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Form Approved OMB
No. 0938-0391

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	06/20/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on interview and record review the facility did not provide a written notice of transfer, including the reason for transfer and appeal rights to the resident, and their representatives, at the time of transfer from the facility. This was observed with 7 (R49, R51, R58, R3, R4, R55, R75) of 7 residents reviewed for transfers. * R49 was transferred to the hospital on 2/3/24 and was not provided a written notice of the transfer including reason for the transfer and appeal rights. * R51 was transferred to the hospital on 4/5/24 and was not provided a written notice of transfer including reason for the transfer and appeal rights. * R58 was transferred to the hospital on 6/15/24 and was not provided a written notice of transfer including reason for the transfer and appeal rights. * R3 was transferred to the hospital on 5/16/24 and was not provided a written notice of transfer including reason for the transfer and appeal rights. * R4 was transferred to the hospital on 5/7/24 and was not provided a written notice of transfer including reason for the transfer and appeal rights. * R55 was transferred to the hospital on 5/4/24 and was not provided a written notice of transfer including reason for the transfer and appeal rights. * R75 was transferred to the hospital on 4/21/24 and was not provided a written notice of transfer including reason for the transfer and appeal rights. Findings include: On 6/18/24, at 2:09 PM, Surveyor spoke with (Director of Nurses) DON-B. DON-B indicated the facility does not have a policy and procedure for written transfer requirements. The transfer requirements would be on the bed-hold form itself. This information is not sent with the resident at the time of transfer. (continued on next page)

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

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) R49 was transferred to the hospital on 2/3/24 due to a change in condition. R49 returned to the facility on [DATE]. R49 has an activated Power of Attorney for Healthcare (POA-HC) . R49's medical record did not contain evidence the required transfer notice information was provided to R49 or their POA-HC at the time of transfer. On 6/19/24, at 10:37 AM, DON-B indicated R49 went out to the hospital on 2/3/24, came back to the facility, then went out to the hospital again. R49 returned to the facility on [DATE]. DON-B stated she did not have any documentation regarding the transfer notice requirements for either transfer. On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified the (Nursing Home Administrator) NHA-A of R49's transfer notice requirements not being provided with either transfer. 2.) R51 was transferred to the hospital on 4/15/24 due to a change in condition. R51 returned to the facility on [DATE]. R51 currently has an activated Power of Attorney for Healthcare. R51's medical record did not contain evidence the required transfer notice information was provided to R1 or their responsible party at the time of transfer. On 6/19/24, at 9:26 AM, Surveyor spoke with the Director of Nursing (DON)-B. DON-B shared the facility had contacted R51's family about a room change that day. DON-B does not have documentation the required transfer notice was provided to R51 or their responsible party. On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified the (Nursing Home Administrator) NHA-A of R51's transfer notice requirements not being provided with transfer. 3.) R58 was transferred to the hospital on 6/15/24 for a change in condition. R58 had not returned to the facility at the time of survey. R58's medical record did not contain evidence the required transfer notice information was provided. On 6/18/24, at 01:38 PM, Surveyor spoke with (Admission Director) AD-G. AD-G documented on 6/19/24 they verbally reviewed the Bed-Hold form with R58's Power of Attorney for Healthcare. The Bed-Hold form contains portions of the required transfer notice information. AD-G shared they try to connect with the resident, or Power of Attorney for Healthcare, the next day (day after transfer). They only go over the bed-hold information and not the transfer notice information. AD-G shared the Bed-Hold form does not go out with the resident at the time of transfer. On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified the (Nursing Home Administrator) NHA-A of R58's transfer notice requirements not being provided with transfer. 38146 4) R55 admitted to the facility on [DATE] and has diagnoses that include acute and subacute infective endocarditis, infection and inflammatory reaction due to cardiac and vascular devices, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Epilepsy, Chronic Atrial Fibrillation, Anemia, and Congestive Heart Failure. R55 is assessed to be cognitively intact and his medical record documents: Responsible party - self. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55 was hospitalized on [DATE] and readmitted to the facility on [DATE]. Surveyor was unable to locate evidence a transfer notice was provided in R55's medical record and asked Director of Nursing (DON)-B to provide. On 6/18/24, at 3:10 PM, DON-B reported the nurses should be completing a change in condition (CIC) form under assessments. R55 did not have a CIC form in his medical record. On 6/19/24, at 9:41 AM, Surveyor again asked DON-B for information regarding R55's hospitalization and the transfer notice provided. Surveyor was advised by DON-B the facility does not have evidence a transfer notice was completed or provided to R55. 49011 5.) R3 was transferred to the hospital on 5/16/24 due to a change in condition. R3 returned to the facility on [DATE]. R3 is responsible for self and does not have an activated Power of Attorney for Healthcare (POA-HC). R3's medical record did not contain evidence the required written transfer notice information was provided to R3 or their representative at the time of transfer. Surveyor reviewed R3's electronic medical record and discovered R3 had been sent to the emergency roiagnom on [DATE] and found documentation that Admission Director-G gave notice via voicemail as signed on the Bed Hold Policy and Notice of Transfer paperwork on 5/19/24 at 2:44pm to R3's representative however there was no evidence a written notice of the reason for transfer, and appeal rights were provided to R3 or their representative. On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified the Facility of R3's written transfer notice requirements not being provided. 6.) R4 was transferred to the hospital on 3/28/24 due to a change in condition. R4 returned to the facility on [DATE]. R4 is responsible for self and does not have an activated Power of Attorney for Healthcare (POA-HC). R4's medical record did not contain evidence the required written transfer notice information was provided to R4 or their representative at the time of transfer. Surveyor reviewed R4's electronic medical record and discovered R4 had been sent to the emergency roiagnom on [DATE] and found documentation that Admission Director-G gave notice via phone related to the Bed Hold Policy and Notice of Transfer paperwork on 3/29/24 at 9:40 am to R4's representative however there was no evidence written notice of the reason for transfer, and appeal rights were provided to R4. On 5/7/24 R4 was again transferred to the hospital due to a change in condition. R4 returned to the facility on [DATE]. R4's medical record did not contain evidence the required written transfer notice information was provided to R4 or their representative at the time of this transfer. Surveyor reviewed R4's electronic medical record and discovered R4 had been sent to the emergency roiagnom on [DATE] and found a progress note that was created on 5/13/24, at 8:39am, effective 5/8/2024, Resident has a 15-day bed hold with his Medicaid benefit and resident confirmed he does want to return to facility once medically ready. Per Director of Nursing (DON)-B there is no additional paperwork for this hospital stay indicating written notice of the reason for transfer and appeal rights was provided to R4. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified the Facility of R4's written transfer notice requirements not being provided. 36161 7.) R75 was admitted to the facility on [DATE] with a diagnosis that included malignant neoplasm of lower lobe, gastroenteropathy, atrial fibrillation and chronic obstructive pulmonary disease. R75's nursing note dated 4/21/24 documents, General Note Text: Writer spoke with daughter on phone in am and misunderstood what daughter was asking, thought she was asking of the BUN (Blood Urea Nitrogen-blood test that measures the amount of nitrogen found in the blood) result, but it was for the BNP (Brain Natriuretic Peptide) which is elevated. I updated NP (nurse practitioner) which she ordered a one-time order of Lasik 20 mg (milligrams) which the resident did not take .Daughter asked resident if she wanted to go to the hospital and she stated yes. Writer called EMS (emergency medical services) for transport to ER (emergency room). Surveyor was unable to locate any written notice of transfer including appeal rights in R75's medical record. On 6/18/24, at 2:45 PM, Surveyor informed Nursing Home Administration (NHA)-A and Director of Nursing (DON)-B of the above findings. Surveyor asked NHA-A if R75 was provided with a transfer notice when R75 was sent to the emergency roiagnom on [DATE]. NHA-A informed Surveyor he would review R75's medical record and let Surveyor know. On 6/20/24, at 10:56 AM, DON-B informed Surveyor the facility did not provide a transfer notice to R75 or R75's representative after R75 was transferred to the emergency roiagnom on [DATE]. No additional information was provided as to why the facility did not provide R75 with a notice of transfer when R75 was transferred to the hospital on 4/21/24.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not provide the written bed-hold requirements to the resident, or their representatives, at the time of transfer from the facility. This was observed with 5 (R49, R51, R58, R55, R75) of 7 resident transfers reviewed. * R49 was transferred to the hospital on 2/3/24 and was not provided the written bed-hold notification. * R51 was transferred to the hospital on 4/5/24 and was not provided the written bed-hold notification. * R58 was transferred to the hospital on 6/15/24 and was not provided the written bed-hold notification. * R55 was transferred to the hospital on 5/4/24 and was not provided the written bed-hold notification. * R75 was transferred to the hospital on 4/21/24 and was not provided the written bed-hold notification. Findings include: On 6/18/24, at 2:09 PM, Surveyor spoke with (Director of Nurses) DON-B. DON-B indicated the facility does not have a policy and procedure for written bed-hold notification requirements. DON-B informed Surveyor the Bed-Hold form is not sent with the resident at the time of transfer. 1.) R49 was transferred to the hospital on 2/3/24 for a change in condition. R49 returned to the facility on [DATE]. R49 has an activated Power of Attorney for Healthcare. R49 medical record did not contain evidence the required bed-hold information was provided at the time of transfer. On 6/19/24, at 10:37 AM, DON-B indicated R49 went out to the hospital on 2/3/24, came back to the facility, then went out to the hospital again. R49 returned to the facility on [DATE]. DON-B shared that staff recall speaking to R49's family, about the bed-hold information, but it was not documented. On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified the (Nursing Home Administrator) NHA-A of R49's bed-hold notice requirements not being provided with transfer. 2.) R51 was transferred to the hospital on 4/15/24 for a change in condition. R51 returned to the facility on [DATE]. R51 currently has an activated Power of Attorney for Healthcare. R51's medical record did not contain evidence the required bed-hold information was provided at the time of transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24, at 9:26 AM, Surveyor spoke with Director of Nursing (DON)-B. DON-B shared the facility had contacted R51's family for a room change that day. However, DON-B does not have documentation the required bed-hold information was provided when R51 was transferred to the hospital. On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified Nursing Home Administrator (NHA)-A of R51's bed-hold requirements not being provided with transfer. 3.) R58 was transferred to the hospital on 6/15/24 due to a change in condition. R58 had not returned to the facility at the time of survey. R58's medical record did not contain evidence the required bed-hold information was provided. On 6/18/24, at 01:38 PM, Surveyor spoke with Admission Director- (AD)-G. AD-G documented on 6/19/24 they verbally reviewed the Bed-Hold form with R58's Power of Attorney for Healthcare. The Bed-Hold form contains portions of the required notice information. AD-G shared they try to connect with the resident, or Power of Attorney for Healthcare, the next day (after transfer). AD-G stated they only go over the bed-hold information a form does not go out with the resident when they are transferred. On 6/19/24, at 3:00 PM, during the daily exit meeting, Surveyor notified Nursing Home Administrator (NHA)-A of R58's bed-hold requirements not being provided with transfer. 38146 4) R55 admitted to the facility on [DATE] and has diagnoses that include acute and subacute infective endocarditis, infection and inflammatory reaction due to cardiac and vascular devices, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Epilepsy, chronic Atrial Fibrillation, Anemia, and Congestive Heart Failure. R55 is assessed to be cognitively intact and his medical record documents: Responsible party - self. R55 was hospitalized on [DATE] and readmitted to the facility on [DATE]. Surveyor was unable to locate evidence a bed hold notice was provided in R55's medical record and asked Director of Nursing (DON)-B to provide. On 6/18/24, at 3:10 PM, DON-B reported the nurses should be completing a change in condition (CIC) form under assessments. Surveyor notes R55 did not have a CIC form in his medical record. On 6/19/24, at 9:41 AM, Surveyor again asked DON-B for information regarding hospitalization and the bed hold information. Surveyor was advised the facility does not have evidence the bed hold notice, to include the required regulatory information, was provided to R55. 36161 5.) R75 was admitted to the facility on [DATE] with a diagnosis that included malignant neoplasm of lower lobe, gastroenteropathy, atrial fibrillation and chronic obstructive pulmonary disease. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R75's nursing note dated 4/21/24 documents, General Note Text: Writer spoke with daughter on phone in am and misunderstood what daughter was asking, thought she was asking of the BUN (Blood Urea Nitrogen- lab test that measures the amount of nitrogen found in the blood) result, but it was for the BNP (Brain Natriuretic Peptide- blood test that measures the levels of protein) which is elevated. I updated NP (nurse practitioner) which she ordered a one-time order of Lasik 20 mg (milligrams) which the resident did not take . Daughter asked resident if she wanted to go to the hospital and she stated yes. Writer called EMS (emergency medical services) for transport to ER (emergency room). Surveyor was unable to locate any notice of a bed hold being provided to R75 or R75's representative in R75's medical record. On 6/18/24 at 2:45 PM, Surveyor informed Nursing Home Administration (NHA)-A and Director of Nursing (DON)-B of the above findings. Surveyor asked NHA-A if R75 was provided with a bed hold notice when R75 was sent to the emergency roiagnom on [DATE]. NHA-A informed Surveyor he would review R75's medical record and let Surveyor know. On 6/20/24 at 10:56 AM, DON-B informed Surveyor that the facility did not provide a bed hold notice to R75 or R75's representative after R75 was transferred to the emergency roiagnom on [DATE]. No additional information was provided as to why the facility did not provide R75 with a notice of bed hold when R75 was transferred to the hospital on 4/21/24.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure the resident's record reflected the accurate resuscitation code status election for 1 (R8) of 18 residents reviewed for code status. R8's hospital discharge paperwork dated [DATE] and facility admission documentation completed on [DATE], indicated R8 elected a full code status. On [DATE] R8's medical record documented a DNR (Do Not Resuscitate) MD (medical doctor) order. After the facility conducted a meeting with R8's POA (power of attorney)-K, R8's code status was changed to a full code and a new full code MD order was placed in R8's medical record on [DATE] per R8's POA-K wishes. On [DATE], R8's code status was changed to DNR. R8's progress notes continue to document R8 is a full code despite the signed paperwork and active MD order for DNR. Findings include: R8 was admitted to the facility on [DATE], and has diagnoses that include Chronic kidney disease, Chronic obstructive pulmonary disease, Type 2 Diabetes, and Dementia. R8's Quarterly Minimum Data Set Assessment, dated [DATE], documents R8 has moderate cognitive impairment. R8 has an activated Power of Attorney (POA) indicating R8 has a designee to help make health care decisions. The POA paperwork was signed on [DATE]. R8 has a Physician signed Determination of Capacity form dated [DATE]. This form documents, I have personally examined and certify that [R8] meets the statutory definition of incapacity; [R8] is unable to receive and evaluate information effectively or unable to communicate decisions to such an extent that [R8] lacks the capacity to manage [R8]'s health care decisions. R8's Hospital After Visit Summary, dated [DATE], documents R8 has requested a full code status. R8's Hospital Discharge Summary, dated [DATE] documents R8 has elected a full code status. Surveyor reviewed R8's CPR (cardiopulmonary resuscitation) consent form dated [DATE]. The consent form has a box checked next to the following statement: NO RESUSCITATION (No cardiopulmonary resuscitation or external defibrillation) . Surveyor notes an illegible signature next to the resident signature section of the consent. Surveyor notes the Resident's Authorized Representative Signature section is blank. On [DATE], at 2:05 PM, Surveyor interviewed Director of Nursing (DON)-B regarding R8's signed CPR election consent form. DON-B indicated at the time of R8's admission, the facility did not have R8's [activated] POA documents and the nurse who admitted R8 to the facility addressed code status with R8. R8 signed the form indicating a DNR election. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted neither POA-K or POA-L signed the CPR election form and there is no documentation POA-K or POA-L was notified of R8's signing of the CPR election form electing a No Resuscitation status. R8's SNF (Skilled Nursing Facility) initial visit progress note entered by R8's Physician Assistant on [DATE], documents: Code status: Full Code/Allow Resuscitation. Surveyor notes R8's Physician Assistant did not identify the discrepancy between the hospital discharge paperwork indicating a full code status and the signed CPR consent from electing a no code status. Surveyor notes R8's MD order, with a start date of [DATE], documents: DNR. Surveyor notes R8's MD order with a start date of [DATE], documents a change in code status to Full Code. On [DATE], R8's POA-L signed the Code Status Election form titled Emergency Care-Do Not Resuscitate Order. The DNR (Code status election form) was signed by R8's physician on [DATE]. R8's MD order with a start date of [DATE], documents: DNR. R8's SNF progress note entered by R8's Physician Assistant on [DATE], documents: Code status: Full Code/Allow Resuscitation. R8's SNF progress note entered by R8's Physician on [DATE], documents: Code status: Full Code/Allow Resuscitation. Surveyor noted inconsistency within R8's Electronic Medical Record (EMR) regarding the most recent code status election between R8's POA signed code status election form, MD orders and MD and Physician Assistant progress note documentation. On [DATE], at 2:02 PM, Surveyor interviewed R8's activated POA-K. POA-K stated R8 was supposed to be a full code status upon admission. POA-K indicated R8's code status was changed to DNR without POA-K's permission or signature. On [DATE], at 2:05 PM, Surveyor interviewed DON-B and Social Services Director (SSD)-C. SSD-C indicated that a few months after R8's admission, they had a care conference with R8 and POA-K. Surveyor asked for the date that the care conference was completed. SSD-C stated she would have to look into that. SSD-C and DON-B stated, at the care conference, the code status was discussed. As a result, R8's code status was changed to full code per POA-K wishes. Surveyor notes SSD-D did not provide Surveyor the date of the care conference or documentation of the care conference and discussion related to the change in code status. On [DATE], at the facility exit meeting, these concerns were shared with Nursing Home Administrator (NHA)-A and DON-B. No further information was provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 1 (R7) of 8 residents reviewed for pressure injuries. R7 was readmitted to the facility from the hospital on 7/19/2023, with a stage 2 pressure injury to the coccyx. The facility did not complete a comprehensive assessment of the pressure injury including measurements and a description of the wound bed documented upon re-admission. R7 had 2 additional re-admissions to the facility from the hospital on 10/3/2023 and 10/12/2023. The facility did not complete a comprehensive assessment of the pressure injury with measurements and description of the wound bed documented upon readmission for these two additional re-admissions. Findings include: The facility policy, titled Pressure Injuries and Non pressure Injuries, dated 7/20/2022 documents: Policy: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity . Upon Admission: A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the admission/readmission evaluation . If pressure injury: initiate the pressure injury weekly tracker . R7 was admitted to the facility on [DATE] with a diagnosis that include Discitis (Infection of the intervertebral disc space that can cause inflammation of the surrounding vertebrae, joints and tissue), Type 2 diabetes, Atrial fibrillation with pacemaker and long-term use of anticoagulants, Prostate cancer and Heart failure. R7's Quarterly Minimum Data Set (MDS) assessment, dated 5/26/2024, documents R7 is moderately cognitively impaired. R7 requires substantial/maximal assistance to roll left or right. R7 requires the assist of one for bed mobility; is at risk for the development of pressure ulcers; has an unhealed stage 4 pressure injury. R7's Care plan, dated 11/22/2022, documents: Resident is at risk for skin integrity condition, or pressure sores [related to] Diabetes, history of pressure sores, impaired mobility, obesity, thin/fragile skin, and prostate cancer [diagnosis] Interventions include: Alternating pressure air mattress ., Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately. Avoid friction/shearing while repositioning . (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct pressure injury skin assessments as indicated. Frequent repositioning in bed and chair. Head to toe assessment by Licensed Nurse performed weekly at minimum. R7 was hospitalized from 7/14/2023 through 7/19/2023 due to discitis. R7's re-admission evaluation, dated 7/19/2023, documents: R7's Braden Scale (Evaluation of Predicting Pressure Sore Risk) score as 12, indicating R7 to be at high risk of developing a pressure injury. R7's skin integrity assessment documents R7 had a skin impairment present. Site: Coccyx. Type was pressure. Stage: stage 2. Surveyor noted the facility did not comprehensively assess the pressure injury upon re-admission. There was no measurements of the wound and no description of the wound bed. On 9/12/23, R7's Coccyx pressure injury was assessed by the Wound Nurse Practitioner and changed to an unstageable pressure injury. The wound was measured at 1.5 x 1.2 x 0.1. 100% slough on 9/12/23. A treatment was put in place. Comprehensive wound assessments were completed. Treatments changed based on the assessments. Interventions were addressed. R7 was hospitalized from 10/1/2023 through 10/3/2023 due to evaluation of chest pain. R7's re-admission evaluation, dated 10/3/2023, documents: R7's Braden Scale score as 14, indicating R7 is at moderate risk for the development of pressure injuries. R7's skin integrity assessment documents R7 had a skin impairment present. Site: Coccyx. Type: pressure. Stage: unstageable. Surveyor noted the facility did not comprehensively assess the wound on re-admission. There was no measurements of the wound and no description of the wound bed. R7 was hospitalized from 10/6/2023 through 10/12/2023 due to sepsis related to a possible pacemaker infection. R7's re-admission evaluation, dated 10/12/2023, documents: R7's Braden Scale score as 13, indicating R7 is at moderate risk for developing a pressure injury. R7's skin integrity assessment documents R7 had a skin impairment present. Site: Coccyx. Type: pressure. Stage: unstageable. Surveyor noted the facility did not comprehensively assess the wound upon re-admission. There was no measurements of the wound and no description of the wound bed. On 6/18/2024, at 1:54 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-J, who is also the wound nurse for the facility. Surveyor asked if a wound should be comprehensively assessed on readmission. ADON-J indicated she would expect the wound be assessed. ADON-J stated R7 was very sick for few months and that is why R7 was in and out of the hospital and had developed the pressure injury. ADON-J stated R7's medical team recommended hospice and R7 and R7's family did not want to go that route. Surveyor informed ADON-J of the concern that on 3 readmissions to the facility, R7 did not have his pressure injury comprehensively assessed. ADON-J stated that ADON-J understood. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/2024, at 2:10 PM, ADON-J informed Surveyor ADON-J spoke to the nurse who completed all 3 of the readmission assessments for R7. ADON-J confirmed the readmission skin assessments were not documented as comprehensive wound assessments. On 6/18/2024, at 3:02 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern R7's pressure injury was not comprehensively assessed upon multiple readmission. No additional information was provided as to why the facility did not ensure that R7 received necessary treatment and services consistent with professional standards of practice to promote healing of R7's pressure injury.

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F 0689 Level of Harm - Minimal harm or potential for 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** 49011 Based on interview and record review, the facility did not ensure the environment remained free of accident hazards for 1 (R3) of 6 residents reviewed for accidents. * R3 fell from bed while receiving cares due to bed frame not being extended to accommodate mattress size. R3 has bed rails attached to frame but there is no maintenance plan in place by facility for inspection after installation. Findings include: The Facility Policy and Procedure titled, Bed Maintenance and Inspections Policy Date Implemented: 6/16/2022, states in part: Policy Explanation and Compliance Guidelines: 1. The Maintenance Director, or designee, is responsible for keeping records of bed inspections and maintenance. 2. Bed frames, mattresses, and bed rails will be maintained, including the manufacturer for each . 3. The Maintenance Director shall review each manufacturer's recommendations and requirements for maintenance and bed inspections, and shall establish a maintenance and inspection schedule accordingly . 6. Bed frame, mattress, and bed rail inspections will be conducted upon each item entering facility and then placed on regularly scheduled inspection and maintenance cycle according to the manufacturer's recommendations, to include manufacturer's timeframe recommendations . The Facility Policy and Procedure titled, Proper Use of Side Rails Date Reviewed/Revised: 9/23/2022, states in part: Policy Explanation and Compliance Guidelines: 4. The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: . e. Inspecting and regularly checking the mattress and bed rails for gaps and areas of possible entrapment. f. Checking rails regularly to make sure they are still installed correctly and have not shifted or loosened over time . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R3 was admitted to the facility on [DATE] with diagnoses that include, in part, chronic diastolic (congestive) heart failure, cognitive communication deficit, Parkinson's disease, dysphagia, morbid obesity, orthostatic hypotension and personal history of transient ischemic attack. R3 is responsible for self and does not have an activated Power of Attorney for Healthcare (POA-HC). The Quarterly MDS (Minimum Data Set) dated 4/25/2024 indicates R3 has a BIMS (Brief Interview for Mental Status) of 14, indicating cognitively intact. On 06/18/24, at 09:47 AM, Surveyor reviewed R3's Plan of care which documents At risk for falls due to: weakness, orthostatic hypotension. The following interventions are listed: - Encourage to transfer and change positions slowly - Medications as ordered - Provide assist to transfer and ambulate as needed - Reinforce need to call for assistance On 06/17/24, at 09:43 AM, Surveyor interviewed R3 who stated they had a fall and landed on their face and that is why they have bars on bed to hang onto so they won't roll out again. On 5/20/2024, at 05:19 am, R3's medical record documents, by Registered Nurse (RN)-M, 0505 (5:05 AM) writer called to residents room, resident lying on floor on back. Resident rolled out of bed. ROM (Range of Motion) adequate to all extremities, small laceration noted to bridge of nose and did complaint of nose discomfort. Pillows placed under head and EMS (Emergency Medical Services) notified for transport. Surveyor reviewed the Post Fall Assessment and noted there was an entry regarding Why do you think that you fell stating bed frame not extended to bari-size, mattress not secured to bed, causing resident to roll out of bed. It was identified the resident was being changed in bed and rolled out of the bed. For the question was equipment used properly and in good repair it was stated that bed not in working order. For Care Plan new intervention on form maintenance contacted to repair bed was entered. On 06/18/24, at 11:27 AM, Surveyor reviewed the EMR and found an order dated 5/23/24 stating Bilateral enabler bars to bed to assist with bed mobility and transfers related to weakness. Surveyor notes there was an assessment completed by the Facility on the same day. On 06/19/24, at 08:30 AM, Surveyor spoke with Licensed Practical Nurse (LPN)-N via phone. LPN-N told Surveyor they were at the nurse station and an aid ran to get them. When they got to the room the resident was face down and the mattress fell off the bed. They proceeded to get the RN-M. who assessed R3 and called 911 for further evaluation. Per LPN-N the bed frame is adjustable, and it was not locked. LPN-N states the injury sustained by R3 was a laceration to the bridge of nose. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/19/24, at 08:36 AM, Surveyor spoke with RN-M via phone. RN-M stated R3 rolled out of bed and RN-M was called over by LPN-N to assess. R3 was on back on the floor. RN-M sent R3 to hospital because R3 hit head. An ambulance was called for the transport. RN-M stated R3 is a larger lady so if she gets to close to edge of the bed she will roll out of bed. On 06/19/24, at 11:14 AM, Surveyor spoke with Maintenance Director-O and asked when maintenance is done on the beds that are extended to mid-bari size. Per Maintenance Director-O when a resident transfers or leaves the bed is gone over. Surveyor asked what if a resident is here long term - is there a maintenance schedule? Per Maintenance Director-O for long term residents bed issues are brought to maintenance attention by nursing. There is no routine maintenance schedule. Surveyor then asked if there was a work order for R3's bed to be repaired lately. Maintenance Director-O stated they do not recall anything, however, nursing writes on the board outside maintenance and the maintenance assistant might have completed that. Surveyor asked Maintenance Director-O if they could verify if a work order for May 20 th had been completed. Maintenance Director-O stated they would verify. On 06/19/24, at 11:31 AM, Maintenance Director-O stated R3 had a mid-bari frame with built in extenders. The extenders weren't locked, so the frame got pushed back to regular size, hence the mattress hung over the side of bed. Per Maintenance Director-O after this was identified at the morning meeting the bed was switched out to a mid-bari bed with no extenders. Surveyor notes Facility has no process in place to maintain safety and prevent accidents for mid-bari bed frame use. On 06/19/24, at 11:35 AM, per Maintenance Director-O bed rails are installed by maintenance. There is a very specific way that they are installed and are then double checked at that time. There is no schedule for routine maintenance, nursing lets know if there is a problem. Surveyor notes Facility has no process in place to maintain safety and prevent accidents for bed rail use. On 06/19/24, at 03:11 PM, Surveyor got requested number of beds converted to mid-bari that are in use in the Facility. Per Maintenance Director-O there are 12 beds in facility that are converted to mid-bari and in use. On 06/20/24, at 10:59 AM, Surveyor spoke with Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-J about the bed and mattress for R3 at time of the fall. It was stated that it was a standard size bed because the extenders were not engaged on the bed as should have been because R3 had mid-bari mattress. The Facility found out on the morning post R3's fall and got Maintenance Director-O to change out the bed frame out to mid-bari with no extenders. Surveyor asked if the Facility does checks on beds and was told no they rely on housekeeping or nurses, nothing formal is set up. However, after this incident they did check the other beds in use. Surveyor informed DON-B and ADON-J of the concern that bed frames do not have regular maintenance checks and R3 fell from bed and sustained a laceration to the nose due to the extenders not being locked into place

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observation, interviews and record review, the facility did not ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight for 1 of 2 (R69) residents reviewed for weight loss. R69 was not weighed as ordered. R69 sustained severe weight loss over a period of less than 2 months. Neither the Physician, nor the Dietician was notified and no new interventions were implemented. R69 continued to lose weight with no Physician or Dietician notification and no new interventions were implmented until an additional month later. Findings include: R69 admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following Cerebral Infarction, Aphasia, Dysarthria, Type 2 Diabetes Mellitus, Obstructive Sleep Apnea and Hyperlipidemia. The facility policy titled Weight Monitoring revised 12/21/22 documents (in part) . . The interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight change for our residents. Weight Assessment 1. The nursing staff will measure resident weights on admission, the next 2 days, and weekly for 3 additional weeks thereafter. 2. If no weight concerns are noted after the initial 3 days and 3 weeks after, routine weights will be measured monthly thereafter, unless ordered more frequently by the physician. 3. Weights will be recorded in the individual's electronic health record. 6. Any weight changes of five (5) pounds or more since the last weight assessment will be retaken for confirmation. 7. The Dietician will review the monthly weights to follow individual weight trends over time. Weight trends will be evaluated by the interdisciplinary team whether or not the criteria for significant weight change has been met. 8. The threshold for significant weight change will be based on the following criteria [where percentage of body weight change = (usual weight - actual weight) / (usual weight) x 100]: a. 1 month - 5% weight change is significant; greater than 5% is severe. b. 3 months - 7.5% weight change is significant; greater than 7.5% is severe. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. 6 months - 10% weight change is significant; greater than 10% is severe. 10. The nursing staff will notify the individual or responsible party, physician and RDN (Registered Dietician) or designee of any individual with an unintended significant weight change. Care Planning 1. Care planning for weight change or impaired nutrition will be an interdisciplinary effort and may include the following members of the interdisciplinary team: Physician, nursing staff, the Dietician, the Consultant Pharmacist, Therapy, and the resident or resident's legal representative. 2. Individualized care plans shall address, to the extent possible: a. The identified causes of weight change; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment. R69's Care Plan dated 1/26/24 documents: At risk for nutritional status change r/t (related to) (specify). -At risk for nutritional status change r/t (specify) high BMI (body mass index), DM (Diabetes Mellitus) and dysphagia s/p (status post) stroke - dated 2/5/24. -At risk for nutritional status change r/t Inadequate oral intakes, dysphagia s/p stroke - dated 5/3/24. Goal: Will maintain weight as evidenced by no significant wt (weight) changes >(greater than)/= 5% in 30 days, >/= 7.5% in 90 days, or >/= 10% in 180 days - dated 1/26/24. Interventions include: Encourage and assist as needed to consume foods and/or supplements and fluids offered - dated 2/6/24. Adaptive equipment: Built up utensils, scoop plate - dated 2/6/24. Eating setup, supervision, upright for meals, no straws, use [NAME] cup - revised 4/12/24 Modify diet as appropriate according to resident's food tolerances and allergies - dated 2/6/24. Nectar Thick Liquids, Mechanical Soft Diet - dated 4/17/24. Provide diet as ordered and record intakes - dated 2/6/24. Provide supplements as ordered - dated 2/6/24. Record weight per facility protocol/MD (Medical Doctor) orders dated 1/26/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review weights and notify RD (Registered Dietician) MD, and responsible party of significant weight change - dated 2/6/24. On 6/17/24, at 10:02 AM, during initial observation and interview, Surveyor noted R69 appeared thin and frail. R69 reported he has probably lost a lot of weight, stating I don't want to eat. R69's Physicians orders document: WEIGHT - on admit, daily x (times) 2, weekly x 3, monthly (Obtain re-weight if change of 5 lbs (pounds) since last weight) one time only until 1/27/24 AND one time a day for 2 Days AND one time a day every Fri (Friday) for 3 Weeks AND one time a day every 1 month(s) starting on the 1st for 1 day(s) - start date 1/27/24. Remeron 15 mg (milligrams) Give 0.5 tablet by mouth at bedtime for depression, Anorexia - start date 2/21/24. On 1/26/24 R69's documented weight was 188 pounds. On 1/28/24 R69's documented weight was 188 pounds. On 2/6/24, at 11:17 AM, Dietician-D's Nutrition Assessment Note documents (in part) . . Diet order: Regular, L3 (level 3)/Adv (advanced) thin, no Straws. Average meal intake: 50-100%. Swallowing disorder present. Other: Dx (diagnosis) Dysphagia, requires adaptive equipment. Built-up utensils. Eating ability: Independent Supervision. Current weight: 188.8 lb (pounds) 1/28/24. BMI (Body Mass Index): 27.9. Weight history unknown. Skin condition: Pressure injury R (right) Heel Stage II - Improving per 2/6 wound rounds. Edema present +1 BLE (bilateral lower extremity). Summary: Current diet order remains appropriate for management of resident. Resident appears to be tolerating diet texture/consistency. Resident is consuming adequate calories to maintain weight. Weight remains stable without significant variances. Resident has potential for weight fluctuation r/t fluid shifts. Resident admitted to facility s/p (status post) hospitalization r/t CVA (Cerebral Vascular Accident), repeated falls. Stated not preferring some meals at facility. Reported difficulty eating with L (left). hand d/t (due to) CVA. Uses built-up utensils. Recommended to also use scoop plate d/t difficulty with L (left) hand. Stated especially hard to eat ice cream cups. BS (blood sugar) well controlled. Res (resident) agreeable to having Fort (fortified) chocolate milk for intake support and wound healing. Food preferences updated. Will cont to monitor and f/u (follow up) prn (as needed). Care plan reviewed and updated. Surveyor noted an order implemented for Fortified Chocolate Milk 8 oz (ounces) with lunch/Dinner -with a start date of 2/6/24. Surveyor noted there were no documented weights for the month of February, 2024 and the Treatment Administration Record did not document refusal of weights. On 3/18/24 R69's documented weight was 163.5 pounds. This indicated a weight loss of 24.5 pounds and 13. 03% over a period of less than 2 months, indicating severe weight loss. There was no evidence the Physician or Dietician were notified and no new interventions were implemented. The NP (Nurse Practitioner) note dated 3/19/24 documented: No weight loss, no anorexia, nausea, vomiting or diarrhea. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 R69's documented weight was 161.4 pounds, indicating further weight loss. There was no evidence the Physician or Dietician were notified. Subsequent NP notes on 3/26/24, 3/28/24 and 4/2/24 documented: No weight loss, no anorexia, nausea, vomiting or diarrhea. Physician notes dated 3/21/24, 4/4/24, 4/18/24 and 5/2/24 documented: No weight loss, fever, chills, + (positive) weakness. On 4/8/24 R69's documented weight was 156 pounds, indicating severe weight loss of 32 pounds and 17.02% since admission. There was no evidence the Dietician or Physician was notified and no new interventions were implemented at this time. R69's Care Conference Summary dated 4/11/24 did not document any concerns regarding weight loss. On 4/12/24 (4 days later) Dietician-D's Nutrition/Dietary Note documented (in part) . f/u (follow up) Wt: 156# (pounds) (4/8), 161.4# (3/20), 163.8# (3/18). BMI: 23-WNL (within normal limits), good for age. Triggers for sig (significant) wt loss of -3.3% x 30 (non-sig), -17% x 90d. (triggers from wt of 188# and wt loss from this wt occurred outside facility). Diet recently changed by SLP (speech language pathologist) to L2 (level 2) with nectar liquids, no straws d/t swallowing troubles. Resident intakes have been poor. Receives fortified chocolate milk TID (three times daily), but acceptance has been varied especially stating on nectar liquids. New Btx (buttocks) stg (Stage) II wounds acquired 4/4. Recommend to continue with fortified milk. Res (resident) son has premier PRO (protein) shakes in wing fridge, recommend to place order for resident to receive 1x/day to monitor intakes. Recommend to give ProStat 30ml BID (twice daily) for wounds. Will cont to monitor and f/u (follow up) prn (as needed). Surveyor noted Dietician-D's documentation weight loss -3.3% x 30 (non-significant) was not accurate, R69 did not have a 30 day weight obtained in February. Surveyor noted Dietician D's documentation -17% x 90 days triggers from wt of 188# and wt loss from this wt occurred outside facility is not accurate. As of 4/8/24, R69 had a documented severe weight loss of 32 pounds/17.02% and has resided in the facility since admission on 1/26/24. In addition, Dietician D documented R69 receives fortified chocolate milk TID, however orders on 2/6/23 were for BID (twice daily). Surveyor noted new orders implemented on 4/13/24: Fortified Chocolate Milk 8 oz (ounces) with meals (times TID), Two times a day Fortified pudding with lunch/dinner, and one time a day Premier Protein shake -family provided. On 5/3/24 Dietician D's Nutrition Assessment Note documented (in part) . Average meal intake: 0-25%, Occasional 76-100%, occasional meal refusals. Received nutritional supplements and/or fortified foods. Fort choc milk TID with meals, Fort pudding BID, Premier PRO shake - family provided. Swallowing disorder present. Current weight: 156.0 lb. BMI 23. Significant weight change present. 4/15/24: -17% x 90 d (days). Current body wt pending. Summary: Current diet order remains appropriate for management of resident Resident appears to be tolerating diet texture/consistency. Triggers for sig wt loss of -17% x 90d (wt loss from Jan-March occurred outside facility). Diet recently changed by SLP to L2 with nectar liquids, no straws d/t swallowing troubles. Resident intakes have been poor. Receives fort choc milk TID, but acceptance has been varied especially stating on nectar liquids. Varied to poor fort food acceptance. Per SLP resident has been refusing to participate in ST. Rec to D/C fort pudding as res does not accept. Rec to start liquid PRO 30ml TID. Will cont to monitor and f/u prn. Care plan reviewed and updated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted Dietician D's documentation Triggers for sig wt loss of -17% x 90 days wt loss from Jan-March occurred outside facility was not accurate. R69 triggered for severe weight loss in March (less than 2 months) and the weight loss did not occur outside the facility. Surveyor noted a Significant Change MDS (Minimum Date Set) dated 5/3/24. MDS Nurse-E reported the MDS was completed because of weight loss and pressure injuries. On 5/16/24 R69's documented weight was 142.3 pounds, indicating severe weight loss of 45.7 pounds and 24.31% since admission. On 5/16/24 at 11:22 AM facility progress notes document: IDT (Interdisciplinary Team) Weekly At Risk Meeting: Resident is noted to have a weight loss last month. Resident is on supplements which he is compliant with. Resident snacks between meals and is on an appetite stimulant. Resident's son brings in snacks as well. Resident has pressure ulcers. Resident is on wound rounds for the pressure ulcers. Resident has behaviors such as rejections of care, verbal towards staff, physical towards staff. Resident will kick off his offloading boots and reposition himself onto his back versus side to side. Resident is re-educated on this. On 5/17/24 at 1:33 PM facility progress note entered by Registered Nurse (RN)-F documented: Resident has not been eating; only bites for meals. Writer talked to resident; resident states he wants a G (gastrostomy) tube and that he is depressed. Resident is in agreement to take something for depression in addition to Remeron. Social Services notified. Resident gave writer permission to talk with his son about resident's eating habits and not wanting to get up out of bed, having a G tube place. Resident son stated that his father was not eating much prior to his stroke. Surveyor located no evidence the Physician, Dietician or Social Worker was notified of R69's request for G-tube and depression. On 6/18/24 at 10:21 AM Surveyor spoke with RN-F regarding her documentation on 5/17/24. RN-F reported she talked to R69's son and the NP, but was unsure of the date. RN-F stated: I must've forgot to write a note that I called the NP. The NP was talking to him and was going back and forth for couple of weeks, he finally decided to go hospice. On 6/19/24 at 9:05 AM Surveyor spoke with Social Service Director-C who reported she is most involved with R69. Social Service Director-C stated: We had plan of care meeting not to long ago and discussed hospice and I'm sure we talked about his weight loss. The only time I heard about him thinking about a G-tube was from his son, he was discussing with family (She was unable to recall when this was). Surveyor asked about RN-F's progress note on 5/17/24. Social Service Director-C reported she was not notified of R69's statement of wanting a G-tube or that he was depressed and in agreement to medications other than Remeron. I've been talking with his son off and on, he visits frequently. We did not talk about antidepressants, but he did tell me that the resident did not want the G-tube. Surveyor asked when this was, as there is no documentation. Social Service Director-C reported she could not remember, adding: There's been no more discussion about depression. We've been talking informally on and off and he was OK with where things were at. We talked about Hospice again last night, his son is going to come in an talk to him about it again. Surveyor asked Social Services Director-C, if she had been notified of R69's statements on 5/17/24, what would she have done. Social Services Director-C reported she would have talked talked to the resident and his family and would expect the nurses to notify the doctor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NP note dated 6/4/24 (more than 2 weeks later) documented: Weight loss/decreased oral intake: Taking Remeron p.o. (by mouth) q (every) h.s. (hour of sleep). Has elected to go hospice route verses feeding tube. Hospice consult to eval and treat has been ordered. Surveyor noted this was the first mention of weight loss or feeding tube by the NP or Physician. On 6/11/24 at 1:24 PM Facility progress notes document: IDT Weekly At Risk Meeting: Resident is triggering for a weight loss related to poor intake. The resident is not always compliant with dietary restrictions. Resident can be combative with staff and resistant to cares. The resident will refuse to reposition and when repositioned, the resident will put himself back onto his back. Resident is on wound rounds for pressure ulcers to the left heel and buttocks. Resident's intake varies day to day. Resident does take fortified milk at times. The resident has an air mattress in place. He is monitored by RD for intake and weights. Resident has had risk and benefits completed for his noncompliance with plan of care. The resident and family alternate between hospice and then they want him to discharge home. Staff will continue to encourage and re-educate the resident. On 6/12/24 R69's documented weight was 138.6 pounds indicating a total (severe) weight loss of 49.4 pounds and 26.28% since admission to the facility. On 6/18/24 at 11:24 AM Surveyor spoke with Dietician-D. Dietician-D reported he has worked for the facility through contracted heath care services since January 2022 or 2023 and has 3 buildings. Dietician-D reported he works 2 days a week (Tuesday and Friday) and is in the other buildings the other days. Dietician-D stated: I can be contacted via email or phone. When I'm in the facility I run the report on weight changes. We also have WAR (weekly at risk) meeting discussion. Surveyor asked how he is notified of weight loss. Dietician-D stated: For high risk patients they will call or email me to look at them the next time I'm in the building. Surveyor asked what is the facility policy regarding weights. Dietician-D stated: Weight daily x 3 days, I think, then monthly after that, unless they have physicians order for more often. Surveyor reviewed and discussed R69's weights with Dietician-D. Surveyor noted 3/18/24 severe weight loss of 24.5 pounds and 13.03% and asked if he was notified. Dietician-D stated: I don't see a note or anything, I can't remember that far back. When asked if he was notfied of the weight loss on 3/20/24, Dietician-D stated: Again, I can't remember that far back. Surveyor advised Dietician-D of the documented weight loss on 4/8/24 which indicated severe weight loss of 32 pounds and 17.02% since admission and asked if he was notified. Dietician-D stated: I'm sure I was probably aware, but I can't remember. Surveyor reviewed Dietician-D's documentation on 4/12/24 which included the statement that the weight loss occurred outside facility. Dietician-D reviewed the note for a long time before stating: I thought he discharged between January and March and that's why they missed his weights. Surveyor advised R69 did not discharge and remained in the facility. Surveyor verified, so you were not aware of the significant weight loss that occurred in March and April. Dietician-D stated: I was likely aware, but don't remember that far back. Surveyor clarified: You said you thought (R69) had discharged between January and March. Dietician-D stated: I did, that's why I don't think I was aware. I know he's been brought up quite a bit because he's a difficult resident. Surveyor asked Dietician-D if he communicates with the NP or Physician regarding weight loss. Dietician-D stated: No, the nurses usually update the doctor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor confirmed with Dietician-D R69 had severe weight loss documented on 3/18/24 of 24.5 pounds and 13.03% and additional weight loss documented on 4/8/24 totaling 32 pounds and 17.02% since admission and he was not notified. Surveyor reviewed interventions implemented on 4/13/24. R69's weight on 5/16/24 documented additional weight loss for a total of 45.7 pounds and 24.31% since admission with no assessment or new interventions implemented. Dietician-D stated: I just know he has been discussed in the WAR meeting. Surveyor asked Dietician-D if he was made aware of R69's request for tube feeding on 5/17/24. Dietician-D read the note and stated: I think I heard something about it, but I'm not sure. I vaguely remember discussing it with the social worker (cannot remember when). But I know he decided to go Hospice instead of doing tube feeding. Surveyor advised Dietician-D the resident is not currently enrolled on Hospice. R69 was not weighed as ordered by the physician. An admission weight was obtained on 1/26/24 and he was not weighed again until almost 2 months later, on 3/18/24, which documented severe weight loss. The Physician and Dietician were not notified and no new interventions were implemented. R69's weight on 4/8/24 documented additional weight loss with no Physician or Dietician notification and no new interventions implemented until 4/13/24. R69 continued to lose weight as evidence by documented weight on 5/16/24 of an additional loss of 14 pounds. No new interventions were implemented. R69 voiced to a nurse the request of G-tube. There is no evidence this was reported to the Dietician or Physician at that time. The Dietician notes were inaccurate indicating R69's severe weight loss occurred outside the facility, when in fact R69 resided in the facility since admission. On 6/19/24 during the daily exit meeting, the facility was notified of the above concern regarding R69's weight loss. No additional information was provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review, the facility did not ensure 1 (R27) of 3 residents was provided with pain management consistent with professional standards of practice. R27 reported being in constant pain. The facility did not identify R27 was assessed to have a significant worsening of pain effecting R27's quality of life while conducting R27's Minimum Data Set (MDS) Pain assessments on 5/13/24. R27 was hospitalized on [DATE] and was readmitted to the facility on [DATE]. R27 did not have an order for scheduled Tylenol order from 5/9/2024 through 6/3/2024 or Tramadol which was in place prior to R27's hospitalization . The facility did not address the potential for R27 to experience increased pain with the change in pain medication orders. R27's Physician Assistant's (PA) documentation indicated R27 was getting Physical therapy (PT) and Occupation therapy (OT) to help with pain management. R27 was not receiving PT or OT to help with pain management. Findings include: The facility policy, entitled Pain Management, documents, in part: .The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice . The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain. Recognition: To help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: . Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs . Assessment: . Impact of pain on quality of life (e.g., sleeping, functioning, appetite and mood). The resident's goals for pain management and his/her satisfaction with the current level of pain control . R27 was admitted to the facility on [DATE] and has diagnoses that include Chronic obstructive pulmonary disease, Osteoarthritis, Osteoporosis, Morbid obesity, and Type 2 diabetes. R27's Annual Minimum Data Set (MDS) assessment, dated 2/8/2024, documents, R27 has a moderate cognitive impairment. R27's pain assessment documents, R27's has a scheduled pain regimen. R27 is in pain frequently. R27's pain effects R27's sleep rarely or not at all. R27's pain interferes with day-to-day activities rarely or not at all. R27's Quarterly MDS assessment, dated 5/13/2024 documents, R27 has a scheduled and PRN (As needed) pain regimen. R27 is in pain almost constantly. R27's pain effects R27's sleep almost constantly. R27's pain interferes with day-to-day activities almost constantly. Surveyor noted the assessed significant increase in pain from the 2/8/24 to 5/13/24 MDS assessment. The pain increased enough to effect R27's sleep and activities of daily living on an almost constant basis. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/2024, at 12:45 PM, Surveyor interviewed R27 related to their pain. R27 reported being in constant pain. R27 stated she is only taking scheduled and as needed Tylenol and that it is not enough to help with the pain that she experiences. R27 stated R27 was taking Tramadol (a stronger pain medication) but after a hospital stay, the doctor told R27 that R27 could not take Tramadol anymore. R27 stated nothing was given in replace of the Tramadol. R27 stated again that R27 is always in pain. R27 was hospitalized from 5/4/2024 until 5/9/20224 for pneumonia. R27's MD (Medical Doctor) order, with a start date of 5/9/2024, Tylenol oral tablet 325 mg (milligrams). Give 2 tablets by mouth every 4 hours PRN (as needed) for fever. R27's MD orders, with a start date of 6/3/2024, documents: Acetaminophen (Tylenol) extra strength tablet 500 mg. Give 2 tablets by mouth two times a day for pain. Acetaminophen extra strength tablet 500 mg. Give 2 tablets by mouth every 12 hours as needed for pain. Max 4 (grams)/24 hours. Surveyor noted that prior to R27's hospitalization on [DATE], R27 was receiving scheduled and PRN Tylenol for pain. Surveyor noted, from readmission to the facility on [DATE] until 6/3/2024, R27 did not have scheduled Tylenol ordered to help with pain control. R27 had a PRN order for Tylenol but the indication was for fever, not for pain. Surveyor noted, after readmission to the facility, Tramadol was not ordered for R27. On 6/19/2024, at 4:01 PM, Surveyor asked Director of Nursing (DON)-B about R27's pain control. Surveyor asked if DON-B was aware of the assessed significant increase in R27's pain reported on the last 2 MDS assessments. DON-B stated DON-B was not aware of R27's pain assessment change on the MDS. DON-B stated DON-B was not aware Tramadol was removed after R27's hospitalization . DON-B stated she would get back to Surveyor. On 6/20/2024, at 9:40 AM, Surveyor returned to R27 to inquire about her pain. R27 stated R27 does use Bio Freeze (topical pain reliever) and it helps a little. R27 stated, nothing took the pain away after R27 stopped taking Tramadol. R27 stated R27 is only taking Tylenol and it does not help. On 6/20/2024, at 9:44 AM, Surveyor interviewed DON-B. Surveyor asked about R27's pain control. DON-B stated DON-B reviewed R27's pain assessments for the month of June. DON-B stated the highest R27 rated her pain was a 5 out of 10. Surveyor noted a rating of 5 was considered moderate pain. DON-B agreed. With a rating of 5 out of 10, DON-B indicated that they would expect nursing to follow up and to assess if Tylenol is working effectively. DON-B stated the facility should have caught it. Surveyor asked about the significant change in the MDS pain assessment. DON-B indicated the facility did not identify the change. Surveyor asked about R27's use of Tramadol. DON-B stated Tramadol was stopped because of a drug interaction and that is why it was not ordered on readmission. On 6/20/2024, at 10:57 AM, DON-B returned to Surveyor with a progress note written by R27's Physician Assistant. DON-B highlighted a section of the Progress note to indicate that the facility was addressing R27's pain control. Progress note dated 5/2/2024 documents: Chronic pain: Affecting extremities and back. Continue current pain regiment. Supportive cares. Encourage out of bed and exercise. PT/OT. R27's MD (Medical Doctor) orders, with a start date of 5/10/2024, documents: OT [evaluate] and treat as indicated. PT [evaluate] and treat as indicated. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's MD (Medical Doctor) order, with a start date of 5/15/2024, documents: OT to [evaluate and treat]. PT to [evaluate and treat]. On 6/20/2024, at 11:22 AM, Surveyor interviewed, Physical Therapist (PT)-H. PT-H stated R27 was discharged from PT on 3/1/2024 and was discharged from OT on 4/16/2024. Surveyor noted R27 had an order placed for PT and OT to help with pain control and the facility did not follow up on those orders. On 6/20/2024, at the facility exit meeting, these concerns were shared with Nursing Home Administrator (NHA)-A and DON-B. No further information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 21855 Based on record review and interview, the facility did not ensure Registered Pharmacist consult recommendations were acted upon promptly, and relayed to the required staff. This was observed with 2 (R58 and R3) of 5 resident medication reviews. * R58 and R3 had Registered Pharmacist (RPH) medication regimen review recommendations that were not relayed to the Physician, Medical Director and Director of Nurses, promptly. Findings include: The Facility policy titled Consultant Pharmacist Services Provider Requirements dated 01/23 documents (in part): Procedures 4 . c. Review and follow-up to previous month's pharmacy recommendations with the nursing care center staff d. Medication Regimen Reviews (MMR) for each Skilled Nursing (SNF) resident at least monthly, or more frequently under certain conditions, incorporating the federally mandated standards of care in addition to other applicable professional standards. e. Communicate to the responsible prescriber, the facility's medical director and the director of nursing potential or actual problems detected and other findings related to medication therapy orders at least monthly. Communicate recommendations for changes in medication therapy and the monitoring of medication therapy. 1.) R58 had a RPH medication review completed on 6/10/24, which indicated, there were recommendations made and staff should review the Clinical Pharmacy Report. R58's medical record did not contain evidence of a Clinical Pharmacy Report for this review. On 6/19/24, at 3:00 PM, at the daily exit meeting, Surveyor shared with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B, that R58 did not have a Clinical Pharmacy Report for 6/10/24. On 6/20/24, 8:39 AM, DON-B met with Surveyor. DON-B provided R58's Clinical Pharmacy Report, signed by the Physician on 6/19/24. The RPH Clinical Pharmacy Report indicates to discontinue Rivaroxaban 15 milligrams every day for A-fib (atrial fibrillation). This medication is to be avoided due to R58's medical condition and potential side effects. This is replaced with Apixaban 2.5 milligrams twice a day. DON-B indicated the RPH Clinical Pharmacy Reports goes to the facility and are printed off, they are separated out by physician and go in a binder on the unit. The physician will review them when they come into the facility. DON-B indicated they did not know the Medical Director and physician were required to receive these reports promptly. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49011 2) R3 had pharmacy medication regimen reviews competed on 2/6/2024 and 3/11/2024 with recommendations made. The Pharmacy Review form provided to this Surveyor by the Facility states to review Clinical Pharmacy Report. The Clinical Pharmacy Report was requested from the Facility for both review dates. On 06/18/24, at 02:11 PM, Surveyor spoke with Director of Nursing (DON)-B who stated they got a new pharmacist in February who did not get the recommendations to facility for review in February so the same were sent in March and the physician signed off on 3/14/2024. On 06/18/24, at 03:13 PM, Surveyor spoke with DON-B and asked since the medication regimen reviews including recommendations should be sent to the DON, medical director and physician so why was February missed. DON-B responded that per the pharmacist they didn't get MRR so resent them the next month. It was a time of transition; the new pharmacist wasn't used to the way of doing things so reissued the same recommendations the next month. Surveyor informed DON-B of the concern with R3's February medication regimen review recommendations were not being followed up on timely by the medical director and physician and the DON acknowledged this concern.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49011 Based on observation and interview the facility did not ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and including labeling drugs and biologicals with the expiration date when applicable. This was observed with 2 (R45 and R55) of 2 residents reviewed who receive insulin. R45 and R55 each had 2 open insulin pens in their respective medication cart that were not labeled with an open or use by date. Findings include: The Facility policy titled Medication Administration Subcutaneous Insulin dated 01/23 documents (in part): Procedures .Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 6. Date vial or device after first use . On 06/19/24, at 12:56 PM, Surveyor was completing a review of the medication cart located on the 100 hallway east. R55 had insulin pens of insulin glargine and latanoprost of which neither had an open date or use by date on documented on the pen. On 06/19/24, at 01:07 PM, Surveyor was completing a review of the medication cart located of the 100 hallway west. R45 had Novolin NPH and insulin lispro pens of which neither had an open date or use by date documented. On 06/19/24, at 03:09 PM, Surveyor informed the Facility at the end of day meeting that four insulin pens were discovered without documented open or use by dates.