STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525704	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehab Suites and Green House Homes	3151 Eden CT Oshkosh, WI 54904

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the right to make healthcare decisions was extended only to those delegated by the resident and in accordance with applicable law for 2 residents (R) (R3 and R28) of 16 sampled residents. R3 was declared incapacitated and had an activated Power of Attorney for Healthcare (POAHC). The facility did not ensure the individual making healthcare decisions on behalf of R3 was the representative delegated by R3. R28 was admitted to the facility on [DATE] and had an activated POAHC. The facility had R28 sign medical consents and did not ensure healthcare decisions were delegated to R28's representative as R28 was deemed incapacitated. Findings include: Wisconsin Stat. Chapter 155.01, defines Health Care Agent as an individual designated by the principal to make healthcare decisions on behalf of the principal or, if that individual is unable or unwilling to make those decisions, an alternate individual designated by the principle to do so .it also defines incapacity as the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her healthcare decisions. The facility's undated Residents' Rights Regarding Treatment and Advanced Directives Policy indicates it is the policy of the facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment .The policy defines advanced directive as a written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law, relating to the provision of healthcare when the individual is incapacitated .1) On admission, the facility will determine if the resident has executed an advanced directive .3) Should the resident have an advanced directive, copies will be made and placed in the chart as well as communicated to the staff. 4) The facility will periodically assess the resident for decision making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 5) The facility will identify .an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant healthcare decisions. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. From [DATE] to [DATE], Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including heart failure, type 2 diabetes, repeated falls, and moderate dementia with agitation. R3's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R3 had moderate cognitive impairment. Significant Other (SO)-E was R3's activated POAHC and was responsible for R3's healthcare decisions. A POAHC document, signed by R3 on [DATE], indicated if R3 was no longer able to make healthcare decisions due to incapacity, R3 designated SO-E to be R3's healthcare agent for purposes of making healthcare decisions. If SO-E was unable or unwilling to do so, R3 designated Alternate Agent (AA)-F to be the alternate healthcare agent. The document stated incapacity exists if two physicians or a physician and psychologist, who have personally examined R3, sign a statement indicating R3 is no longer able to make healthcare decisions. A provider visit note, dated [DATE], indicated R3 was hospitalized from [DATE] through [DATE] due to altered mental status and urinary tract infection. The note indicated R3 was deemed incapacitated on [DATE] and R3's POAHC was activated. SO-E was listed as R3's healthcare decision maker. R3's medical record included a handwritten note, dated [DATE] and signed by SO-E, that stated SO-E was resigning as R3's primary POAHC agent and would like Family Member (FM)-G to act as primary healthcare decision maker. FM-G was not listed on R3's POAHC document as a designated agent. R3's medical record contained documented healthcare decisions by FM-G, including: ~ A pneumococcal vaccine declination, signed and dated by FM-G on [DATE] ~ An informed consent for medication form for Xanax, signed and dated by FM-G on [DATE] ~ A progress note, dated [DATE] at 8:19 PM, indicated FM-G gave permission for nursing staff to administer morphine for signs of pain. ~ A progress note, dated [DATE] at 5:37 PM, stated FM-G gave verbal consent to begin Xanax as ordered and wanted all as needed (PRN) medications put on hold until the effectiveness of Xanax was known. ~ A progress note, dated [DATE], indicated FM-G was updated on R3's fall and behavior. On [DATE] at 11:54 AM, Surveyor interviewed Social Worker (SW)-H who confirmed SO-E was R3's primary POAHC agent but chose to resign and asked FM-G to take over. Surveyor and SW-H reviewed R3's POAHC document. SW-H did not know who AA-F was and indicated SW-H needed to follow-up with R3's family. SW-H was not aware that FM-G was not listed as a healthcare agent on R3's POAHC document. SW-H confirmed if FM-G was not listed on the document, FM-G should not be making healthcare decisions for R3. On [DATE] at 2:20 PM, Surveyor interviewed SW-H who stated SO-E would resume responsibility for R3's healthcare decisions. SW-H stated AA-F was not involved with the family any longer and was not involved in R3's healthcare. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From [DATE] to [DATE], Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE] and had diagnoses including dementia, cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. R28's MDS assessment, dated [DATE], had a BIMS score of 9 out of 15 which indicated R28 had moderate cognitive impairment. R28 had an activated POAHC who was responsible for R28's healthcare decisions. R28's medical record included a POAHC document, signed by R28 on [DATE], and two Statement of Incapacity documents, one activated on [DATE] and the other on [DATE], that indicated R28's primary POAHC agent (POAHC-I) was R28's healthcare decision maker when R28 admitted to the facility on [DATE]. R28's medical record included healthcare documents signed by R28 after R28 was deemed incapacitated. The documents included: ~ An informed consent for medication form for trazodone, dated [DATE] ~ An informed consent for medication form for Ativan, dated [DATE] ~ An informed consent for medication form for clomipramine, dated [DATE] ~ A cardiopulmonary resuscitation (CPR) directive form, dated [DATE] ~ A podiatry consent form, dated [DATE] ~ A COVID-19 vaccine consent form, dated [DATE] On [DATE] at 11:54 AM, Surveyor interviewed SW-H who confirmed R28 was deemed incapacitated and had an activated POAHC. SW-H confirmed R28 should not have signed healthcare documents and verified R28's POAHC should have signed medical consents.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure a call light was accessible for 1 resident (R) (R13) of 16 sampled residents. On 5/12/25, R13's call light was not within reach or accessible for R13 to use. Findings include: The facility's Call Lights: Accessibility and Timely Response policy, revised 5/25, indicates the call system must be accessible to the resident while in bed or other sleeping accommodations within the resident's room. From 5/12/25 to 5/14/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and a history of urinary tract infections. R13's Minimum Data Set (MDS) assessment, dated 2/14/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R13 had moderate cognitive impairment. The MDS assessment also indicated R13 required assistance with transfers, ambulation, and toileting. R13 used a wheelchair and a walker. R13 had an activated Power of Attorney for Healthcare (POAHC). On 5/12/25 at 9:17 AM, Surveyor observed R13 in bed. Surveyor interviewed R13 and observed R13's call light lying on the floor approximately 5 feet from the bed. On 5/12/25 at 9:52 AM, Surveyor observed R13's call light in the same position on the the floor approximately 5 feet from the bed. On 5/12/25 at 11:03 AM, Surveyor interviewed R13 who indicated R13 needed to use the bathroom and could not find the call light. Surveyor noted R13's call light was still on the floor approximately 5 feet from R13's bed. Surveyor informed R13 that Surveyor would ask staff to assist R13 to the bathroom. On 5/12/25 at 11:05 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-D who verified R13's call light was on the floor and R13 was unable to reach it. CNA-D placed the call light on R13's bed and assisted R13 to the bathroom. On 5/12/25 at 11:15 AM, Surveyor interviewed CNA-D who verified call lights should always be in reach for all residents. On 5/14/25 at 12:19 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R13's call light should always be in reach per the facility's call light policy and procedure.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure Pre-admission Screen and Resident Review (PASRR) requirements were met for 3 residents (R) (R3, R6 and R28) of 15 sampled residents. R3's medical record indicated R3 had a mental illness (MI) diagnosis and was prescribed psychotropic medication. The facility did not update R3's PASRR Level I Screen with medication changes and did not submit for a PASRR Level II Screen timely when R3 remained in the facility past 30-days. In addition, the facility did not obtain a county exemption (Department of Health Services (DHS) form F-20822) when R3 was admitted to the facility. R6's medical record indicated R6 had MI diagnoses and was prescribed psychotropic medication. The facility did not submit for a PASRR Level II Screen timely when R6 remained in the facility past 30-days. In addition, the facility did not obtain a county exemption (DHS form F-20822) when R6 was admitted from the hospital. R28's medical record indicated R28 had an MI diagnosis and was prescribed psychotropic medication. The facility did not update R28's PASRR Level I with medication changes and did not submit for a PASRR Level II Screen timely when R28 remained in the facility past 30-days. In addition, the facility did not obtain a county exemption (DHS form F-20822) when R28 was admitted from the hospital. Findings include: According to the State of Wisconsin Department of Health Services (DHS), PASRR is a federal requirement that all applicants to Medicaid-certified nursing facilities be assessed to determine whether they might have an intellectual disability (ID)/developmental disability (DD) and/or an MI. This is called a Level I Screen. The purpose of a Level I Screen is to identify individuals whose total needs require that they receive additional services for their ID/DD and/or MI. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an ID/DD and/or MI for PASRR purposes. This is a Level II Screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. Nursing facilities may seek county exemption (DHS form F-20822) for applicants with ID/DD and/or MI whose stay in the facility is expected to be recuperative care or short-term. 1. From 5/12/25 to 5/14/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and has diagnoses including major depressive disorder and moderate dementia with agitation. R3's Minimum Data Set (MDS) assessment, dated 3/20/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R3 had moderate cognitive impairment. R3's PASRR Level I Screen, with admission date 4/4/24, was marked Yes for MI and psychotropic medications and indicated R3 was prescribed Seroquel (an antipsychotic medication) and Ativan (an antianxiety medication). The Screen stated R3 was on medication for restlessness and agitation associated with end of life. R3's PASRR Level I Screen was marked No for county exemption. R3 had physician orders for risperidone (an antipsychotic medication) 1 milligram (mg) twice daily for agitation and Xanax (an antianxiety medication) 0.5 mg twice daily and as needed for agitation. R3's physician orders did not include Seroquel or Ativan. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 12:05 PM, Surveyor interviewed Social Worker (SW)-H who confirmed SW-H was responsible for completion of the PASRR process. SW-H confirmed R3's Level I Screen should have been updated with the medication changes. SW-H stated SW-H completed an audit of all PASRRs within the last couple of months and did submit for a PASRR Level II Screen which SW-H would provide. SW-H indicated SW-H submits for county exemption from the county where the resident lives. SW-H was unable to confirm if a county exemption was requested for R3 but stated SW-H would get back to Surveyor. On 5/14/25 at 1:00 PM, Surveyor reviewed R3's PASRR Level II Screen with a referral date of 3/31/25 and determination date of 4/1/25. The PASRR Level II Screen did not include R3's medication changes. R3's PASRR Level II Screen was not submitted timely when R3 remained in the facility. 2. From 5/12/25 to 5/14/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had a diagnosis of acute respiratory failure. R6's diagnoses list does not indicate R6 had diagnoses of depression and anxiety, however, R6 was prescribed psychotropic medication for depression and anxiety. R6's MDS assessment, dated 3/4/25, had a BIMS score of 13 out of 15 which indicated R6 had intact cognition. R6's undated PASRR Level I Screen was marked Yes for MI, psychotropic medications (Ativan), and 30-day hospital exemption. R6 had physician orders for Lexapro (an antidepressant medication) 10 mg daily for depression (dated 2/26/25) and Ativan 0.5 mg every 8 hours as needed for anxiety (dated 2/26/25). On 5/12/25 at 2:45 PM, Surveyor requested R6's PASRR Level II Screen and county exemption F-20822 form. On 5/14/25 at 10:30 AM, Surveyor reviewed R6's medical record and noted a PASRR Level II Screen was uploaded to R6's medical record on 5/14/25. The PASRR Level II Screen had a submit date of 5/12/25 and a determination date of 5/13/25. Surveyor also noted an updated PASRR Level I Screen that included Lexapro and Ativan and was marked No for MI and 30-day exemption and Yes for medications. R6's PASRR Level II Screen was not submitted timely after R6 remained in the facility past 30-days. On 5/14/25 at 12:05 PM, Surveyor interviewed SW-H who stated R6's PASRR Level II Screen was submitted because R6 continued to stay at the facility for long term care. SW-H stated SW-H did not know when the PASRR Level II Screen was submitted or when the determination was received. SW-H denied submitting for R6's PASRR Level II Screen after Surveyor requested the documents. SW-H stated SW-H submitted to the county for a 30-day exemption for R6 and SW-H would provide a copy of the exemption form. 3. From 5/12/25 to 5/14/25, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE] and had diagnoses including non-ST-elevation myocardial infarction (NSTEMI) and dementia. R28's diagnoses list did not include diagnoses of anxiety or obsessive-compulsive disorder (OCD) with skin picking, however, R28 was prescribed medication for anxiety and OCD skin picking. R28's diagnosis list also did not include a diagnosis of depression, however, physician visit notes listed a history of depression as an active diagnosis. R28's MDS assessment, dated 2/18/25, had a BIMS score of 9 out of 15 which indicated R28 had moderate cognitive impairment. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28 had physician orders for clomipramine (an antidepressant medication) 50 mg once daily for OCD skin picking (dated 10/24/24), sertraline 50 mg once daily for anxiety, and trazodone 150 mg once daily for sleep. On 5/12/25 at 2:45 PM, Surveyor requested R28's PASRR Level I Screen, PASRR Level II Screen, and county exemption form F-20822. On 5/13/25, Surveyor reviewed R28's PASRR Level I Screen, admission date 5/22/24, which was marked No for MI and psychotropic medications but listed trazadone and lorazepam as medications taken for non-MI related diagnoses. R28's Level I Screen did not include sertraline or clomipramine A provider visit note, dated 10/24/24 and completed by R28's Nurse Practitioner, indicated under active diagnoses that R28 had a history of depression. The note also listed OCD with picking of the skin. On 5/14/25 at 12:05 PM, Surveyor interviewed SW-H who was not aware of R28's history of depression and did not know if OCD was a symptom of a medical condition or MI. SW-H confirmed R28's Level I Screen should have been updated with the changes in medication but could not confirm if a PASRR Level II Screen was submitted. SW-H indicated SW-H would have submitted to the county for a 30-day exemption. Surveyor requested R28's county exemption form F-20288 and PASRR Level II Screen. From 5/12/25 to 5/14/25, Surveyor made several requests for PASRR paperwork from the facility. The facility did not provide R28's PASRR Level II Screen or county exemption forms for R3, R6, or R28.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure 2 residents (R) (R31 and R10) of 2 sampled residents received assistance with activities of daily living (ADLs) in order to maintain their highest practicable physical well being. R31 had a perirectal abscess that extended to the left gluteal region following surgery. Staff did not provide timely care which caused R31 to be incontinent and posed a risk for wound infection. R10's Physical Therapy Discharge Summary contained an ambulation program that indicated to ambulate R10 in the hallway once per shift with caregiver stand-by assist (SBA)/contact guard assist (CGA) and wheelchair follow for 30-35 foot intervals. The ambulation program was not consistently implemented. In addition, R10's care plan did not include ambulation or a restorative program. Findings include: The facility's Dignity Policy for All Staff Category: Resident Rights, dated May 2025, indicates: Staff are employees in the resident's home. Residents have the right to be treated with respect and dignity in their home. It is the responsibility of the staff to protect residents' rights. Violations of residents' rights can be subtle and elusive. Staff members will be held accountable for the effects of careless, thoughtless, tactless, or insensitive actions because these undermine self-esteem, dignity and the respect the resident deserves. The facility's Call Lights: Accessibility and Timely Response Policy, revised May 2025, indicates: .10. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. The facility's Activities of Daily Living (ADLs) policy, dated January 2025, indicates: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: .2. Transfer and ambulation .2. The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment .5. The facility will maintain individual objectives of the care plan and periodic review and evaluation. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Restorative Nursing Program, with a copyright date of 2024, indicates: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living independently and as safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning .7. Residents may receive restorative nursing services .upon discharge from therapy .10. A resident's restorative nursing plan will include: a. The problem, need, or strength the restorative tasks are to address; b. The type of activities performed; c. Frequency of activities; d. Duration of activities; e. Measurable goal and target time . 12. Restorative aides will implement the plan for a designated length of time, performing the activities and documenting on the Restorative Aide Documentation Form or other facility designated form. 1. From 5/12/25 to 5/14/25, Surveyor reviewed R31's medical record. R31 was admitted to the facility on [DATE] and had diagnoses including diabetes, perirectal abscess status post incision and drainage on 9/24 with a large residual wound that extended onto the left gluteal region, obesity, anxiety, and urinary incontinence. R31's Minimum Data Set (MDS) assessment, dated 2/19/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R31 had intact cognition. R31 made R31's own healthcare decisions. R31's medical record indicated R31 received daily (and as needed after incontinence) wound care. R31 had an order to clean the wound, apply collagen directly to the wound, and apply an ABD dressing. Wound care nurses at the facility saw R31 during weekly wound rounds. The wound clinic saw R31 approximately every three weeks. R31 had an indwelling Foley catheter to enhance wound healing. A provider note, dated 11/14/24, indicated R31 had a rectal abscess that measured 18.5 centimeters (cm) x 7 cm x 9.5 cm. A skin note, dated 12/12/24, indicated R31 had an open perirectal lesion that measured 19 cm x 4.5 cm x 4.5 cm and was in direct line with the anus. The note indicated R31 was incontinent of bowel during the assessment which presented an infection risk and hindered successful wound vac placement. R31 was referred to the wound clinic. A wound clinic note, dated 12/18/24, indicated R31 was seen for the first time. A colostomy was discussed given the proximity of the wound to the rectum. There was a concern regarding the potential ramifications of fecal soiling. A wound clinic note, dated 4/9/25, indicated R31 was upset because R31 asked staff to toilet R31 prior to the appointment. Staff did not toilet R31 who had been sitting in stool. R31 was fearful it would affect wound healing. R31's wound measured 14.4 cm x 4.7 cm x 0.2 cm and was improving. R31 was reminded to be diligent about asking staff to provide assistance when needed. A wound clinic note, dated 4/30/25, indicated R31 presented with stool impacted in the wound. It appeared as though dressings and stool were becoming balled up and stuck in the gluteal cleft which created increased pressure and delays in wound healing. A wound clinic note, dated 5/5/25, indicated R31 complained of incontinence since R31's Foley catheter was removed and stated R31 had to sit in urine/stool for hours at times. The wound was smaller and measured 13.0 cm x 4.0 cm x 1.0 cm. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note, dated 5/9/25 at 11:08 AM, indicated R31 was functionally incontinent of bowel and bladder and had a bedside commode. R31 complained of general discomfort related to the left buttock wound and stated, I want the Foley back in. This just isn't working. I've been sitting here wet for an hour and now it's burning. R31 stated, I'm just having too many accidents. By the time I turn on my call light I've already went. On 5/12/25 at 9:23 AM, Surveyor interviewed R31 who indicated call light response time was approximately two hours. On 5/13/25 at 12:44 PM, Surveyor interviewed R31 in the presence of R31's sisters. R31 indicated R31 had a wound clinic appointment on 4/30/25 and told Certified Nursing assistant (CNA)-J that R31 had a bowel movement. CNA-J stood at the edge of the bed, spread R31's legs, and twice stated there was no stool. R31 stated CNA-J did not turn R31 to look. After getting in the wheelchair, R31 noticed stool on R31's Chux pad and sheet. CNA-J told R31 that CNA-J did not have time to clean R31 and stated staff at the wound clinic could do it. R31 stated R31 was embarrassed to ask wound clinic staff to clean R31. R31 noted two other instances when the call light response time was approximately two hours. R31 stated on the 5/6/25 AM shift at approximately 1:00 PM, R31 was incontinent of urine and stool. On the 5/6/25 PM shift at approximately 7:00 or 8:00 PM, R31 was incontinent of urine. R31 had a voiding trial on 5/5/25 and indicated staff could not get R31 to the commode in time. R31 eventually requested a Foley catheter. R31 indicated R31 activated the call light on the morning of 5/8/25. CNA-J turned off the call light from the nurses' station and said CNA-J would be right there. R31 indicated CNA-J left R31 sitting in stool and R31 was told by a nurse that CNA-J left the facility to go to CNA-J's pharmacy. R31 was upset and called R31's insurance company to check on home care so R31 could leave the facility. On 5/13/25 at 2:30 PM, Surveyor observed Licensed Practical Nurse (LPN)-S complete wound care for R31. LPN-S changed R31's dressing and indicated R31's left buttock was healing. On 5/13/25 at 3:40 PM, Surveyor interviewed Director of Nursing (DON)-B who was not aware of the 4/30/25 wound clinic note and indicated the nurses had not relayed concerns. On 5/13/25 at 4:00 PM, Surveyor interviewed Social Worker (SW)-H and NHA-A who met with R31 to follow-up on the concerns. SW-H indicated R31 liked CNA-J as a person but did not feel R31 was being washed up appropriately. R31 asked if the facility could retrain CNA-J. SW-H planned to talk to CNA-J prior to CNA-J's next shift. R31 wanted CNA-J to continue to care for R31 and wanted to reestablish a good relationship. SW-H planned to follow-up with R31 regarding cares. SW-H also planned to interview other residents. On 5/14/25 at 1:24 PM and 1:37 PM, Surveyor interviewed RN-P who indicated the facility had wound care meetings on Fridays during which RN-P compared wound measurements from week to week. RN-P indicated nurses review wound care notes when a resident returns from the wound clinic. RN-P was not aware if R31 was properly cleaned after incontinence episodes. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehab Suites and Green House Homes	3151 Eden CT Oshkosh, WI 54904

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 5/12/25 to 5/14/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including diabetes type 2 with polyneuropathy (a condition that affects the nerves of the hands and feet), infection and inflammatory reaction due to internal right hip prostheses, and repeated falls. R10's MDS assessment, dated 2/26/25, had a BIMS score of 8 out of 15 which indicated R10 had moderate cognitive impairment. The MDS assessment also indicated R10 could walk 50 feet and make 2 turns with partial/moderate assistance. R10 had an activated Power of Attorney for Healthcare (POAHC). On 5/12/25 at 10:09 AM, Surveyor interviewed R10 who stated R10 had a couple spots of irritation on R10's buttocks and was not walking much. R10 stated R10 would walk to the bathroom independently with a 2-wheeled walker, however, R10 no longer had PT and the CNAs did not walk R10 in the hallway. R10 was unsure if R10 had a restorative program and expressed a desire to walk in the hallway with staff. R10's medical record indicated R10 participated in physical therapy from 3/5/25 to 4/2/25. R10's PT Discharge Summary indicated R10 met the maximum benefit from skilled PT interventions with R10 staying long term in the facility. The note indicated R10 had a restorative ambulation program that included ambulating in the hallway once per shift with caregiver SBA/CGA and wheelchair to follow for 30-50-foot intervals. Surveyor noted R10's care plan did not include ambulation or a restorative program. On 5/12/25 at 10:19 AM, Surveyor interviewed CNA-J who indicated R10 did not have a restorative program and staff did not walk R10 in the hallway. CNA-J stated R10 needed assistance with pericare at times and completed R10's own exercises. On 5/14/25 at 3:45 PM, Surveyor interviewed CNA-J and Registered Nurse (RN)-K. CNA-J was not aware R10 had a walking schedule for restorative care until CNA-J was shown a CNA sheet by RN-K. On 5/14/25, Surveyor reviewed a follow-up question report for ADL-Walk in corridor in R10's medical record. Surveyor noted between 4/2/25 and 5/14/25, R10 had approximately 84 opportunities to ambulate on the AM and PM shift. Surveyor noted R10 ambulated once per day on 4/2/25, 4/4/25, 4/13/25, 4/14/25, 4/18/25, 4/26/25, 4/27/25, 5/2/25, 5/8/25, and 5/12/25. The documentation did not indicate R10 was walked twice on any day. The documentation also indicated R10 had 2 refusals, 2 not availables, and 55 not applicables. On 5/14/25 at 4:59 and 5:21 PM, Surveyor interviewed DON-B who reviewed R10's follow-up question report for ADL-Walk in Corridor for 4/2/25 to 5/14/25 and agreed with Surveyor's findings. DON-B indicated not applicable meant the task did not occur. DON-B stated restorative program notes are hung in resident rooms, including the resident's transfer status and ADLs. DON-B also verified R10 did not have a care plan that included ambulation or a restorative program.

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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** 3. From 5/12/25 to 5/14/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including dementia, encephalopathy, osteoarthritis, and weakness. R7's MDS assessment, dated 3/20/25, had a BIMS score of 9 out of 15 which indicated R7 was moderately cognitively impaired. The MDS assessment also indicated R7 required substantial/maximal assistance for transfers. R7's medical record indicated R7 had unwitnessed falls on 2/1/25 and 3/24/25. R7 was found on the floor following both falls. Surveyor reviewed the investigations for both falls and noted the facility did not identify a root cause for the falls or update R7's care plan with new interventions. R7's falls care plan (revised 3/11/25) did not contain any new interventions following the falls on 2/1/25 and 3/24/25. Surveyor reviewed R7's neuro checks for the unwitnessed falls. Several neuro checks were missing following the fall on 2/1/25, including the second, third, and fourth fifteen minute check, the first and third hourly check, and all three shift checks. R7's fall on 3/24/25 had missing neurochecks for every shift x 3 shifts. In addition, staff did 30 minute neuro checks four times versus hourly 4 times. On 5/14/25 at 3:21 PM, Surveyor interviewed DON-B who verified the fall investigations did not identify a root cause for R7's falls and R7's care plan was not updated with any new interventions. DON-B also verified there were missing neuro checks for R7's falls on 2/1/25 and 3/24/25. Based on staff interview and record review, the facility did not ensure fall procedures were followed and preventative measures were implemented to ensure safety for 3 residents (R) (R3, R28, and R7) of 6 sampled residents. R3 had five falls from 3/31/25 to 4/13/25. The facility did not identify a root cause for the falls or update R3's care plan with new fall interventions. In addition, R3's neurological checks were incomplete. R28 had six falls from 5/23/24 to 2/8/25. The facility did not identify a root cause for the falls or update R28's care plan with new fall interventions. R28's neurological checks were also incomplete. In addition, the facility did not complete a fall investigation for R28's fall on 6/4/24. R7 had unwitnessed falls on 2/1/25 and 3/24/25. The facility did not identify a root cause for the falls or update R7's care plan with new fall interventions. In addition, R7's neurological checks were incomplete. Findings include: On 5/14/25 at 2:04 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the facility did not have a falls policy. DON-B indicated staff are expected to follow the facility's Fall Checklist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Fall Checklist indicates there is no need to do neurochecks for a witnessed fall unless the resident hit their head. Ask resident if they recall hitting their head. If the fall is unwitnessed, neuro checks should be completed no matter what. Initiate Neuro Check Forms .neuro checks every 15 minutes times 4, then every hour times 4, and then every shift times 3 .Complete Fall Incident Report in electronic medical record. 1. From 5/12/25 to 5/14/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes, major depressive disorder, repeated falls, and moderate dementia with agitation. R3's Minimum Data Set (MDS) assessment, dated 3/20/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R3 had moderate cognitive impairment. Significant Other (SO)-E was R3's activated Power of Attorney for Healthcare (POAHC) and was responsible for R3's healthcare decisions. R3's fall care plan (initiated 10/9/24) stated R3 was at high risk for falls related to deconditioning, frequent falls, and confusion. R3's care plan contained the following interventions (dated 10/9/24): ~ Anticipate and meet R3's needs ~ Be sure R3's call light is within reach and encourage R3 to use it for assistance as needed. R3 needs prompt response to all requests for assistance. ~ Educate R3/family/caregivers about safety reminders and what to do if a fall occurs. ~ Follow fall protocol. (revised on 12/9/24 to include Call Don't Fall poster.) ~ Physical therapy evaluation and treat as ordered or as needed. ~ Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate R3/family/caregivers/interdisciplinary team as to the cause. R3's medical record indicated R3 had unwitnessed falls in R3's room on 3/31/25, 4/3/25, 4/9/25, 4/11/25, and 4/13/25. Surveyor reviewed fall investigations for R3's falls. The fall investigations did not indicate the root cause of the falls. For 4 of the 5 falls (3/31/25, 4/3/25, 4/9/25, and 4/11/25), neither the fall investigation or R3's care plan were updated with new interventions to prevent additional falls. (Between 12/9/24 and 4/13/25, no additional safety measures were added to R3's care plan.) In addition, R3's post-fall neuro checks were inconsistently filled out or incomplete for all of R3's unwitnessed falls. On 5/14/25 at 2:04 PM, Surveyor interviewed DON-B who confirmed the fall investigations did not identify a root cause for R3's falls. DON-B confirmed safety measures/interventions were not implemented and R3's care plan was not updated following the unwitnessed falls. DON-B also verified neuro checks were not thoroughly completed following R3's unwitnessed falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 5/12/25 to 5/14/25, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE] and had diagnoses including dementia, cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. R28's MDS assessment, dated 2/18/25, had a BIMS score of 9 out of 15 which indicated R28 had moderate cognitive impairment. R28 had an activated POAHC for healthcare decisions. R28's falls care plan (initiated 11/26/24) stated R28 was at high risk for falls related to deconditioning. R28's care plan contained the following interventions (dated 11/26/24): ~ Anticipate and meet R28's needs. ~ Be sure R28's call light is within reach and encourage R28 to use it for assistance as needed. R28 needs prompt response to all requests for assistance. ~ Educate R28/family/caregivers about safety reminders and what to do if a fall occurs. ~ Follow fall protocol. ~ Physical Therapy eval and treat as ordered or as needed. ~ Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate R28/family/caregivers/interdisciplinary team as to the cause. R28's medical record indicated R28 had unwitnessed falls on 5/23/24, 5/24/24, 6/2/24, 6/4/24, 1/23/25, and 2/8/25. A fall investigation, dated 5/23/24, indicated R28 had an unwitnessed fall in R28's room. The investigation did not specify the root cause of the fall and did not indicate if safety interventions were implemented. In addition, R28's care plan was not updated following the fall. The fall investigation and R28's medical record did not include post-fall neuro checks following the initial assessment. A fall investigation, dated 5/24/24, indicated R28 had an unwitnessed fall in the bathroom. R28 complained of hip pain and was sent to the emergency room (ER) A progress note, dated 5/24/24 at 1:22 PM, indicated R28 returned to facility after a computed tomography (CT) scan with X-ray revealed no fracture. R28 was placed on 1:1 supervision. R28's care plan was not updated. The fall investigation and R28's medical record did not include post-fall neuro checks following the initial assessment. A fall investigation, dated 6/2/24, indicated R28 had an unwitnessed fall in R28's room. The investigation did not specify a root cause. The fall investigation and R28's medical record did not include post-fall neuro checks following the initial assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 6/4/24 at 11:29 AM, indicated R28 had an unwitnessed fall in the bathroom while attempting to self-transfer. Staff noted bruising and a bulging mass on R28's right hip and a bruise behind R28's right ear. R28's provider was updated and ordered an X-ray that indicated R28 had a contusion on the right hip. A fall investigation, dated 1/23/25, indicated R28 had an unwitnessed fall in the bathroom that resulted in a laceration on the right side of head. R28 was transferred to the hospital. A CT scan and X-ray revealed no acute findings. R28 received 3 staples to the right occipital scalp and returned to the facility. Neither the investigation or R28's care plan indicated new safety interventions were implemented. Neuro checks were incomplete following the fall. A fall investigation, dated 2/8/25, indicated R28 had an unwitnessed fall. The investigation did not specify the root cause of the fall and did not indicate safety interventions were implemented. R28's care plan was not updated. Neuro checks were incomplete following the fall. No additional interventions were added to R28's care plan after 11/26/24. (R28 had a previous care plan (dated 9/2/24), however, the interventions were not transitioned to R28's current care plan.) On 5/14/25 at 2:04 PM, Surveyor interviewed DON-B who confirmed the fall investigations did not identify a root cause and safety measures were not implemented. DON-B confirmed R28's care plan was not updated following the unwitnessed falls. DON-B also verified neuro checks were not thoroughly completed following the unwitnessed falls. In addition, DON-B verified the facility did not complete an investigation following R28's fall on 6/4/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 35 residents residing in the facility. The kitchen microwave was not kept in a clean and sanitary condition to prevent cross-contamination. The refrigerator in the main kitchen contained food that was past the discard date and/or open to air. The facility's dishwasher did not reach minimum temperature requirements to prevent the spread of foodborne illness. Findings include: On 5/12/25 at 9:25 AM, Surveyor began an initial tour of the kitchen with Dietary Manager (DM)-N who stated the facility followed the State Food Code. Microwave Cleanliness: The Wisconsin Food Code documents at section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The Wisconsin Food Code documents at section 4-602.12 Cooking and Baking Equipment: (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. The facility's Cleaning and Sanitizing Surfaces policy, dated March 2025, indicates: .A. Clean and sanitize to remove food and debris using hot soapy water, and sanitize using a food-safe sanitizer on all food contact surfaces .Frequency: Before and after food prep .After spills or contamination. During the initial tour of the kitchen with DM-N on 5/12/25 at 9:25 AM, Surveyor and DM-N observed the microwave in the main kitchen and noted the interior had dried food debris on the top and sides. DM-N stated the microwave should be cleaned after each use. On 5/14/25 at 7:51 AM, Surveyor interviewed DM-N who stated DM-N cleaned the microwave right after Surveyor completed the kitchen tour. Food Storage: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Wisconsin Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food:(A) .Refrigerated, ready to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees Celsius (C) (41 degrees Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. The Wisconsin Food Code documents at 3-202.15 Package Integrity: Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. The Wisconsin Food Code documents at 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation: (A) Food shall be protected from cross-contamination by .(4) except as specified in subparagraph 3-501.15 (b)(2) and in (b) of this section, storing the food in packages, covered containers, or wrappings. Food Safety.gov indicates celery if kept refrigerated should be consumed within 1-2 weeks. During the initial tour of the kitchen with DM-N on 5/12/25 at 9:25 AM, Surveyor and DM-O observed a partially open container of marinara sauce in the cooler with a prepared date of 5/6/25 and a use-by date of 5/9/25. DM-N confirmed the marinara sauce should have been discarded. Surveyor and DM-N also observed a package of celery in the original bag and open to air with an open date of 4/25/25 and no use-by date. Dishwasher: The Wisconsin Food Code documents at 4-204.113 Warewashing Machine, Data Plate Operating Specifications: A warewashing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operating specifications including the: (A) Temperatures required for washing, rinsing, and sanitizing; (B) Pressure required for the fresh water sanitizing rinse unless the machine is designed to use only a pumped sanitizing rinse; and (C) Conveyor speed for conveyor machines or cycle time for stationary rack machines. The Wisconsin Food Code documents at 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature: (A) The temperature of the wash solution in spray type warewashers that use hot water to sanitize may not be less than: (1) For a stationary rack single temperature machine, 74 degrees C (165 degrees F); (2) For a stationary rack dual temperature machine, 66 degrees C (150 degrees F); (3) For a single tank, conveyor, dual temperature machine, 71 degrees C (160 degrees F); or (4) For a multi-tank, conveyor multi-temperature machine, 66 degrees C (150 degrees F). (B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 49 degrees C (120 degrees F). The Wisconsin Food Code documents at 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures: (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90 degrees C (194 degrees F), or less than: (1) For a stationary rack single temperature machine, 74 degrees C (165 degrees F); or (2) For all other machines, 82 degrees C (180 degrees F). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/13/25 at 1:02 PM, Surveyor observed DM-N wash dishes. Surveyor noted the facility had a [NAME] AM15 dish machine. A data plate on the front of the machine indicated a minimum wash temperature of 150 degrees F and a minimum rinse temperature of 180 degrees F. Surveyor observed DM-N run the machine and noted the machine reached a wash temperature of 148 degrees F and a rinse temperature of 178 degrees F. DM-N ran the machine again which resulted in a wash temperature of 151 degrees F and a rinse temperature of 175 degrees F. DM-N indicated at times the machine needs to be run a few times to reach the appropriate temperatures. DM-N ran the machine again with a wash temperature of 154 degrees F and a rinse temperature of 168 degrees F. DM-N stated because the machine was run 3 times and still did not reach the appropriate rinse temperature, DM-N would have maintenance staff check the machine. Maintenance Director (MD)-O drained and refilled the dish machine and ran the machine an additional 7 times. The rinse temperature remained below the 180 degrees F minimum temperature. DM-N confirmed the machine did not reach the minimum rinse temperature.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. From 5/12/25 to 5/14/25, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, mononeuropathy of bilateral lower limbs, adult failure to thrive, and urinary retention due to neurologic bladder. R27's MDS assessment, dated 4/7/25, had a BIMS score of 13 out of 15 which indicated R27 had intact cognition. R27 had a Foley catheter and was on EBP. On 5/13/25 at 1:27 PM, Surveyor observed CNA-J and CNA-M complete pericare for R27 and transfer R27 to a recliner via Hoyer lift. CNA-J and CNA-M completed hand hygiene and donned gloves and a gown prior to care. CNA-M provided peri-rectal care after R27 was incontinent of a large amount of stool. Without completing hand hygiene, CNA-M changed gloves and assisted R27 onto the left side. CNA-J then washed R27's rectal area, removed soiled gloves, and donned clean gloves without completing hand hygiene. CNA-J applied cream to R27's rectal area and again changed gloves without completing hand hygiene. Surveyor noted CNA-J and CNA-M changed gloves numerous times during the observation without completing hand hygiene between glove changes. CNA-J and CNA-M touched R27's clean incontinence brief, clothing, bedding, trash bin, Foley bag and tubing, recliner, and the Hoyer lift without changing gloves or without completing hand hygiene between glove changes. CNA-J removed CNA-J's gown and gloves after care and left R27's room to cleanse hands with an ABHR. CNA-M removed CNA-M's gown and gloves and washed hands before leaving R27's room. On 5/13/25 at 2:08 PM, Surveyor interviewed CNA-J and CNA-M who verified hand hygiene should have been completed between glove changes. On 5/13/25 at 2:47 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed hand hygiene should have been completed between glove changes. Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 2 residents (R) (R23 and R27) of 3 sampled residents. R23 had a percutaneous endoscopic gastrostomy (PEG) tube. There was not an enhanced barrier precautions (EBP) sign on or near the entrance to R23's room or a personal protective equipment (PPE) cart outside R23's room. During an observation of pericare for R23, Licensed Practical Nurse (LPN)-C did not wash hands prior to applying gloves and did not wear a gown. During an observation of perineal care for R27, Certified Nursing Assistant (CNA)-J and CNA-M removed soiled gloves and did not wash or sanitize hands before donning clean gloves. Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525704	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehab Suites and Green House Homes	3151 Eden CT Oshkosh, WI 54904

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Enhanced Barrier Precautions (EBP) Policy (last updated January 2025) indicates: Enhanced Barrier Precautions are infection control interventions designed to reduce the transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) . Examples of high-contact resident care activities requiring a gown and gloves for EBP include: transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care or use: . urinary catheter. The facility's Infection Control-Hand Hygiene Policy, dated 1/2025, indicates: .1. Indications for hand washing and hand antisepsis .staff is to understand that glove use does not replace the need for hand hygiene. A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. B If hands are not visibly soiled, use an alcohol-based hand rub (ABHR) for routinely decontaminating hands .C. Decontaminate hands before having direct contact with patients . F. Decontaminate hands after contact with patient's intact skin. G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. H. Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. J. Decontaminate hands after removing gloves. The facility's Transmission-Based Precautions policy, dated 4/2055, indicates: EBP expands the use of personal protective equipment (PPE) beyond situations in which exposure to blood and bodily fluids is anticipated .refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDRO) to staffs' hands and clothing. EPB is recommended for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition .Examples of high-contact resident care activities requiring gown and glove use . Device care or use: central line care, urinary catheter, feeding tube, tracheostomy/ventilator .When implementing contact precautions or EBP, it is critical to ensure staff have an awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside the resident's room indicating the type of precautions and required PPE. For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Make PPE including gloves and gowns available immediately outside the resident's room. 1. From 5/12/25 to 5/14/25, Surveyor reviewed R23's medical record. R23 was admitted to the facility on [DATE] and had a diagnosis of Parkinson's disease and a PEG tube. R23's Minimum Data Set (MDS) assessment, dated 5/17/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R23 had intact cognition. On 5/15/25 at 11:06 AM, Surveyor observed LPN-C complete pericare for R23. LPN-C did not wash hands prior to applying gloves and did not wear a gown. Surveyor interviewed LPN-C who indicated LPN-C did not think LPN-C needed to wear a gown during pericare for a resident with a PEG tube. LPN-C indicated a gown was only needed if a resident was sick. LPN-C verified there was not an EBP sign or PPE cart outside R23's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525704	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 11:18 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated there should be an EBP sign outside R23's room. DON-B indicated LPN-C should have washed hands before donning gloves for cares and should have worn a gown per the facility's EBP policy and procedure.