having any behaviors. R14 is assessed as requiring partial/moderate assistance for toileting hygiene, rolling left & right, chair/bed to chair transfer, and toilet transfer. R14 is assessed as occasionally incontinent of urine and always continent of bowel. Yes is answered for fell in the last month prior to admission and fracture related to fall in 6 months prior to admission. R14 has not fallen since admission. The fall CAA (care area assessment) dated 7/17/24 under analysis of findings is blank. Under care plan considerations documents, here for rehab s/p (status post) hospitalization d/t (due to) fall severe right hip, knee, and shoulder pain, a comminuted right pubic bone fracture, DJD (degenerative joint disease), WBAT (weight bearing as tolerated); has hx (history) of falling, no falls since admn (admission); proceed to POC (plan of care). The nurses note dated 7/17/24 at 09:28 (9:28 a.m.) documents: The current status is resident sent to hospital for evaluation. Resident sent to hospital for evaluation. This nurses note was written by RN-II. APNP (Advance Practice Nurse Prescriber)-JJ note dated 7/17/24 under subjective documents: Patient seen sitting up in wheelchair. She stated that her pain is much better today. No nausea or vomiting after taking food with her pain medication. She feels like she is having sciatica pain on her left side, and is doing gentle stretching. Looking forward to therapy today. She stated that she does not feel feverish today or any further URI (upper respiratory infection) sx (symptoms). Denies fevers, chills, chest pain, shortness of breath, dizziness, constipation diarrhea, nausea or vomiting. Care discussed with nursing. No other concerns today. Notified by nursing later that patient had fallen and had head trauma - sent to ED (emergency department) for eval (evaluation). Under Assessment and Plan includes Fall *: 7/17 notified by nursing [R14's first name] fell today and hit her head. Nursing noticed a hematoma on her head. She is currently on Plavix. Sent to ED for further assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall risk assessment dated [DATE] documents a score of 8 which is low risk. The nurses note dated 7/18/24 at 09:44 (9:44 a.m.) documents: Writer called to Resident's room by med tech who heard a loud noise from Resident's room. Upon entry to Resident's room, Resident was sitting on buttocks in front of TV area, Resident sated she hit the back of her head and her right hip-there was a golf ball sized bump to the back of her head. Call light was not on. Resident was wearing gripper socks. All personal items and table were within reach. Resident transferred via [Fire Department initials] to [Hospital initials]; report given to [first name], RN in ED. The nurses note dated 7/23/24 at 11:35 a.m. documents: IDT (interdisciplinary team) review of unwitnessed fall 07/17/2024: Resident was found by medication tech. Resident was found sitting on her buttocks in front of her television area. Resident reported that she hit her head and her right hip. Upon inspection, the resident had a bump noted to the back of her head. Resident reported she stood up by herself and used the wheelchair as support to stand. She then reached for a blanket and fell . Call light was not on at the time of the fall. Gripper socks were in place and her personal items were within reach. Wheelchair brakes were locked. Resident was seen five minutes prior to the fall and she was resting comfortably in her wheelchair at the time. Provider was notified of the fall. Resident is her own person. Resident admitted status post fall at home with pubic fracture. Resident was an assist of one with transfers and ambulation. Due to complaints of pain post fall and head injury, resident was sent to the hospital for further evaluation and treatment. Resident was taken to the hospital by EMS (emergency medical services). Resident did not return at this time. Root Cause: Resident stood unassisted, using her assistive device improperly, and fell while reaching for a blanket. Intervention: Resident was sent out to the hospital for further evaluation and treatment. She has not returned at this time. This nurses note was written by RN-KK. On 10/22/24, Surveyor received and reviewed R14's emergency department hospital records dated 7/17/24. HPI (history of present illness) documents [R14's name] is a 87 y.o. (year old) female with a past medical history of COPD (chronic obstructive pulmonary disease), coronary disease on Plavix, hypertension, complete heart block with pacer in place, with recent fall on 7/5 with right pubic rami fracture who presents from Lake Country rehab with a chief complaint of sacral pain/fall. Per the patient she has been intermittently having left leg numbness since her fracture. She notes that her roommate spent several hours in the bathroom this morning and she could not get in there so she accidentally several other close. She notes that no one answered when she pushed her call bell so she went up getting to the bathroom on her own. She notes when she got over there she did get help getting dressed and changed but later was uncomfortable and started having numbness in her leg again which tends to happen to her when she tried to adjust a pillow and blanket and she fell forward hitting her head and her body in the ground. Since that time she has had increased pain to her sacrum as well as some slight pain to her head. She notes that she did get a Norco prior to coming in but did not take her blood pressure medication. She notes no additional complaints. Under ED course documents: Patient here for mechanical fall. CT head and cervical spine are unremarkable. CT abdomen pelvis showing new sacral fractures . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 7:26 a.m., Surveyor interviewed ADON (Assistant Director of Nursing)-X. Surveyor inquired, after a resident is admitted what is the care planning process? ADON-X explained the baseline care plan is developed by the admitting nurse then the social worker and dietitian put in their care plans. ADON-X indicated she goes through all the admission paperwork and updates the care plans. ADON-X informed Surveyor she also believes MDS does some of them and stated there are a lot of people that update and develop the care plan. Surveyor asked ADON-X if she remembers R14. ADON-X replied vaguely. ADON-X informed Surveyor the only thing she can remember about R14 is her fall. ADON-X explained she was working the floor at this time and was not the ADON. ADON-X informed Surveyor she was not working at the time but was told R14 fell and went to the hospital. Surveyor inquired what is the process after a resident has a fall? ADON-X explained the nurse would assess the resident for any injury or if something is not at their baseline. They will update the doctor, sometimes the doctor will send them to the hospital other times they will say to monitor the resident. If the resident is not sent out they will complete neuro checks if the fall is unwitnessed or they hit their head. A post event assessment is completed and fall is documented. ADON-X informed Surveyor the IDT meets to review the assessments and tries to find the root cause of the fall. ADON-X informed Surveyor the IDT meets twice daily and they will update the care plan with interventions as well as the floor nurse is also responsible for interventions. Surveyor inquired if she was involved with developing R14's care plan. ADON-X replied not that I'm aware of; I know RN-II was the nurse and she is no longer employed. Surveyor asked if there was anyone else Surveyor should speak with regarding R14's fall and care plan. ADON-X informed Surveyor [first name] MDS nurse but she no longer works here. Surveyor informed ADON-X R14's care plan interventions were not resident centered and were generic which could be interventions for any resident. Surveyor also informed ADON-X one of R14's interventions was to encourage to transfer slowly but R14 required assistance & should not be self-transferring. On 10/23/24 at 7:49 a.m., Surveyor asked RN-E if she remembers R14. RN-E informed Surveyor R14 came in with a hip fracture, fell , they sent her out, and R14 didn't come back. Surveyor asked RN-E if she was involved in the fall investigation. RN-E replied just IDT. RN-E informed Surveyor R14 got up by herself, didn't use the call light, and was trying to get a blanket. RN-E informed Surveyor R14 didn't want to go out but she hit her head and needed a scan. Surveyor asked if R14 had a history of self-transferring. RN-E replied, I didn't know her that well so don't know the ins and outs. On 10/23/24 at 8:00 a.m., Surveyor asked CNA (Certified Nursing Assistant)-LL if she remembered R14. CNA-LL informed Surveyor she doesn't remember her a lot. Surveyor asked CNA-LL if R14 would self-transfer herself. CNA-LL replied yes. On 10/23/24 at 8:12 a.m., Surveyor asked CNA-D if she remembered R14. CNA-D informed Surveyor she kind of remembers R14. CNA-D informed Surveyor she kind of remembers R14's fall. CNA-D informed Surveyor either RN-II or RN-E told her to give R14 her breakfast tray which she did. CNA-D informed Surveyor she was not there when R14 fell but R14 stood up and hit her head on the dresser. Surveyor asked CNA-D if R14 would self-transfer. CNA-D informed Surveyor R14 was not supposed to but would. CNA-D informed Surveyor she talked to R14 about not self transferring and using her call light. CNA-D informed Surveyor she continually had to tell R14 not to self transfer & use her call light and she wasn't sure if R14 was all there mentally. CNA-D informed Surveyor she would report to the nurse when R14 would self transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 8:21 a.m., Surveyor spoke to DON (Director of Nursing)-B about R14. R14 was discharged prior to DON-B working at the facility. Surveyor informed DON-B R14 was admitted to the facility with a fracture and history of falls. R14's care plan was not resident centered. R14 would frequently self transfer herself but there is no documentation of this in her record nor does the care plan address R14's self transferring. Surveyor informed DON-B the facility was aware of R14 self transferring but there is nothing in the record as to what they were doing to prevent R14 from self transferring. Surveyor informed DON-B Surveyor reviewed the hospital ED records dated 7/17/24 the date of the fall which indicate R14 sustained a new sacral fracture. On 10/23/24 at 8:56 a.m., Surveyor informed NHA-A. R14 was admitted to the facility with a fracture and history of falls. R14 would frequently self transfer at the facility. R14's care plan was not resident centered and did not address R14 self transferring. R14 was transferred to the hospital following the fall and hospital ED records indicate R14 sustained a new sacral fracture. No additional information was provided to Surveyor regarding R14's fall. 49435 2.) The facility policy titled Safe Resident Handling and Transfers dated 8/5/22, documents in part: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines . The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly . Two staff members must be utilized when transferring residents with a mechanical lift. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire. The staff must demonstrate competency in the use of mechanical lifts prior to use. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. Resident lifting and transferring will be performed according to the resident's individual plan of care. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device . R5 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia and hemiparesis following stroke, Contracture of left knee, Heart failure, Emphysema, Morbid obesity, Atrial-fibrillation, and Depression. R5's Annual Minimum Data Set Assessment (MDS) dated [DATE] documents R5 is cognitively intact. R5 is dependent on staff for bathing, toileting, lower body dressing, mobility, and transfers. R5's Care Area Assessment (CAA) for Functional Abilities dated 8/3/24, documents, Resident requires assistance [with] most Activities of Daily Living (ADLs) [due to] impaired mobility. Goal is to ensure resident is safe and needs are met. Nursing staff will continue to offer and assist [with] ADLs and ensure to meet resident's daily needs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/21/24 at 10:03 AM, Surveyor interviewed R5. R5 informed Surveyor that during a Hoyer lift transfer a few weeks ago, R5 was hit on the top of the head. R5 stated that 2 Certified Nursing Assistants (CNAs) were helping R5 get into her wheelchair. R5 stated one CNA was behind her and another one was in front of her. R5 stated that the CNAs were talking back and forth to each other about the transfer. R5 stated that R5 was lowered into the chair and the top bar of the Hoyer lift hit R5's head very hard. R5 stated that she began to cry because the hit was hard and hurt a lot. R5 stated she was sent to the hospital for evaluation in the ER. R5 stated the emergency room doctor told her that she had a mild concussion. R5 returned to the facility. R5 stated the pain lasted a few days and then resolved. R5's incident report entered by Licensed Practical Nurse (LPN)-Z, dated 9/6/24 at 11:35 documents: [CNA-CC] informed writer that resident had a hit to the head from the Hoyer and is in pain. Upon entering room, writer observed resident holding her head crying in the wheelchair. [CNA-DD and CNA-CC] explained to writer how the bar fell on to resident's head with a good amount of blunt force. No bleeding or obvious bump noted upon immediate inspection. Resident stated that the Hoyer lift bar hit her on top of her head and that it is throbbing. Immediate Action taken: neuro checks, vitals, [Nurse Practitioner (NP)] notified, DON notified, family notified, 911 to [hospital] per NP. R5's progress note dated 9/6/24 at 1:55 PM documents: Resident came back from [Name of local hospital] ER with a closed head injury, mild concussion, and scalp contusion. Resident states it feels like she got hit in the head with a baseball bat and that her head is just pounding. Tylenol was given prior to her departure and will be given when needed. On 10/22/24 at 9:46 AM, Surveyor interviewed CNA-DD via telephone. Surveyor asked CNA-DD to explain what occurred on 9/6/24 during the Hoyer lift transfer of R5. CNA-DD stated that CNA-CC asked CNA-DD for help getting R5 into R5's wheelchair. CNA-CC stated that CNA-DD had the remote for the Hoyer and was controlling the Hoyer movements. CNA-DD was behind the resident guiding the resident into the chair. CNA-CC was lowering the Hoyer lift bar so resident would be in the chair. CNA-DD stated that CNA-CC let R5 down without supporting the top bar of the Hoyer lift and the bar hit R5's head. CNA-DD indicated it was an accident. CNA-DD stated that CNA-DD put her hand in between R5's head and the bar of the Hoyer until it was lifted. CNA-DD stated R5 was crying and CNA-CC went to get the nurse. Surveyor asked what kind of training is provided for Hoyer lift transfers. CNA-DD stated that CNA-CC was new to working in nursing homes and CNA-DD did not think that CNA-CC was comfortable working with the Hoyer lift. CNA-DD stated she thought training happens when you first start working at the facility during orientation. On 10/22/24 at 1:30 PM, Surveyor interviewed CNA-CC via telephone. Surveyor asked CNA-CC to explain what occurred on 9/6/24 during the Hoyer lift transfer of R5. CNA-CC started by stating that CNA-CC did not have a ton of experience with the Hoyer lift. CNA-CC stated that CNA-DD came to help CNA-CC transfer R5 from R5's bed to the wheelchair. CNA-CC stated that CNA-DD was behind the resident and CNA-CC was directing the Hoyer movements. CNA-CC stated they were lowering R5 into the chair, when R5's weight weighed down the Hoyer and caused R5 to land in the chair and the Hoyer lift bar to come down on R5's head. CNA-CC stated one of us got the nurse and one of us stayed with R5. CNA-CC stated that CNA-CC checked on R5 at the end of CNA-CC's shift to make sure that R5 was ok. Surveyor asked what training CNA-CC received on Hoyer lift transfers. CNA-CC stated she did not get any formal training. CNA-CC stated some other aides showed CNA-CC the basics but again CNA-CC she did not get any formal training. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 7:09 AM, Surveyor reviewed CNA-CC's employee file. Surveyor noted a completed hand hygiene competency for CNA-CC. Surveyor noted trainings completed in the following categories: Reporting, HIPPA, Resident Rights, Abuse, Neglect and Exploitation, Infection control, and Falls. Surveyor did not locate a competency related to safe patient handling or Hoyer lift education. On 10/23/24 at 8:57 AM, Surveyor interviewed DON-B. DON-B indicated that the incident was reenacted by the 2 CNAs and DON-B to determine what happened. DON-B indicated that the resident's weight shifted when lowering R5 to the chair and it caused the bar to hit R5's head. DON-B indicated that after this incident, DON-B watched CNAs complete Hoyer lift transfers to make sure that CNAs were completing them correctly. Surveyor asked what training is completed before a CNA can assist in Hoyer transfers. DON-B stated that Hoyer training is part of the orientation process for new hires. Surveyor asked for CNA-CC's training record for the Hoyer lift. DON-B stated that competencies should have been done on hire. Surveyor informed DON-B that Surveyor did not locate CNA-CC's competency for Hoyer lifts in CNA-CC's employee file. DON-B stated that DON-B will get CNA-CC's competencies. On 10/23/24 at 12:25 PM, Nursing Home Administrator (NHA)-A informed Surveyor that NHA-A could not find training competencies regarding safe patient handling or Hoyer lift transfers for CNA-CC. On 10/23/24 at 3:50 PM, NHA-A and DON-B were informed of the concern that R5 was transferred via a Hoyer lift and the bar hit R5's head causing pain. CNA-CC informed Surveyor that CNA-CC did not receive any formal training for the Hoyer lift and the facility did not locate CNA-CC's competencies regarding safe patient handling or Hoyer lift transfers. No additional information was provided.

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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. 38829 Based on interview and record review, the facility did not ensure residents with urinary incontinence were comprehensively assessed to receive appropriate treatment and services to prevent complications and restore continence to the extent possible for 1 (R16) of 1 Resident reviewed for incontinence. * A bladder assessment and care plan with person centered interventions was not implemented when R16's urinary continence declined from occasionally incontinent to frequently incontinent. Findings Include: 1.) R16's Admission Minimum Data Set (MDS) completed on 9/23/24 documents R16 has a Brief Interview for Mental Status(BIMS) score of 15, indicating R16 was cognitively intact for daily decision making. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for shower/bathing, lower dressing, personal hygiene, rolling left to right, and sit to lying. R16 required partial/moderate assistance for upper dressing. R16 was dependent for sit to stand, transferring from chair to bed, and toileting transfers. R16 was occasionally incontinent of bladder and always continent of bowel on the admission MDS. R16's MDS documents R16 desired to discharge to the community and required active discharge planning. R16's quarterly MDS completed on 10/9/24 documents R16's BIMS score to be 11, indicating R16 was demonstrating moderately impaired skills for daily decision making. R16's MDS also documents at this time that R16 is frequently incontinent of bowel and bladder. R16's Discharge MDS completed on 10/17/24 does not assess R16's cognitive skills. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for lower dressing, personal hygiene. Shower/bathing was not attempted due to medical condition. R16 required partial/moderate assistance for upper dressing, sit to lying and lying to sitting, sit to stand, chair to bed transfer, and toilet transfer. Transferring to to tub/shower was not attempted due to medical condition. R16 was supervision for rolling left to right. R16 was frequently incontinent of bladder and always incontinent of bowel. R16's completed Care Area Assessment(CAA) dated 9/23/24 documents: .Urinary incontinence CAA triggered secondary to the level of assistance needed with toileting needs and actual incontinence episodes. Contributing factors include weakness, impaired mobility, and cognitive loss. Risk factors include skin breakdown, falls and recurrent UTI's. Care plan will be initiated/reviewed to improve/maintain current toileting skills and ability to transfer to the commode, continence status, decrease fall and pressure ulcer risk, and decrease risk for UTI. Resident at decreased level of adls which requires staff assist with toileting which can impact residents level of continence, increase risk for skin impairment, proceed to careplan. R16's comprehensive care plan documents R16 has urinary incontinence due to impaired mobility initiated 10/1/24. The following interventions are listed for R16: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Administer medication per MD orders 10/1/24 -Apply skin moistures/barrier creams as needed 10/1/24 -Place urinal/bedpan within Residents reach 10/1/24 -Provide assistance with toileting 10/1/24 -Provide incontinent care as needed 10/1/24 On 9/20/24 a grievance was filed by R16 in regards to incontinence care. A toileting plan was to be implemented at night. R16 was occasionally incontinent of bladder, always continent of bowel at admission and was frequently incontinent of bladder and always incontinent of bowel at time of discharge. R16's care plan was not revised to include person centered interventions for a toileting plan or interventions to address R16's continence decline. On 10/22/24 at 10:01 AM, Surveyor interviewed Director of Nursing (DON-B). DON-B agreed that R16's comprehensive care plan was not person centered and the care plan was lacking for person centered interventions. DON-B stated that R16's toileting plan was every 2-3 hours and upon call light. DON-B acknowledges this toileting plan was not documented on R16's care plan. On 10/23/24 at 10:21 AM, Certified Nursing Assistant (CNA)-P informed Surveyor that R16 was always incontinent and was not aware of any toileting plan. On 10/23/24 at 12:18 PM, Surveyor shared with Nursing Home Administrator (NHA)-A that R16's toileting program was not documented on R16's care plan. R16 had a decline in continence from occasionally incontinent of bladder to frequently incontinent of bladder. A toileting program was not implemented for R16. On 10/23/24 at 12:57 PM, DON-B stated that the facility does not complete a formal bladder assessment on all residents. Assessing continence is done at admission only. DON-B confirmed that R16's continence status changed during R16's stay and was not addressed. DON-B understands Surveyor's concern of R16's continence declined, was not addressed, and R16's care plan was not updated to include interventions to improve R16's continence status. On 10/23/24 at 2:50 AM, Registered Nurse (RN)-N was interviewed by Surveyor. RN-N was not aware of R16 having a toileting plan. RN-N stated that R16's continence status did change during R16's stay and required the sit to stand to transfer to the toilet. On 10/23/24 at 3:22 PM, NHA-A informed Surveyor the facility does not have a policy and procedure for a bowel/bladder program. Per [NAME] President of Clinical (VP)-GG, bladder training should be incorporated into a Resident care plan. No additional information was provided as to why the facility did not ensure R16 was comprehensively assessed to receive appropriate treatment and services to receive appropriate treatment and services to prevent complications and restore continence to the extent possible.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48391 Based on observation, interview, and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. There were observations of call lights not being answered for an extended period of time, Director of Nursing (DON)-B expressed concern regarding nurse staffing levels, record review and residents expressing concerns regarding lack of sufficient staff. The facility had low staffing on night shift on 10/1/24 and 10/4/24, while having a census of 74 and 75 residents. R2 did not receive a scheduled shower on 9/26/24 due to short staffing. Findings include: 1.) Surveyor reviewed the facility's night shift schedule for 10/1/24 which documents 1 nurse and 1 CNA for the 100 and 200 units, and 1 nurse and 2 CNAs (with one CNA marked as late) on the 300 and 400 units. Surveyor noted there are 5 staff members (with one CNA coming in late) that are present in the facility on night shift with a census of 75 residents. Surveyor reviewed the facility's night shift schedule for 10/4/24 which documents 1 nurse and 1 CNA for the 100 and 200 units, and 1 nurse and 1 CNA on the 300 and 400 units. Surveyor noted there are 4 staff members present in the facility on night shift with a census of 74 residents. Surveyor interviewed Business Office Assistant (BOA)-Q on 10/22/24 at 10:37 am. BOA-Q stated she works closely with the Director of Nursing (DON)-B when making the schedule. BOA-Q starts with a master schedule by placing facility staff in blocks for their scheduled hours. BOA-Q will then ask agency staff or facility staff to pick up hours if there are open shifts. BOA-Q stated daily staffing is based on census and acuity. BOA-Q stated she will schedule 1 nurse that oversees the 100 and 200 units on night shift, 1 nurse on the 300 unit and 1 nurse on the 400 unit. BOA-Q stated she will schedule 1-2 CNAs that will oversee the 100 and 200 units, 1 CNA for the 300 unit, and 1 CNA for the 400 unit. Surveyor asked BOA-Q about night shift staffing on 10/1/24 and 10/4/24. BOA-Q stated on 10/4 she had planned for the evening shift nurse to stay and help with nursing and CNA cares on night shift; however, this nurse had left the facility due to another nurse being present on the 100-200 units. BOA-Q stated she will investigate the 10/1/24 night shift staffing and get back to Surveyor with additional information. On 10/22/24 at 1:16 pm, Nursing Home Administrator (NHA)-A notified Surveyor the CNA marked as late on the 10/1/24 night shift schedule started working at 11:00 pm, and an evening staff member stayed late until 11:00 pm to cover. Surveyor notified NHA-A of concerns with low staffing on night shift on 10/1/24 and 10/4/24 with having a census of 74 and 75 residents. Surveyor requested additional information if available. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 9:29 am, Surveyor observed a call light activated on the 100 unit. Surveyor observed 7 staff members walking the halls, sitting in the nursing station, and not responding to the call light. Surveyor observed the call light being answered by staff at 9:43 am. On 10/21/24 at 1:29 pm, Surveyor interviewed Certified Nursing Assistant (CNA)-D who stated CNAs within the facility have an average of 12 residents per shift. CNA-D reported the facility is assigning CNAs 13-15 residents per shift due to not having a full census. CNA-D indicated staff help each other out when they are short staffed. CNA-D stated there have been times when she has worked by herself, and a nurse may not have time or have helped with CNA tasks. Surveyor reviewed R7's medical records which documents a progress note dated 10/9/24 at 9:55 pm, which states R7 has complaints of her call light being on for an hour and no one is coming to answer her call light. R7 states she has been having to call her brother-in-law to call the facility to get someone to come to her room for help. R7 stated she is worried that long call light times will continue. Surveyor reviewed the facility's grievance log which includes two grievances with long call light times dated 10/5/24 and 10/9/24. Surveyor noted the grievance dated 10/5/24 for long call light times was resolved on 10/8/24. Surveyor noted the grievance dated 10/9/24 for long call light times was resolved on 10/9/24. On 10/22/24 at 11:24 am, Surveyor interviewed DON-B, who stated call light concerns are related to staffing. DON-B indicated the facility has been doing a lot to improve staffing. The facility has been conducting call light audits, discussing call light concerns at QAPI, discussing call light concerns at management rounds, and discussing call light concerns at staff meetings. On 10/22/24 at 3:15 pm, Surveyor notified NHA-A and DON-B of concerns with low staffing on night shift for 10/1/24 and 10/4/24, long call light times, grievances discussing long call lights, and observations of long call light times. 20483 2.) R2's diagnoses includes chronic kidney disease, chronic obstructive pulmonary disease, diabetes mellitus, and dementia. The annual MDS (minimum data set) with an assessment reference date of 7/29/24 indicates R2 has a BIMS (Brief Interview for Mental Status) score of 8 which indicates moderate cognitive impairment. R2 is assessed as being dependent for showers/bathing. R2's physician orders with an order date of 8/13/24 include: Resident has shower scheduled Monday PM (evening) shift and Thursday AM (morning) shift every day shift every Thur (Thursday). An order date of 8/13/24 documents: Resident has shower scheduled Monday PM shift and Thursday AM shift every evening shift every Mon (Monday). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The order administration note dated 9/23/24 at 21:26 (9:26 p.m.), documents: Note Text: Resident has shower scheduled Monday PM (evening) shift and Thursday AM (morning) shift every evening shift every Mon. Did not occur due to low staff. This nurses note was written by LPN (Licensed Practical Nurse)-FF. The order administration note dated 9/26/24 at 14:34 (2:34 p.m.), documents: Note Text: Resident has shower scheduled Monday PM (evening) shift and Thursday AM (morning) shift every day shift every Thu (Thursday). Did not occur short staffed. This note was written by LPN-FF. On 10/23/24 at 10:38 a.m., Surveyor informed ADON (Assistant Director of Nursing)-X R2 did not receive her scheduled showers due to low staffing. Surveyor informed ADON-X of R2's order administration notes dated 9/23/24 & 9/26/24 which document R2 did not receive her scheduled shower due to low/short staffing. ADON-X replied, We're not supposed to write anything like that, let me look to see if she had one another date. ADON-X then informed Surveyor R2 had a shower on the 23rd but did not have one on the 26th. On 10/23/24 at 3:56 p.m., Surveyor informed NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, [NAME] President of Success-G, and [NAME] President of Clinical-GG of R2 not receiving a shower on 9/26/24 due to short staffing. No additional information was provided to Surveyor. 3.) On 08/10/2024 and 08/24/2024, during night shift, the facility did not have sufficient staff to meet the needs of residents, per the facility's Assessment. Surveyor reviewed the facility's document titled, Daily Attendance Sheet, dated 08/10/2024, which documents 2 Nurses and 2 Certified Nursing Assistants worked the night shift. The census on 08/10/2024 was 80, per the facility's document titled, Today's Staffing. Surveyor reviewed the facility's document titled, Daily Attendance Sheet, dated 08/24/2024, which documents 2 Nurses and 2 CNAs worked the night shift. The census on 08/24/2024 was 78, per the facility's document titled, Today's Staffing. On 10/21/2024 at 11:43 AM, Surveyor interviewed CNA-SS. CNA-SS expressed to Surveyor that when the facility is not fully staffed, due to call-ins or no shows, residents are not able to receive the care needed. CNA-SS explained to Surveyor that there have been shifts with 1 CNA for 20 residents. CNA-SS informed Surveyor, with only 1 CNA to a unit, with 20 residents, staff are unable to complete baths/showers, and residents are not being toileted. On 10/21/2024 at 11:54 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-FF. LPN-FF informed Surveyor that low staffing has been an issue for a while. LPN-FF informed Surveyor that call light wait times are over an hour when there is low staffing, causing residents to become upset. LPN-FF informed Surveyor that she has verbally communicated concerns to Director of Nursing (DON)-B. LPN-FF informed Surveyor that LPN-FF was not confident on how the grievance/concern process works, but states LPN-FF will either fill out the grievance form and give to DON-B or the concern is communicated verbally. LPN-FF informed Surveyor that LPN-FF is not sure what happens in the grievance process once information is given to DON-B. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/2024 at 10:37 AM, Surveyor interviewed Business Office Assistant-Q. Business Office Assistant-Q informed Surveyor that Business Office Assistant-Q oversees the schedule with DON-B. Business Office Assistant-Q indicated to Surveyor that on night shift, Business Office Assistant-Q scheduled 1 Nurse on for the 100 and 200 units and 1 Nurse for 300 and 400 units. Business Office Assistant-Q informed Surveyor that Business Office Assistant-Q schedules 1 CNA for the 300 unit, 1 CNA for the 400 unit, and will schedule 1-2 CNAs for the 100 and 200 units. On 10/23/2024 at 07:44 AM, Surveyor interviewed DON (Director of Nursing)-B. DON-B informed Surveyor that the facility does not schedule low staffing and if call ins occur on the shift nurses will help with call lights. DON-B informed Surveyor the facility is working on staffing and that low staff happens due to call ins or unexpected changes. DON-B indicated to Surveyor that if nurses are unable to meet the needs of residents, the nurses or CNA call DON-B and DON-B will come in to help. DON-B also informed Surveyor that the charge nurse would be responsible for reaching out to agency staff or asking other staff to stay late or come in early, if short staffed. On 10/23/2024 at about 03:40 PM, Surveyor notified NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, [NAME] President of Success-G, and [NAME] President of Clinical-GG of above concerns. No additional information was provided.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure therapy services were provided in a timely manner for 2 (R4 and R16) of 2 residents reviewed for therapy services. *R4 returned to the facility on [DATE] after receiving Cortisone (a steroid medication that can help with pain and inflammation) injections to both knees. R4's orthopedic doctor advised that R4 should start Physical Therapy (PT). R4 did not start PT until 9/5/24. *R16 did not receive a home evaluation before discharge. Findings include: 1.) On 10/23/24 at 10:40 AM, Surveyor was informed by Nursing Home Administrator (NHA)-A that the facility does not have a policy for the communication process between staff and the therapy department, for the timing of therapy services, or for the process of home evaluations. R4 was admitted to the facility on [DATE] with diagnosis that includes Stroke, Type 2 Diabetes and Osteoarthritis of the left knee and Bilateral (both sides) knee arthritis. R4's Annual Minimum Data Set Assessment (MDS) dated [DATE], documents R4's cognition is moderately impaired. R4 is independent with toileting, dressing, mobility, and transfers. R4 requires partial to moderate assistance with bathing. R4 started physical therapy on 9/5/24. R4's Functional Abilities Care Area Assessment (CAA) dated 9/12/24 documents: Activities of daily living (ADL) function CAA triggered secondary to assistance required in ADLs. Impaired balance and transition during transfers and functional impairment in activity. R4's Care plan with a start date of 10/31/23 documents: Pain/potential for pain [related to] impaired mobility. Interventions include: Therapy eval and treat as ordered. On 10/21/24 at 9:55 AM, Surveyor interviewed R4. R4 stated that R4 received injections in R4's knees to help with pain a few months ago. R4 indicated that R4 was supposed to receive therapy after the injections but that therapy did not start right away. R4 stated that R4 complained to a staff member that R4 was not getting therapy and therapy started after that. R4 indicated that after the injections, physical therapy, and scheduled medications, R4's knee pain is controlled. R4's orthopedic doctor note dated 7/25/24 documents: [Bilateral] knee arthritis. Provided [bilateral] knee cortisone injections. Therapy 2-3 [times per] week for leg strengthening simple balance. [Follow up] as needed for [increased] pain. R4's MD order dated 7/25/24 documents, PT therapy 2-3 [times per] week for leg strengthening and simple balance. Surveyor reviewed R4's PT notes provided by the facility and noted that PT started on 9/5/24. This was 42 days after R4's orthopedic doctor ordered PT to be done 2 to 3 times per week. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's progress note entered by Physician Assistant (PA-AA) dated 7/29/24 at 9:06 AM, documents, in part: . [status post] cortisone injections to knees on 7/25. Therapy 2-3 [times per] week ordered for strengthening, balance. [Follow up] [as needed] for increased pain. [R4] reports pain has improved at this time. Surveyor noted that the facility PA, PA-AA, also acknowledged that therapy was ordered to start on 7/25/24. On 10/21/24 at 3:44 PM, Surveyor interviewed PT Director (PT)-W. Surveyor asked when R4 started physical therapy. PT-W stated that therapy started after R4 received knee injections. PT-W indicated that there was a delay because the PT order was not brought to their attention until one of the doctors spoke to the therapy department. Surveyor informed PT-W that R4's order for PT was placed on 7/25/24 and PT was not started until 9/5/24. PT-W indicated that the over a month delay was a big delay and not typical for the facility. PT-W stated, we should have been on that. On 10/21/24 at 3:59 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-Y. Surveyor asked what the process is when a resident returns from an outside doctor appointment with therapy orders. LPN-Y stated LPN-Y would enter a progress noted, notify the provider, and enter the order. LPN-Y stated a copy of the therapy order would be printed off and either handed to the therapy department or placed in their mailbox. On 10/21/24 at 4:05 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-X. ADON-X stated that if PT is ordered for a resident, a copy of the order is given to the therapy department. If no one is available to take the order, it is placed in the therapy mailbox. Surveyor informed ADON-X of the delay in R4's therapy after knee injections. Surveyor asked if that type of a delay is typical or expected. ADON-X stated, not at all. On 10/22/24 at 1:44 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor informed DON-B of the delay in PT for R4. Surveyor asked if a delay is expected when PT is ordered by an outside MD. DON-B stated that PT is typically started immediately after an order is received. On 10/23/24 at 8:25 AM, Surveyor interviewed PA-AA about R4's therapy delay. PA-AA indicated that the PT orders should have been followed. PA-AA stated that there have been issues in the past with communication between staff and PT. PA-AA stated that PA-AA has personally gone to the PT departed and communicated the need for PT in the past. PA-AA stated that communication has improved with new management. Surveyor noted that the facility procedure of getting orders to the PT department was not followed and was missed, causing R4's delay in therapy treatment. On 10/22/24 at 3:20 PM, Surveyor informed Nursing Home Administrator (NHA)-A, DON-B, and [NAME] President of Success (VP)-G of the concern that R4 had a MD order for PT that was entered on 7/25/24 and PT did not start until 9/5/24. No further information was provided as to why the facility did not ensure therapy services were provided in a timely manner for R4. 38829 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525702	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Country Health Services	2195 North Summit Village Way Oconomowoc, WI 53066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R16 was admitted to the facility on [DATE] with diagnoses of Other Specified Diseases of Liver, Muscle Weakness, Hypertensive Heart Disease with Heart Failure, Unspecified Asthma, Arthropathic Psoriasis, Immunodeficiency, Type 2 Diabetes Mellitus, and Adjustment Disorder with Muscle Weakness. R16 discharged from the facility on 10/17/24. R16's Admission Minimum Data Set (MDS) completed on 9/23/24 documents R16 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R16 was cognitively intact for daily decision making. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for shower/bathing, lower dressing, personal hygiene, rolling left to right, and sit to lying. R16 required partial/moderate assistance for upper dressing. R16 was dependent for sit to stand, transferring from chair to bed, and toileting transfers. R16 was occasionally incontinent of bladder and always continent of bowel on the admission MDS. R16's MDS documents R16 desired to discharge to the community and required active discharge planning. R16's quarterly MDS completed on 10/9/24 documents R16's BIMS score to be 11, indicating R16 was demonstrating moderately impaired skills for daily decision making. R16's Discharge MDS completed on 10/17/24 does not assess R16's cognitive skills. R16's MDS documents R16 had no range of motion impairments. R16 was independent for eating. R16 required substantial/maximum assistance for lower dressing, personal hygiene. Shower/bathing was not attempted due to medical condition. R16 required partial/moderate assistance for upper dressing, sit to lying and lying to sitting, sit to stand, chair to bed transfer, and toilet transfer. Transferring to to tub/shower was not attempted due to medical condition. R16 was supervision for rolling left to right. R16 was frequently incontinent of bladder and always incontinent of bowel. R16's verification of benefits documented on 9/16/24, 1 day prior to R16's admission to the facility documents that R16 only had 30 days of benefits at the facility. The facility did not acknowledge this documentation and did not prepare R16 for discharge to occur on 10/17/24, 30 days later. On 10/22/24 at 1:42 PM, Director of Rehabilitation (DOR)-W stated that R16 was a sit to stand with assistance of 2 and all ADLS was an assist of 1. DOR-W informed Surveyor that the therapy department did not know R16 only had 30 days of benefits. DOR-W confirmed that therapy completes home evaluations. DOR-W stated that therapy did not do a home evaluation prior to discharge because it was not recommended by therapy that R16 return home. DOR-W confirmed that R16 was making minimal improvements slowly and was slowed down when R16 got COVID. DOR-W stated that R16 was not at baseline at time of discharge and that there was no sit to stand currently at home for R16. Surveyor notes that therapy did not recognize that R16 only had 30 days of benefits at the facility. Therapy did not monitor insurance updates and complete a home evaluation. If a home evaluation had been completed, recommendations and safety issues could have been identified in order to help R16's discharge to the community successful. R16 ended back up in the hospital less than 24 hours from discharge from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525702	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Country Health Services	2195 North Summit Village Way Oconomowoc, WI 53066

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 11:21 AM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A the concern that R16 did not receive rehabilitation services in order for R16 to reach baseline and/or improve in physical ability to ensure safety upon discharge from the facility. The therapy staff did not complete a home evaluation prior to R16 being discharged to determine the need for durable medical equipment and safety status resulting in R16 not having a safe discharge and the need for re-admission to the hospital. NHA-A agreed this is a concern. Surveyor requested from NHA-A documentation of R16's re-admission to the hospital on 10/18/24. On 10/23/24 at 3:22 PM, NHA-A confirmed hospital documentation refers to R16 not being able to be cared for at home and required placement in a skilled nursing facility. Surveyor requested multiple times for the hospital documentation which NHA-A stated would be provided. NHA-A stated the hospital documentation would be forwarded to Surveyor. At the time, the facility provided no additional information. No additional information was provided as to why the facility did not ensure that R16 received therapy services in a timely manner.