STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay at Belmont Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 21 residents (R367) and 1 supplement resident (R366) observed during medication pass. R367 was observed to have a clear medication cup with 4 tablets of [MEDICATION(S)] in her room on her bedside table. R366 was observed to have a clear medication cup with morning medication in her room on her bedside table. This is evidenced by: The facility's policy Self-Administration of Medications, revised April 2022, documents, in part: . Policy Interpretation and Implementation 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medications; and d. Ability to recognize risks and major adverse consequences of his or her medications . 5. The practitioner will document their findings and the choices of residents who are able to self-administer medication whether they wish to do so . 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them . 12. Nursing staff will review the self-administered medication record on each nursing shift, and they will transfer pertinent information to the medication administration (MAR) kept at the nursing station, appropriately noting that the doses were self-administered. Example 1 (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R367 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 7/14/22 indicates R367's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 14 out of 15. R367's has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R367's current Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . R367's medical record does not contain a self-administration assessment. R367's current plan of care does not indicate that R367 is to self-administer any medications. On 7/26/22 at 9:03 AM, Surveyor observed [MEDICATION(S)], 4 tablets in a medication cup on R367's bed side table. R367 was not in her room. On 7/26/22 at 9:35AM, Surveyor observed [MEDICATION(S)], 4 tablets in a medication cup on R367's bed side table. Surveyor asked R367 what was in the medication cup, she replied, Those are my TUMS, the girls set them there so I can take it when I get my breakfast. Surveyor asked R367 do the nurses normally leave the TUMS at your bedside, R367 stated yes, all the time. Example 2 R366 was admitted to the facility on [DATE]. R366's most recent MDS dated [DATE], documents a score of 15 out of 15 on her BIMS which indicates that she is cognitively intact. R366 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R366's current Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . R366's medical record does not contain a self-administration assessment. R366's current plan of care does not indicate R366 is to self-administer any medications. On 7/26/22 at 9:05 AM, Surveyor observed a medication cup with several medications inside the cup in R366's room on her breakfast tray. Surveyor asked R366 what was in the medication cup, she replied, that is my morning medicine. Surveyor asked R366 if the nurses normally leave them in her room, R366 stated Yes, because I need to take them with breakfast and I never know when breakfast is coming. On 7/27/22 at 8:05 PM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F if R366 can self-administer her medication. LPN F replied that she did not know if R366 has gone through the process and will check. Surveyor observed LPN F check into the computer. LPN F reports that she does not see if R366 can self -administer her medication, there is not an order to self-administer. Surveyor asked LPN F if there is any information in the care plan, after verifying in the computer she replied, no. Surveyor asked LPN F if R367 can self-administer her medication. LPN F verified with Surveyor after checking the computer that R367 does not have an order and does not see anything written in the care plan for R367 to self-administer medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/22 at 8:10 AM, Surveyor interviewed IDON B (interim Director of Nursing). Surveyor described to IDON B of the 2 cases of medication at the bedside and asked if this is okay. IDON B replied to Surveyor You cannot do that, that's a no-no, you have to watch them take it. Surveyor asked IDON B if the residents should have a self-administration order, IDON replied Yes, you have to have a self-administer order and it has to be in the chart.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately notify and consult with the resident's physician when a significant change in the resident's physical, mental, or psychosocial status occurred for 3 residents (R118, R45 and R46) of a total sample of 21 residents reviewed. On [DATE] R118 had two (2) seizures with subsequent falls. The first [CONDITION(S)]/fall occurred at 7:30 AM. The facility did not notify R118's Physician. R118's second [CONDITION(S)] occurred at approximately 3:00 PM (during shift change). During R118's second [CONDITION(S)]/fall, DOT OO was walking down the hall when he observed R118 falling forward right before hitting the floor. DOT OO reported to Surveyor that no staff were with R118 at the time of his [CONDITION(S)]/fall. Facility staff moved R118 and never consulted with his Physician. When R118 was sent to the ED (Emergency Department) approximately 2 hours later, he was diagnosed with life-threatening injuries including: [NAME] I and II (two facial fractures), SAH (Subarachnoid Hemorrhage), and C7 fracture (7th cervical spinal vertebra). R118 passed away at the hospital on [DATE]. The facility failed to notify R118's Physician of two falls/seizures on [DATE]. The second [CONDITION(S)]/fall resulted in R118's death two (2) days later. R46 had a weight loss in [DATE] of 6.1% and a weight gain in June of 6.39%. The facility did not consult with the physician about the weight changes. R45 had a [CONDITION(S)] event without a [CONDITION(S)] diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . As evidenced by The facility's policy, Change in a Resident's Condition or Status, dated [DATE], indicates the following: Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care,) Policy Interpretation and Implementation 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; d. significant change in the resident's physical/emotional/mental condition e. need to alter the resident's medical treatment significantly g. need to transfer the resident to a hospital/treatment center (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting) 3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: e. It is necessary to transfer the resident to a hospital/treatment center. Example 1 R118 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R118's Admission MDS (Minimum Data Set) dated [DATE] indicates R118 has a BIMS (Brief Interview of Mental Status) of a 5 out of 15, which indicates he is severely cognitively impaired. Section G indicates that R118 is independent for walking in the corridor, locomotion on the unit, supervision and 1 staff assist with transferring. (Note, R1 was independent with transfers at the time of his seizures/falls.) R118's Comprehensive Care Plan indicates the following focus area: (Date Initiated: [DATE], Date Revised: [DATE]) R118 is at risk/has potential for falls, accidents and incidents r/t (related to deconditioning, generalized weakness, seizures. Resident is able to place self on the floor safely and is able to get off floor safely, however this does increase risk of falls. Goals: Injuries will be minimized through review date. Interventions: Update MD PRN (Medical Doctor as needed). ([DATE]) Follow therapy recommendations for transfers and mobility. On [DATE] R118 had two (2) seizures with subsequent falls. (Note, this is a late entry for a fall that occurred on [DATE] at 7:30 AM.) On [DATE] at 11:21 PM, R118's Progress Notes indicates the following: R118 observed by staff in hallway conversating with another resident when he leaned back and hit his upper back/shoulder area against the wall. Resident then slightly leaned forward and went onto the floor on his butt. When staff member got closer to resident, he was actively having a [CONDITION(S)]. Seizing lasted about 3 minutes, then another 3 minutes in the post-ictal stage, prn (as needed) [MEDICATION(S)] was administered. Resident was agitated after [CONDITION(S)] and repeating tour. hospice updated and APOAHC (Activated Power of Attorney for healthcare). Note, the physician was not notified regarding this [CONDITION(S)]. The Fall Report documents the following: Date: [DATE] at 7:30 AM - Same description as above Immediate Action Taken: hospice updated and came to see resident (Note, the hospice nurse did not arrive until R118 was being sent out nearly 2 hours after the 2nd fall at approximately 5:00 PM.) Resident Taken to Hospital: No (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Level of Pain: 0 Mental Status: Oriented to person Level of Consciousness: Alert Mobility: Ambulatory without assistance Predisposing Environmental Factors: None Predisposing Situation Factors: Ambulating without assist Witness (and writer): No longer employed at facility Agencies/People Notified: Hospice [DATE] at 7:30 AM, Family Member (APOAHC) [DATE] at 11:30 PM (Note, this is a late entry for a fall that occurred on [DATE] around 3:00 PM.) On [DATE] at 6:28 PM, R118's Progress Note indicates the following: Found resident face down on the floor and had [CONDITION(S)] in hallway near nurses station. [CONDITION(S)] lasted for 5 mins (minutes)/assisted R118 to lying position on his side. Resident was bleeding from nose, face, nose swollen and bruises on face. Called hospice, notified on unable to stop bleeding and need of resident to send to hospital/will send nurse ASAP (as soon as possible) to do evaluation for resident per hospice triage nurse. Called resident's APOAHC (Activated Power of Attorney for Health Care), APOAHC said resident's family member is coming to see resident and hospice will come an evaluate resident and do not want resident to send to hospital for evaluation. Res (resident) was bleeding from face, combative with staffs [sic], refusing to do vitals, assessments or take any meds (medication). Received call back from APOAHC at 4:45 PM and APOAHC stated that she wants the resident sent to the hospital for evaluation after a second family member was in the building (family member sent pictures to APOAHC). Called 911 send resident to hospital for evaluation. Hospice nurse was at facility when 911 paramedic took resident to hospital/will update APOAHC per hospice nurse. DON (Director of Nursing) was with writer when res was found on the floor and paramedic took resident to hospital for evaluation. Note, the physician was not notified regarding the second [CONDITION(S)]. R118's hospital reports documents the following: First documented care in emergency room : [DATE] 5:47 PM admitting diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] Steps to Achieve Goals: Provide supportive care, Pain management Goal review with: Patient and family Admitting Service: Palliative care Brief Summary: R118 is a 73 y/o (year old) man with hx (history) of dementia, [CONDITION(S)], presenting after having a [CONDITION(S)], fall [NAME] I and II (two facial fractures), SAH (Subarachnoid Hemorrhage), and C7 fracture (7th cervical spinal vertebra). (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	C-collar overnight. No invasive cares. Sonorous respirations. Rescinded hospice for trauma eval (evaluation). Talk to trauma/palliative regarding any acute changes. Patient had interim discussions with trauma and palliative and ultimately was admitted to the palliative care service. Code Status: DNR/DNI (Do not Resuscitate/Do not intubate) .While in the ER he experienced 2 subsequent seizures and received 1 mg IV [MEDICATION(S)]. .Briefly R118 was admitted after a fall with facial fractures and found (SAH) (Subarachnoid Hemorrhage), with goals discussed to pursue comfort care. He died [DATE] and was pronounced deceased at 3:44 AM. On [DATE] at 10:49 AM, Surveyor spoke with VPO G (Vice President of Operations) and INHA A (Interim Nursing Home Administrator). Surveyor asked VPO G, regarding R118's first [CONDITION(S)]/fall on [DATE], if staff should have contacted R118's Physician. VPO G stated, yes. Surveyor asked VPO G, why is this important? VPO G responded, to ensure there are no active changes that would require different interventions. Surveyor asked VPO G if staff contacted R118's Physician on [DATE] after his second [CONDITION(S)]/fall with injuries. VPO G stated the facility contacted hospice, however, there is no evidence that the facility or hospice contacted the Physician. R118 remained at the facility with life-threatening injuries for nearly 2 hours prior to being transferred to the ED. Surveyor asked VPO G should R118's Physician have been consulted. VPO G stated, yes. Surveyor asked VPO G why is it important to contact the Physician. VPO G stated once the Physician is notified staff should follow the Physician's instructions about what to do next. Surveyor asked VPO G how often R118 had seizures. VPO G stated, [DATE] is the last [CONDITION(S)] we witnessed and documented. Surveyor asked VPO G, did the facility provide education to staff following R118's seizures and falls. VPO G stated, yes, we had fall education and she believe there are several educations that stem from this. VPO G stated she will have to look at the education sheets and give that information to Surveyor. Note, no additional information was provided to Surveyor. The facility failed to notify R118's Physician of two falls/seizures on [DATE]. The second [CONDITION(S)]/fall resulted in R118's death two (2) days later. Example 2 Facility policy titled Weight and Hydration Management Practice Guidelines, revision date ,d+[DATE] states in part .2. Weigh all residents upon admission and readmission, and then monthly or as indicated by physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . As residents are weighed, staff can compare current weight to previous weight. Residents with weight variance are reweighed within 24 hours. Weight variance include and require reweight: a. Weight change of 5 lbs (pounds). b. Weight change of 3 lbs. if weight is less than 100lbs .Significant Weight Loss: d. 5% in one month (30 days) .8. Residents identified as a significant weight loss with have a SBAR (Situation, Background, Assessment, and Recommendation) completed and physician and family will be notified. R46 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	R46 has a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . R46's physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE], R46 weighed 203.4 lbs. On [DATE], the resident weighed 191 pounds which is a 6.10 % loss. Facility staff did not reweigh R46, and there is no documentation that the physician or family was updated. On [DATE], the resident weighed 191 lbs. On [DATE], the resident weighed 203.2 pounds which is a 6.39 % gain. Facility staff did not reweigh R46, and there is no documentation that the physician or family was updated. The facility did not have any documentation that R46 was assessed for potential worsening CHF. On [DATE] at 10:40 AM Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B what her expectations was for notifying the physician regarding weight loss or weight gain, IDON B stated that the physician and dietician should be notified if there is a 5% weight loss. Surveyor asked IDON B if she would expect staff to notify the physician if a resident with CHF had weight gain, IDON B stated that staff should be notifying the physician with a 5 pound weight gain. Example 3 R45 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of [DATE] indicates R45's cognition is severely impaired with a BIMS (Brief Interview of Mental Status) score of 1 out of 15. R45 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R45 has an activated POA (Power of Attorney). R45's Progress Note on [DATE] at 10:09 PM, written by LPN BB (Licensed Practical Nurse) state: Resident had a [CONDITION(S)] this PM. Resident was lowered to the floor by the CNA (Certified Nursing Assistant). Writer and CNA placed resident on bed. Resident is resting peacefully. No noted injury. Message left for POA and Provider. Note: Surveyor does not find any documentation confirming the POA and Provider have received the message and any revision of care. This is the only note in the electronic medical record pertaining to this event. On [DATE] at 4:20 PM, Surveyor interviewed CNA DD. Surveyor asked CNA DD if she was aware of R45 having a [CONDITION(S)], she replied yes, today and before today. Surveyor asked CNA DD if there was any training after the [CONDITION(S)] of what to do if there is a [CONDITION(S)], she replied, no, I know it has happened before with R45 and we talk about it. Surveyor asked CNA DD if anything has been added to the care plan for seizures, she then pulled out a piece of paper from her pocket and replied no, there is nothing there in the Kardex. On [DATE] at 4:35 PM, Surveyor interviewed LPN CC. Surveyor asked LPN CC, if you had a resident that has a [CONDITION(S)] what would you do, she replied, to keep them safe, time it, if it was not stopping to tell someone else like a Nurse Practitioner or Doctor. Surveyor asked LPN CC how she would notify the Doctor, she replied, on the phone. Surveyor asked LPN CC if she should get a nurse to do an assessment, she replied, yes, definitely. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 4:52 PM, Surveyor interviewed LPN BB. Surveyor asked LPN BB to describe R45's [CONDITION(S)] of what she did, she replied I called the on-call and left message with a physician and Nurse Practitioner, left on their voicemail. Surveyor asked LPN BB if she ever heard back from the Nurse Practitioner or physician, she replied, I was waiting, and it was close to the end of my shift and so I reported to the night nurse and let her know about the [CONDITION(S)] and awaiting a call back. Surveyor asked LPN BB if she has had any training of what to do if you do not hear back, she replied No. I tried to call the acting DON (Director of Nursing) at the time and the INHA (Interim Nursing Home Administrator) but couldn't get ahold of anyone. On [DATE] at 4:42 PM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B what the expectation is if a resident is having a new [CONDITION(S)], she replied, document, call physician, call POA, and check the MAR (Medication Administration Record) for any medications, if an LPN is on duty, notify the RN (Registered Nurse). Surveyor asked IDON B what the standards of practice is for physician notification, she replied notify the physician for any change of condition, we put a note in the chart and on the 24-hour log.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure each resident had a safe, clean, comfortable, and homelike environment or ensure housekeeping provided necessary services to maintain a sanitary, orderly, and comfortable area for 1 of 21 resident rooms (R367). Surveyor observed R367's room has a strong odor of urine and feces, including outside of the room and in the hall. R367 reports having to leave her room for warmth and fresh air. Example 1 R367 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 7/14/22 indicates R367's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 14 out of 15. R367's has the following diagnosis: Type 1 Diabetes Mellitus, [CONDITION(S)], [CONDITION(S)], Displaced Fracture of body of Talus, Right Femur Fracture. On 7/21/22 at 10:13 AM, Surveyor interviewed R367. Surveyor asked R367 how she liked her room, she replied, I think they mop with piss water. R367 reports that the room smells of urine and feces, she reports if she closes the door her room becomes too smelly and will wake up with a sinus headache. Surveyor asked R367 if she has informed staff or filed a grievance. R367 asked Surveyor what a grievance was and reports she has told staff But they don't do anything. R367 reports she leaves on Monday, Wednesday, and Friday for [CONDITION(S)], so At least I don't have to smell it those days. R367 offered Surveyor to walk into her room, Surveyor did walk into her room and confirm a strong odor of feces and urine. R367 reports that her room is very cold, she cannot turn the heater on due to it being turned off for the summer in the whole facility. Surveyor asked if R367 informed staff, she replied that they just give her another blanket. R367 elaborates that she is thankful it is summer so she can go outside to get fresh air and warm up. The only way R367 reports she can sleep is to completely cover her head with a blanket in her bed for the warmth. On 7/25/22 at 7:28 AM, Surveyor walked by R367's room and the strong odor of urine and feces in the Aspen hallway. R367 was not in the facility at the time due to [CONDITION(S)]. Surveyor found odor coming from a specific room and found a resident resting soundly. On 7/25/22 at 9:05 AM, Surveyor interviewed CNA AA (Certified Nursing Assistant) and asked if she could smell any odor. CNA AA replied that The room is awful in there; I will let the nurse know. On 7/26/22 at 9:50 AM, Surveyor obtained INHA A (Interim Nursing Home Administrator) and brought her to R367's room. Surveyor asked INHA A if there was an odor in the room, she replied, yes, it was urine. R367 validated the odor and provided the concern of headaches. INHA A apologized to R367 and was moved to another room further away from the odor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/22 at 11:15 AM, Surveyor interviewed CNA AA and inquired of the odor in the hallway. CNA AA described the odor of another resident; this was discussed in round and is happening more frequently. CNA AA went into the room to check on a nearby resident and found him sleeping soundly. On 7/27/22 at 8:23 AM, Surveyor interviewed RN Y (Registered Nurse) in the Cedar wing hallway. Surveyor asked RN Y what the odor was in the hallway, RN Y replied, I think that is urine, but I don't see anyone. At 8:28 AM, Surveyor observed RN Y removing a dirty linen cart from the Cedar wing.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation and interview, the facility did not ensure residents were made aware of how to file a grievance nor notify residents individually or have prominent posting throughout the facility identifying the grievance process or correct grievance official for 5 (R31, R47, R46, R2, R54) of 21 sampled residents and 8 (R39, R64, R59, R30, R15, R366, R11, R43) of 8 supplemental residents who attended the group meeting. The posting for the grievance officer, throughout our inspection, listed an employee who no longer works in the facility. R31, R39, R64, R47, R59, R46, R30, R2, R15, R54, R366, R11, and R43 (Resident) indicated during the resident council survey task they were unaware of how to file a grievance and indicated a different grievance officer than reported by the facility or found in the posting. This is evidenced by: The facility policy titled Grievances/Complaints, Filing, with a revised date of April 2017, indicates in part: Policy Statement Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances . Policy Interpretation and Implementation .4 .A copy of our grievance/complaint procedure is posted on the resident bulletin board .6. The contact information for the individual(s) with whom a grievance may be filed is provided to the resident and/or representative upon admission. On 7/21/22, Surveyors completed the resident council task with 13 residents of the facility in attendance. Surveyors asked if residents knew how to file a grievance. R31, R39, R64, R47, R59, R46, R30, R2, R15, R54, R366, R11, and R43 all indicated they were unaware of how to file a grievance in the facility. Surveyors asked residents if they were aware of who the grievance officer was for the facility. R31, R39, R64, R47, R59, R46, R30, R2, R15, R54, R366, R11, and R43 all agreed it was a therapist. On 7/26/22 at 10:40AM, Surveyor interviewed, HR D (Human Resources), and asked who the facility grievance officer is. HR D indicated it is SSD C. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/26/22 at 4:13PM, Surveyor interviewed SSD C (Social Services Director) and asked who the grievance officer is for the facility. SSD C indicated she was and that she took over the role about a month ago. Surveyor asked who the grievance officer prior to her was. SSD C indicated, the administrator, but there have been several. Surveyor asked SSD C how residents are informed of who the grievance officer is. SSD C indicated, I don't know to be honest. Surveyor asked who would be able to assist with that information. SSD C indicated, maybe AD E (Activities Director) or INHA A (Interim Nursing Home Administrator). Surveyor asked SSD C how residents can file a grievance. SSD C indicated, what I've done in the last few weeks that I have been learning is if the volunteer ombudsman checks in with me when they leave and has anything then I will make that into a grievance. If they check out with someone else, like AD E, he will then give me the list or give it to the administrator. When I get the list, I make them up as a grievance and give them to the INHA and review with INHA and they get sent to the appropriate department. On 7/26/22 at 4:28 PM Surveyor interviewed AD E and asked how long he had been in his position. AD E indicated, since about April. Surveyor asked AD E, how residents are informed of how to file a grievance. AD E indicated, if someone talks to me about an issue, I tell them we can fill out a grievance. Surveyor asked what the process is for new residents. AD E indicated, I am not sure about that, I believe it happens during admission when they are presented with their resident rights and how to get help if they can't fill it out. Surveyor asked AD E, if this information is reviewed when he meets with them one on one for resident council. AD E indicated, not specifically, but sometimes they will ask, and I will let them know. Surveyor asked AD E who the grievance officer is for the facility. AD E indicated; I would have to ask the administrator. Surveyor asked AD E, who he would refer a resident to for a grievance concern. AD E indicated, I would ask them if they wanted to fill out a form and depending on the grievance, I would give them to the department head. On 7/27/22 at 9:20AM, Surveyor requested AD E to show Surveyor where the resident bulletin board is that is referenced in the grievance policy. Surveyor read information from policy to AD E. AD E took Surveyor to resident bulletin board which is located in the hall straight down from the main entrance and is on a wall across from the therapy department. There is information on resident rights posted on the bulletin board. Surveyor asked AD E if he could locate any information regarding the grievance procedure or the information on who the grievance official is in the information. AD E indicated he could not. Surveyor asked AD E if he felt a resident in a wheelchair could read the information posted on the bulletin board. AD E, indicated, no. AD E then took me to the front foyer area, located to the left, if you are walking into the building from the main entrance, near the screening kiosks. AD E showed a framed paper on the counter that lists the grievance officer. Surveyor asked AD E if the officer listed was the current grievance officer. AD E indicated it was not, that it was a previous employee, and that it changed last month to the social worker. AD E removed the paper from the frame and stated he was going to get it updated. On 7/27/22 at 1:54PM Surveyor interviewed R59 and asked if he was aware of where the resident bulletin board is. R59 stated, not off hand. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/27/22 at 2:00PM, Surveyor interviewed R2 asked if she was aware of where the resident bulletin board was. R2 pointed down the hall to a bulletin board that had birthdays posted on it, but was not the Resident Bulletin Board shown to Surveyor by AD E. On 7/27/22 at 9:45AM, Surveyor interviewed INHA A (Interim Nursing Home Administrator) and asked what the process for grievances is. INHA indicated the SW (Social Worker) is the grievance officer; residents can tell anyone and anyone can write up a grievance and it goes to the SW; the SW and I review it together and do the investigation and whatever is found to be needed, whether education or whatever; we discuss the findings with the resident or whoever made the grievance; and usually I have the SW follow-up with the resident weekly after the resolution. Surveyor asked INHA A, how residents know who the grievance officer is or how to file a grievance. INHA A indicated, when the SW meets them and talks to them she should be introducing herself as the grievance officer and telling them how to file one and where the forms are at. Surveyor asked INHA A if she was aware that several residents did not know who the grievance office is or how to file a grievance. INHA A indicated, I did not and I will meet with the residents to let them know.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident was free from verbal abuse for 1 of 7 facility reported incidents involving (R118). On 5/12/22 at 7:12 PM, hospice RN PP (Registered Nurse) observed a CNA QQ (Certified Nursing Assistant) state to R118, Sit your ass down and stay put, I cannot chase you all night. Hospice RN PP did not immediately intervene when she heard CNA QQ continuing to yell at R118. CNA QQ continued working and caring for residents that evening until 11:37 PM and continued providing direct care to residents on 5/12/22 from 3:07 PM - 4:04 PM when she was removed from the facility. RN PP did not protect R118 as well as other residents. The facility substantiated that abuse occurred in the facility. This is evidenced by: The facility's policy and procedure, Abuse and Neglect Prevention, dated, 3/30/21, documents in part, the following: Purpose: To establish guidelines that presents, identifies, and report resident abuse and neglect. Policy: The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. It is the policy of the facility to ensure that each resident is treated with dignity and care, free from abuse and neglect and to take family member and immediate action to investigate and adjudicate alleged resident abuse and neglect. Definitions: Verbal Abuse - is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. Definition: Involuntary seclusion is defined as separation of a Resident from other Residents or from his or her room or confinement to his or her room against the Resident's will, or the will of the Resident's legal representative. Prevention: Provide residents, families, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution, and provide feedback regarding the concerns that have been expressed.The supervision of staff to identify inappropriate behaviors, such as using derogatory language R118 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R118's Admission MDS (Minimum Data Set) dated 12/29/21 indicates R118 has a BIMS (Brief Interview of Mental Status) of a 5 out of 15, which indicates he is severely cognitively impaired. Section G indicates that R118 is independent for walking in the corridor, locomotion on the unit, supervision and 1 staff assist with transferring. (Note, R1 was independent with transfers at the time of his seizures/falls.) R118 has a APOAHC (Activated Power of Attorney for Health Care). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/22 at 1:40 AM, RN PP sent the following email to 3 hospice staff. I apologize for bothering you as I know you are a busy lady with so many patients at this facility. I understand that the situation there is complex and difficult. I was originally there to see (different resident) and R118's family member wanted to speak with me. I am sure you have read or will read my long note in the collaboration charting so I will try not to add too much duplicate information, but I wanted to note some things that I did not think were appropriate to chart. R118's family member [NAME] up several concerns but one of them was the way staff has been treating R118. She says they are constantly yelling at him. This was unfortunately verified later when I was in the facility including a caregiver, that another caregiver identified as CNA QQ, yelling at him multiple times for leaving his room as well as telling him to sit your ass down and stay put, I cannot chase you all night. I continued to hear her yelling at the patient continuously when I was in another hallway, and this is while his wife was present. I attempted to educate that yelling at the patient is not an appropriate way to handle his wandering and suggested giving him something to occupy him as just sitting him on his bed was not working but this was ignored, and I continued to hear her yelling at the patient a couple of minutes later. I know wandering patients can be difficult to handle, and especially with staffing shortages but I cannot image being yelled at continuously and then being asked to let these same people provide care for you. It cannot be helping with the agitation. I don't know what can be done if anything but wanted to bring this to your attention. On 5/13/22 at 9:23 AM, a hospice Manager sent the following email to Human Resources D (Human Resources/Business Office): .We spoke yesterday about the incident that occurred on 5/11/22 with R118. Below (this is the email referenced above) is the email we received from the visit nurse that spoke with R118's family member the night of 5/11. The visit nurse confirmed with me last night that she started observing the yelling around 7pm. She said she did not tell anyone else at the facility about it, but she said there was no way that staff didn't know what was going on. She said she could hear this caregiver yelling at R118 from a different hallway, so she knew that other staff could hear it as well. She said that everyone just carried on like it was normal. I think this is all the information I have related to the event, but please let me know if you have more questions, and I can do my best to find answers. The facility reported this allegation of abuse to the State Agency. Summary of Incident: Was informed by R118's family member (a different family member) that a hospice nurse witnessing staff member refusing to provide c Describe the effect: None noted, family was followed up with and were happy with the results. Explain what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct: Immediate suspension, resident interviews, staff educations, care plan update, hospice interviews. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's summary states, in part, the following: .The facility was able to substantiate the allegation. The staff member isolated, denied the allegation but the hospice nurse witnessed the incident. Education regarding abuse reporting and dealing with difficult residents implemented and remains ongoing. The facility takes incident of this nature very serious. The staff member is no longer employed at the facility. Rand (Random) admits will be implemented to ensure residents feel safe and are treated with dignity. The facility terminated CNA QQ's employment 5/19/22 due to Verbal abuse to resident hospice with statement and other resident complaints On 7/26/22 at 9:31 AM. Surveyor left a message for RN PP (Registered Nurse). Surveyor did not receive a return phone call. On 7/25/22 at 4:47 PM, Surveyor spoke with HR D (Human Resources/Business Office). Surveyor asked HR D, what was reported to you regarding R118. R118's family member received a call from hospice regarding RN PP (Registered Nurse) observing verbal abuse. HR D stated we received a call from hospice stating a nurse reached out to her regarding concerns about a CNA the night before. HR D stated, she received a call from R118's family member about an abuse allegation. HR D stated, we did not hear anything from hospice at first. R118's family member wanted to know what happened. HR D stated, we were completely in the dark about what had occurred. Hospice management came to the facility and spoke with management regarding the incident. HR D stated, the hospice nurse was not here for R118 specifically but could hear the verbal abuse. RN PP tried to address it with CNA QQ and CNA QQ went in a second time and did it again. HR D stated, unfortunately we weren't made aware until the following day when we spoke with R118's family member. HR D stated, she believes R118's other family member was here but, it is not sure if she was there for that moment. HR D stated the email from hospice didn't come until 3:00 PM (that identified CNA QQ by name). HR D stated, we had already started our investigation late that morning. As soon as we received the email, we suspended CNA QQ. CNA QQ was here for about 1 hour before she was suspended. That was before they could give us CNA QQ's name. There was a hospice meeting we did tell them any possibilities of abuse need to be reported immediately. On 7/27/22 at 9:58 AM, Surveyor spoke with VPO G (Vice President of Operations) and INHA (Interim Nursing Home Administrator) VPO G stated, hospice did not immediately intervene to stop the abuse from occurring. Hospice did not immediately intervene and report the abuse to the facility, which she should have done.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility failed to implement written policies and procedures to ensure staff are screened prior to working with residents for 9 (CNA/MT L, CNA J, Housekeeper M, CNA K, Speech Therapy N, CNA O, CNA P, RN Q and Maintenance R) of 10 staff reviewed for background checks. CNA/MT L (Certified Nursing Assistant/Medication Technician) did not have an out of state background check completed upon hire. CNA J did not have a BID (Background Information Disclosure) completed upon hire, therefore there is no record of military status or if worked/lived outside of Wisconsin. Housekeeper M had a BID completed on 6/12/18 the DOJ (Department of Justice) and the IBIS (Integrated Background Information System) results weren't resulted until 7/20/22, after Surveyors requested documentation. CNA K had a BID completed on 6/6/22 but the DOJ and the IBIS weren't resulted until 7/21/22, after Surveyors requested documentation. ST N (Speech Therapist), CNA O, CNA P, RN Q (Registered Nurse), and Maintenance R all do not have reference checks. This is evidenced by: The Facility's Abuse and Neglect Prevention Policy and Procedure, dated February of 2022, documents in part: .Screening .1. The facility will conduct a state criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire. 2. Facility will make reasonable attempts to request and obtain information from previous employers and/or current employers that may be indicative of a history of abuse, neglect or mistreating Residents . The Facility's Background Screening Investigation Policy and Procedure, dated November 2015, documents in part: Our facility conducts employment screening checks, reference checks and criminal conviction investigation checks on direct access employees .1. There Personnel/Human Resources Director, or other designee, will conduct background checks, reference checks and criminal conviction checks .on all potential employee and contract personnel who meet the criteria for direct access employee, as stated above . Example 1 CNA/MT L had a BID ran 5/11/22 which documented she resided and was employed out of state in December of 2018-March of 2019 and November of 2019-November of 2020. The Facility did not run an out of state background check for CNA/MT J. Example 2 CNA J did not have a BID ran upon hire, which was 6/15/22. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 3 Housekeeper M's hire date was 6/21/18, her DOJ and IBIS are dated 7/20/22 which was after Surveyors requested documentation. Example 4 CNA K's hire date was 6/9/22, her DOJ and IBIS are dated 7/21/22 which was after Surveyors requested documentation. Example 5 ST N (Speech Therapist), CNA O, CNA P, RN Q (Registered Nurse), and Maintenance R all do not have reference checks. On 7/20/22 at 4:07 PM, Surveyor interviewed HR/BOM D (Human Resources/Business Office Manager). Surveyor asked HR/BOM D why CNA J did not have a background check, HR/BOM D said, we started using a new company and weren't aware BID still needed to be done. On 7/25/22 at 1:29 PM, Surveyor interviewed HR/BOM D (Human Resources/Business Office Manager). Surveyor asked HR/BOM D if they had CNA/MT's out of state background check, HR/BOM D stated no, it was not in house, so it was ran it today. Surveyor asked HR/BOM D when the BID is sent in, how long does it typically take for DOJ and IBIS results to come back; HR/BOM D said 24 hours, unless sent on a Friday then we don't get until Monday afternoon. Surveyor asked HR/BOM D how she ensures that Agency or Contracted Staff have the correct information completed, HR/BOM D explained that Contracted Services run their own stuff and then gives it to us; she said she does need to check with Agency but is trying to get into compliance with them. Surveyor asked HR/BOM D why she thought a BID would be dated 6/6/22 and DOJ and IBIS dated 7/21/22, HR/BOM replied she was not sure if they run based on new assignments or how they do theirs. Surveyor asked HR/BOM D how out of state background checks are completed, HR/BOM D said through the new company which is a national search. Surveyor asked HR/BOM D if they complete reference checks upon hire, HR/BOM D said that is part of their new policy. Surveyor asked HR/BOM D why CNA J didn't have a BID completed once they identified the error, HR/BOM D stated we noted the error when Surveyors asked for BID. Surveyor asked HR/BOM D if CNA J should have had BID completed, HR/BOM D said yes. It is important to note that the Background Screening Investigation Policy and Procedure given to Surveyors is dated November 2015 and the Abuse and Neglect Prevention Policy and Procedure is dated February 2022. On 7/27/22 at 3:40 PM, Surveyor interviewed INHA A (Interim Nursing Home Administrator). Surveyor asked INHA A if BID should be completed upon hire and DOJ and IBIS resulted timely, INHA A said yes. Surveyor asked INHA A if a prospective staff lived or was employed outside of Wisconsin, should an out of state background check be ran, INHA A said yes. Surveyor asked INHA A if reference checks should be completed upon hire, INHA A said if that is part of the policy here, then yes. Example (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Abuse and Neglect Prevention, revision date 2/2022, states in part .Investigation: .3. If there is an indication that an injury has or may have occurred, a physical assessment must be completed by the Director of Nursing or charge nurse immediately; 4. Documentation of any physical assessment conducted will be made in the resident's chart and a copy of this documentation will be included in the abuse investigation; .12. In circumstances where the allegation involves an employee, interview other Residents to whom the accused employee provides care of services; . Initial/ Immediate Protection during Facility Investigation: Upon receiving a report of an allegation of abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; and/ or (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. Following completion of the investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee will be allowed to return to job duties involving resident contact. On 7/11/22 R46's sister reported to facility staff that R46 alleged that a staff member had hit her. The facility initiated an investigation. On 7/25/22 Surveyor reviewed the facility's investigation. The facility did not suspend or remove from resident care, the accused nurse; she continued to work the entire shift. There is no documentation that facility staff completed a physical assessment on R46. Staff and resident interviews were not completed until 7/12/22. Resident interviews did not address abuse, but instead asked if staff was treating them respectfully, and only 6 residents were interviewed. On 7/26/22 at 10:03 AM Surveyor interviewed DON B. Surveyor asked DON B if a staff member is accused of abuse, should the staff member be sent home, DON B stated yes. Surveyor asked DON B if more than 6 residents should have been interviewed, DON B stated yes. Surveyor asked DON B if she would expect the resident interview questions to include questions about abuse, DON B stated yes. On 2/27/22 at 1:54 PM Surveyor interviewed RDO NN (Regional Director of Operations). Surveyor asked RDO NN why the facility did not send the accused nurse home or remove her from resident care areas, RDO NN stated that she had completed her investigation and determined that the accusation was unfounded, and the nurse was not working on the same hall as R46. Surveyor asked RDO NN if a physical assessment was completed on R46, RDO NN stated that she performed a skin check and interviewed residents and staff. The facility did not follow their policy when investigating an allegation of abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately report alleged violations of abuse to the Interim Nursing Home Administrator (INHA) or designee for 1 of 7 facility reports incidents (R118). On 5/12/22 at 7:12 PM, hospice RN PP (Registered Nurse) observed a CNA QQ (Certified Nursing Assistant) state to R118, Sit your ass down and stay put, I cannot chase you all night. RN PP did not immediately intervene nor report the abuse to facility staff. Subsequently, RN PP heard CNA QQ yell at R188 again after the first occurrence of abuse. This is evidenced by: The facility's policy and procedure, Abuse and Neglect Prevention, dated, 3/30/21, documents in part, the following: Purpose: To establish guidelines that presents, identifies and report resident abuse and neglect. Policy: The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. It is the policy of the facility to ensure that each resident is treated with dignity and care, free from abuse and neglect and to take family member and immediate action to investigate and adjudicate alleged resident abuse and neglect. Definitions: Verbal Abuse - is defined as any use of oral, written or gestured language that wilfully includes disparaging and derogatory terms to residents or their families, or witin their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her famiy again. Definition: Involuntary seclusion is defined as separation of a Resident from oher Residents or from his or her room or confinement to his or her room against the Resident's will, or the will of the Resident's legal representative. Prevention: Provide residents, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution, and provie feedback regarding the concerns that have been expressed.The supervision of staff to identify inappropriate behaviors, such as using derogatory language R118 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R118's Admission MDS (Minimum Data Set) dated 12/29/21 indicates R118 has a BIMS (Brief Interview of Mental Status) of a 5 out of 15, which indicates he is severely cognitively impaired. R118 has a APOAHC (Activated Power of Attorney for Health Care). (continued on next page)

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	525074	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay at Belmont Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/22 at 1:40 AM, RN PP sent the following email to 3 hospice staff. I apologize for bothering you as I know you are a busy lady with so many patients at this facility. I understand that the situation there is complex and difficult. I was originally there to see (different resident) and R118's family member wanted to speak with me. I am sure you have read or will read my long note in the collaboration charting so I will try not to add too much duplicate information, but I wanted to note some things that I did not think were appropriate to chart. R118's family member [NAME] up several concerns but one of them was the way staff has been treating R118. She says they are constantly yelling at him. This was unfortunately verified later on when I was in the facility including a caregiver, that another caregiver identifed as CNA QQ, yelling at him multiple times for leaving his room as well as telling him to sit your ass down and stay put, I cannot chase you all night. I continued to hear her yelling at the patient continuously when I was in another hallway, and this is while his wife was present. I attempted to educate that yelling at the patient is not an appopriate way to handle his wandering and suggested giving him something to occupy him as just sitting him on his bed was not working but this was ignored, and I continued to hear her yelling at the patient a couple of minutes later. I know wandering patients can be difficult to handle, and especially with staffing shortages but I cannot image being yelled at continuously and then being asked to let these same people provide care for you. It cannot be helping with the agitation. I don't know what can be done, if anyting but wanted to bring this to your attention. On 5/13/22 at 9:23 AM, a hospice Manager sent the following email to Human Resources D (Human Resources/Business Office): .We spoke yesterday about the incident that occurred on 5/11/22 with R118. Below (this is the email referenced above) is the email we received from the visit nurse that spoke with R118's family member the night of 5/11. The visit nurse confirmed with me last night that she started observing the yelling around 7pm. She said she did not tell anyone else at the facility about it, but she said there was no way that staff didn't know what was going on. She said she could hear this caregiver yelling at R118 from a different hallway, so she knew that other staff could hear it as well. She said that everyone just carried on like it was normal. I think this is all the information I have realted to teh event, but please let me know if you have more questions, and I can do my best to find answers. On 7/25/22 at 4:47 PM, Surveyor spoke with HR D (Human Resources/Business Office). Survyeor asked HR D, what was reported to you regarding R118. HR D stated, she received a call from R118's family member about an abuse allegation. HR D stated, we did not hear anything from hospice at first. R118's family member wanted to know what happened. HR D stated, we were completely in the dark about what had occurred. Hospice management came to the facility and spoke with management regarding the incident. HR D stated, the hospice nurse was not here for R118 specifically but could hear the verbal abuse. RN PP tried to address it with CNA QQ and CNA QQ went in a second time and did it again. HR D stated, unfortunately we weren't made aware until the following day when we spoke with R118's family member. There was a hospice meeting after this (not educational) regarding how we can better support each other. We did tell them any possibilities of abuse need to be reported immediately. On 7/27/22 at 9:58 AM, Surveor spoke with VPO G (Vice President of Operations) and INHA (Interim Nursing Home Administrator) VPO G stated, hospice did not immediately intervene to stop the abuse from occurring and report the abuse to the facility. VPO G stated RN PP should have immediately intervened to stop the abuse and reported her observation to facility staff.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate incidents of verbal abuse and take steps to prevent further abuse for 3 of 7 facility reported incidents (R118), (R45) and (R46). On 5/12/22 at 7:12 PM, hospice RN PP (Registered Nurse) observed a CNA QQ (Certified Nursing Assistant) state to R118, Sit your ass down and stay put, I cannot chase you all night. RN PP did not immediately intervene to prevent further abuse from occurring. Subsequently, RN PP heard CNA QQ yell at R118 again after the first occurrence of abuse. CNA QQ continued working and caring for residents that evening until 11:37 PM and continued providing direct care to residents on 5/12/22 from 3:07 PM - 4:04 PM when she was removed from the facility. The facility did not educate hospice RN PP that she needs to immediately intervene and report the abuse to the facility. R55 (Resident) reported CNA H (Certified Nursing Assistant) did not meet his care needs on 6/22/22. The facility failed to thoroughly investigate these allegations This is evidenced by: The facility's policy and procedure, Abuse and Neglect Prevention, dated, 3/30/21, documents in part, the following: Purpose: To establish guidelines that presents, identifies, and report resident abuse and neglect. Policy: The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. It is the policy of the facility to ensure that each resident is treated with dignity and care, free from abuse and neglect and to take family member and immediate action to investigate and adjudicate alleged resident abuse and neglect. Definitions: Verbal Abuse - is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. Definition: Involuntary seclusion is defined as separation of a Resident from other Residents or from his or her room or confinement to his or her room against the Resident's will, or the will of the Resident's legal representative. Prevention: Provide residents, families, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution, and provide feedback regarding the concerns that have been expressed.The supervision of staff to identify inappropriate behaviors, such as using derogatory language Example 1 R118 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R118's Admission MDS (Minimum Data Set) dated 12/29/21 indicates R118 has a BIMS (Brief Interview of Mental Status) of a 5 out of 15, which indicates he is severely cognitively impaired. R118 has a APOAHC (Activated Power of Attorney for Health Care). On 5/12/22 at 1:40 AM, RN PP sent the following email to 3 hospice staff. I apologize for bothering you as I know you are a busy lady with so many patients at this facility. I understand that the situation there is complex and difficult. I was originally there to see (different resident) and R118's family member wanted to speak with me. I am sure you have read or will read my long note in the collaboration charting so I will try not to add too much duplicate information, but I wanted to note some things that I did not think were appropriate to chart. R118's family member brought up several concerns but one of them was the way staff has been treating R118. She says they are constantly yelling at him. This was unfortunately verified later on when I was in the facility including a caregiver, that another caregiver identified as CNA QQ, yelling at him multiple times for leaving his room as well as telling him to sit your ass down and stay put, I cannot chase you all night. I continued to hear her yelling at the patient continuously when I was in another hallway, and this is while his wife was present. I attempted to educate that yelling at the patient is not an appropriate way to handle his wandering and suggested giving him something to occupy him as just sitting him on his bed was not working but this was ignored, and I continued to hear her yelling at the patient a couple of minutes later. I know wandering patients can be difficult to handle, and especially with staffing shortages but I cannot image being yelled at continuously and then being asked to let these same people provide care for you. It cannot be helping with the agitation. I don't know what can be done if anything but wanted to bring this to your attention. Of note, RN PP did not intervene or protect R118 when she heard the abuse occurring or report the abuse to the facility. CNA QQ proceeded to verbally abuse R118 a second time, yet RN PP did not stop the abuse from occurring. On 7/25/22 at 4:47 PM, Surveyor spoke with HR D (Human Resources/Business Office). Surveyor asked HR D, what was reported to you regarding R118. R118's family member received a call from hospice regarding RN PP (Registered Nurse) observing verbal abuse. HR D stated we received a call from hospice stating a nurse reached out to her regarding concerns about a CNA the night before. HR D stated, she received a call from R118's family member about an abuse allegation. HR D stated, we did not hear anything from hospice at first. R118's family member wanted to know what happened. HR D stated, we were completely in the dark about what had occurred. Hospice management came to the facility and spoke with management regarding the incident. HR D stated, the hospice nurse was not here for R118 specifically but could hear abuse. RN PP tried to address it with CNA QQ and CNA QQ went in a second time and did it again. HR D stated, unfortunately we weren't made aware until the following day when we spoke with R118's family member. As soon as we received the email, we suspended CNA QQ. CNA QQ was here for about 1 hour before she was suspended. That was before they could give us CNA QQ's name. There was a hospice meeting after this we did tell them any possibilities of abuse need to be reported immediately. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/22 at 9:58 AM, Surveyor spoke with VPO G (Vice President of Operations) and INHA (Interim Nursing Home Administrator) VPO G stated, hospice did not immediately intervene and report the abuse to the facility. VPO G stated, RN PP should have immediately intervened and reported her observation to facility staff. The facility did not provide education to RN PP that she must immediately intervene and report abuse to facility staff. VPO G stated that hospice provided training to RN PP however, there is not documentation that RN PP must immediately intervene and report directly to facility staff first. VPO G voiced understanding that this is required. Example 2 R55 was admitted to the facility on [DATE] and has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] .His most recent MDS (Minimum Data Set), dated 6/14/22, includes a BIMS (Brief Interview for Mental Status) score of 14, which indicates R55 is cognitively intact. On 7/25/22 Surveyor began reviewing a self-report investigation for R55 submitted to the State by the facility on 6/22/22. The Initial Brief Summary of Incident notes: Resident complained of rude staff. Investigation to follow. A Summary of Investigation was included in the self-report file provided by the facility and indicated: On 6/22/22, resident R55, stated: I hit the button for the CNA to turn off air conditioner. I closed my eyes for a few minutes, and she came in and shut the light off and closed the door. I turned the call light on again. She came in and turned off the air conditioner and said why do you need the air conditioner off? R55 was asked if the CNA treated him in an unprofessional or mean manner. Resident stated, 'No, just loud. I told her not to get mad at me. I told her there is urine to be emptied. She said, 'That's urine.' It was 3 inches from the top. She emptied it. After that I didn't call again so I didn't see her . As part of the investigation, CNA H was interviewed. Per the summary, CNA H stated, .resident put his call light on and wanted his urinal emptied. He also asked for his air conditioner to be turned off. I emptied his urinal and shut off his air. He was upset after I said, I was just in here and could have shut off his conditioner then . Resident interviews were not initially included with the self-report file provided to the Surveyor. These were requested and 6 resident interviews were received from the facility on 7/26/22 at 8:00AM. Each interview was documented on a separate piece of paper. The interviews contained two questions: Do you feel safe here? Does the staff meet your needs? The following information was noted on the interviews: --1 of 6 had the following documented in the upper right hand corner: 5/16/22 2:24pm unable to leave voice message. Of note, this date is prior to the incident date. --2 of 6 only contained a room number and no resident name. --0 of 6 contained any information on who was completing the interviews. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/22 at 9:56AM, Surveyor interviewed, IDON B (Interim Director of Nursing) and asked who is responsible for completing the self-reports and investigations. IDON B indicated either the DON (Director of Nursing) or ADON (Assistant Director of Nursing) and the ED (Executive Director). Surveyor asked IDON B what should be included in an investigation. IDON B indicated, as soon as we hear about it we interview residents, staff, call the doctor, call the family member, and the ED usually notifies the state and sends the report. If it is an allegation of abuse, the employee is suspended, and we do a full investigation. When they are suspended, they leave the building and they cannot come back until they hear from us. Surveyor asked IDON B, what is considered a thorough investigation. IDON B indicated, interviewing everyone involved; talk to the nurse; staff; residents; and ask staff to write a statement. Surveyor asked IDON B if all of that information should be dated. IDON B indicated, yes. Surveyor asked IDON B if resident interviews should indicate who spoke with them and should they be signed, dated and timed. IDON B indicated, yes, we should sign our name and date and time so that you have timeline. Surveyor reviewed the resident interviews that were provided by the facility with IDON B and asked if these would be considered part of a thorough investigation. IDON B indicated, they should be more thorough. There should be more questions and times and dates, and questions that tie to what the allegation is. Surveyor asked IDON B if the interviews that showed only room numbers should include resident names. IDON B indicated yes. The facility did not ensure a thorough Investigation was completed to ensure the further safety of all residents in the building. Example 3 Facility policy titled Abuse and Neglect Prevention, revision date 2/2022, states in part .Investigation: .3. If there is an indication that an injury has or may have occurred, a physical assessment must be completed by the Director of Nursing or charge nurse immediately; 4. Documentation of any physical assessment conducted will be made in the resident's chart and a copy of this documentation will be included in the abuse investigation; .12. In circumstances where the allegation involves an employee, interview other Residents to whom the accused employee provides care of services; . Initial/ Immediate Protection during Facility Investigation: Upon receiving a report of an allegation of abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; and/ or (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. Following completion of the investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee will be allowed to return to job duties involving resident contact. On 7/11/22 R46's sister reported to facility staff that R46 alleged that a staff member had hit her. The facility initiated an investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/22 Surveyor reviewed the facility's investigation. The facility did not suspend or remove from resident care, the accused nurse; she continued to work the entire shift. There is no documentation that facility staff completed a physical assessment on R46. Staff and resident interviews were not completed until 7/12/22. Resident interviews did not address abuse, but instead asked if staff was treating them respectfully, and only 6 residents were interviewed. On 7/26/22 at 10:03 AM Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B if a staff member is accused of abuse, should the staff member be sent home, IDON B stated yes. Surveyor asked IDON B if she would expect the resident interview questions to include questions about abuse, DON B stated yes. On 7/27/22 at 1:54 PM Surveyor interviewed RDO NN (Regional Director of Operations). Surveyor asked RDO NN why the facility did not send the accused nurse home or remove her from resident care areas, RDO NN stated that she had completed her investigation and determined that the accusation was unfounded, and the nurse was not working on the same hall as R46. Surveyor asked RDO NN if a physical assessment was completed on R46, RDO NN stated that she performed a skin check and interviewed residents and staff. Surveyor asked RDO NN if, according to the facility's abuse policy, should the accused nurse have been removed from resident care areas, RDO NN stated that she found the allegation untrue, so she allowed the nurse to continue working. Surveyor asked RDO NN how could the investigation be completed and found untrue if the resident and staff interviews were not completed until the next day, RDO NN stated that the interviews were completed on 7/11/22, but they weren't documented until 7/12/22.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 2 R367 was admitted to the facility on [DATE]. R367's has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R367's most recent MDS (Minimal Data Set), dated 7/14/22, documents a score of 14 out of 15 on her BIMS (Brief Interview of Mental Status) which indicates that she is cognitively intact. There is no evidence that the facility shared or reviewed R367's baseline care plan with her. Example 3 R366 was admitted to the facility on [DATE]. R366 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R366's most recent MDS dated [DATE], documents a score of 15 out of 15 on her BIMS which indicates that she is cognitively intact. There is no evidence that the facility shared or reviewed R366's baseline care plan with her. Example 4 R55 was admitted to the facility on [DATE]. R55 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R55's most recent MDS dated [DATE], documents a score of 14 out of 15 on his BIMS which indicates that he is cognitively intact. On 7/26/22 at 9:10 AM, Surveyor interviewed R55 and asked if he had any document of a baseline care plan that was signed and provided a copy to him, he replied, no. There is no evidence that the facility shared or reviewed R55's baseline care plan with him. On 7/27/22, at 4:14 PM, Surveyor interviewed HR (Human Resources/Business Office) D and asked for base line care plans for R62, R55, R366 and R367. HR D indicated HR D can not tell Surveyor where the baseline care plans are. HR D indicated she just started at facility in April and HR D can not find anything prior to that. Based on observation, interview, and record review the facility did not ensure that each resident and his/her family member received a written summary of the baseline care plan for 4 of 21 residents (R62, R55, R366 and R367) reviewed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility had no evidence that they provided a written summary of the resident baseline or comprehensive care plan for R62. The facility had no evidence that they provided a written summary of the resident baseline or comprehensive care plan for R55. The facility had no evidence that they provided a written summary of the resident baseline or comprehensive care plan for R366. The facility had no evidence that they provided a written summary of the resident baseline or comprehensive care plan for R367. Evidenced by: The facility policy, entitled Care Plans- Baseline, with a revised date of April 2022, states, in part: . Policy Statement- A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation . 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. 4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and d. Any updated information based on the details of the comprehensive care plan, as necessary. Example 1 R62 was admitted to the facility on [DATE] and has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . There is no evidence that the facility shared R62's care plan with R62 or her POA (Power of Attorney).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not conduct care conferences which included the participation of the IDT (Interdisciplinary Team) and the resident or resident's representative after completion of each comprehensive assessment (at least quarterly) or include an explanation in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan for 4 of 21 residents (R) sampled (R19, R46, R47, R48). R19- The facility did not hold timely Care Conference Meetings for R19 or include involvement of R19's representative in those meetings. R46- The facility did not hold timely Care Conference Meetings for R46 or include involvement of R46's representative in those meetings. R47- The facility did not hold timely Care Conference Meetings for R47 or include involvement of R47's representative in those meetings. R48- The facility did not hold timely Care Conference Meetings for R48 or include involvement of R48's representative in those meetings. This is evidenced by: The facility policy titled, Care Planning- Interdisciplinary Team, last revised September 2021, states in part, 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS (Minimum Data Set)) .3. The resident, the resident's family and/ or the resident's legal representative/ guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of day for the resident and family. Example 1 R19 admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R19's most recent MDS completed on 5/9/22 shows that R19 has a BIMS (Brief Interview of Mental Status) of 10/15, indicating that R19's cognitive status is moderately impaired. R19 has an activated Health Care Power of Attorney (HCPOA). On 7/26/21 at 10:30 AM Surveyor spoke with SSD C (Social Services Director) and requested Care Plan Conference notes from the last year for R19, R46, R47, and R48. SSD C provided Surveyor with one completed Care Conference assessment for R19 with an effective date of 3/3/22 there were no other Care Conference assessments provided. Example 2 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R46 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R46's most recent MDS completed on 6/10/22 shows that R46 has a BIMS of 00/10, indicating that R46 is severely cognitively impaired. R46 has an activated HCPOA. SSD C provided Surveyor with one Care Conference assessment for R46 with an effective date of 6/29/22 there were no other Care Conference assessments provided. Example 3 R47 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R47's most recent quarterly MDS completed on 6/11/22, indicates that R47 is rarely/ never understood. R47 has a POA that is involved in his care. SSD C provided Surveyor with 2 Social Services progress notes for R47, neither progress note was representative of a Care Conference meeting. Example 4 R48 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R48's most recent MDS completed on 6/17/22 shows that R48 has a BIMS of 3/10, indicating that R48 is severely cognitively impaired. R48 has an activated HCPOA. SSD C was unable to provide Surveyor with any documentation showing that R48 had any Care Conference meetings since admission. On 7/26/22 at 4:06 PM, Surveyor interviewed SSD C. Surveyor asked SSD C what the facility's process was for care conferences, SSD C stated that care conferences should be held quarterly. SSD C reported to Surveyor that she is aware that the facility is out of compliance, but she is in the process of getting everyone scheduled with a care conference, and then moving forward they will follow the MDS schedule. Surveyor asked SSD C if they had started the care conferences yet, SSD C stated that she was still working on getting everyone scheduled. The facility did not hold Care Conference meetings on the required schedule or with all required members involved.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure that residents' who are unable to carry out ADL (activities of daily living) receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 8 of 12 residents (R366, R54, R4, R55, R46, R19, R1, and R32) reviewed for ADL's. R366 requests to have 2 showers per week and is scheduled for once per week. R54 reports bariatric shower chair pinches skin and requests showers twice per week. R4 and R32 have long unkept fingernails. R4's toenails are thick, discolored and about 1/2 inch long. R4 states his toenails have not been trimmed since his admission (nearly 4 months). R4 and R32 require assistance with nailcare. R55 is not cleaned up thoroughly during cares, does not shower anymore due to getting caught in the shower chair. R19 had long facial hair R46 is not toileted per plan of care R1 nails were not trimmed This is evidenced by: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facilities Activities of Daily Living (ADLs), Supporting policy states, in part: Policy Statement- Residents will [sic] provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical conditions(s) demonstrate that diminishing ADLs are unavoidable . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems) .5. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS (Minimum Data Set). Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions: a. Independent- Resident completed activity with no help or staff oversight at any time during the last 7 days. b. Supervision- Oversight, encouragement or cueing provided 3 or more times during the last 7 days. c. Limited Assistance- Resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance 3 or more times during the last 7 days. d. Extensive Assistance- While resident performed part of activity over the last 7 days, staff provided weight-bearing support. e. Total Dependence- Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look-back period. 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The resident's response to interventions will be monitored, evaluated and revised as appropriate. Example 1 R366 was admitted to the facility on [DATE]. R366's most recent MDS dated [DATE], documents a score of 15 out of 15 on her BIMS which indicates that she is cognitively intact. R366 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R366's current Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . R366's care plan dated July 2022: Focus-I have ADL Self Care Performance Deficit. I will improve current level of function in Bed Mobility. Interventions- . Dressing/Hygiene: 1 assist .Transfer: Independent with FWW (Front Wheeled Walker) in room. (Note: Bathing is not found in the care plan). On 7/20/22 at 2:38 PM, Surveyor interviewed R366. Surveyor asked R336 how bathing and showering is going. R336 responded to the Surveyor stating she gets a shower every day and would like to do at least every other day. Surveyor asked R336 is she has asked for more showers, she replied she did and was told that that I can only have one shower per week because that is the state's requirement, that blows my mind. Example 2 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R54 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/13/22 indicates R54's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. R54 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] R54's current Physician order [MEDICAL RECORD OR PHYSICIAN ORDER] R54's care plan dated July 2022: Focus-Self care deficit r/t (related to) decreased mobility, generalized weakness. Goal- Increase in ability to perform ADL's. Interventions- Bathing: assist of 1 . Encourage resident to complete as many ADL's for self as is able .Personal Hygiene- assist of 1 . Toileting: independent with 2ww (2 wheeled walker) occasional urine incontinence, check for needs on rounds .Focus- The Resident is at risk/has potential for falls, accidents and incidents r/t deconditioning, generalized weakness, new environment. Goal-Injuries will be minimized through review date. Interventions- .Encourage resident to ask for assistance. On 7/20/22 at 2:27 PM, Surveyor interviewed R54. Surveyor asked R54 how the bathing and showering schedule is going. R54 replied that she gets a bath once per week and feels it should be twice per week. R54 elaborates that the shower schedule used to be twice per week, but I don't know if it was the state of Wisconsin that does once per week. R54 informed Surveyor that she has had a wound on her bottom that comes and goes. R54 reports that her skin gets caught in the shower chair and is worried about opening her wound again and she is not able to see it. On 7/27/22 at 10:00 AM, Surveyor interviewed CNA Z. Surveyor walked with CNA Z to the shower room. Surveyor asked CNA Z to demonstrate the process of how R54 takes a shower. CNA Z demonstrated and pointed to the bariatric shower chair, she reports that the hole in the shower chair can catch the skin and the skin sometimes get stuck when she is done showering in the chair to a standing position. On 7/27/22 at 9:30 PM, During an exit interview with NHA A (Nursing Home Administrator) and IDON B (Interim Director of Nursing), Surveyor explained R54's the skin getting caught in the shower chair and R55 has the same concern, NHA A reports they will look into that. Example 3 R4 was admitted to the facility 3/31/22 with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R4's Admission MDS (Minimum Data Set) notes a BIMS (Brief Interview of Mental Status) is 8/15, indicating he is mildly cognitively impaired. R4's Comprehensive Care Plan notes R4 is dependent on 1 staff for cares. On 7/20/22 at 3:37 PM, R4 asked Surveyor if somebody can cut his toenails. R4 added, he has asked five times for staff to cut his toenails and nobody does it. Surveyor asked R4 when is the last time his toenails were cut at the facility. R4 stated, not since I've been here. Note, R4 was admitted [DATE] (nearly 4 months ago). Surveyor noted R4's fingernails to be long and unkept. Surveyor asked R4 if he would like his fingernails trimmed. R4 stated, yes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/20/22 at 3:44 PM, Surveyor asked LPN BB (Licensed Practical Nurse) to come to R4's room and remove his socks. Surveyor observed R4's toenails to be thick, discolored, and about 1/2 an inch long. Surveyor asked LPN BB, do R4's nails need to be cut. LPN BB stated, Yes, I'm wondering if he might be on the list for Podiatry. LPN BB stated she would add him to the Podiatry list if he is not on there. Surveyor asked LPN BB to observe R4's fingernails. Surveyor asked LPN BB are R4's fingernails long and unkept. LPN BB stated, Yes. LPN BB stated she will take care of cutting his fingernails. On 7/26/22 at 1:58 PM, Surveyor spoke with IDON B (Interim Director of Nursing). The Podiatrist comes to the facility monthly, if we see a resident that needs that service we will add them to the list. IDON B stated she will check to confirm that R4 is on the Podiatry list to be seen. R4 was not on the Podiatry list to be seen since admission to the facility. The facility has no documentation that his toenails were trimmed since admission to the facility or when his fingernails were last trimmed. Example 4 R32 was admitted to the facility 5/18/21 with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R32's Quarterly MDS (Minimum Data Set) notes a BIMS (Brief Interview of Mental Status) is 13/15, indicating she is cognitively intact. R32's Comprehensive Care Plan notes R32 is dependent on 2 staff for cares. On 7/26/22 at 9:05 AM, Surveyor observed R32's fingernails to be long and unkept. Surveyor asked R32 if she would like her nails cut. R32 stated, Cut my fingernails! On 7/26/22 at 9:15 AM, Surveyor asked RN Y (Registered Nurse) to observe R32's fingernails and asked it they are long and need to be trimmed. RN Y stated yes, R32's fingernails are long and he will trim them today. The facility does not have documentation of the last time R32's fingernails were trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/22 at 5:37 PM, Surveyor spoke with IDON B regarding ADL (Activities of Daily Living) Care. Surveyor asked IDON B, when are residents' fingernails and toenails trimmed. IDON B stated, if a resident is not diabetic the CNAs will trim their nails. IDON B stated, if a resident is diabetic the nurse will trim their nails. IDON B stated, if a resident has thick toenails they should be referred to Podiatry. IDON B stated, she would not expect staff to attempt to trim thick fingernails or toenails. Surveyor asked IDON B, how often should residents nails be trimmed. IDON B stated, I don't think we have a set scheduled, I would usually ask the resident if they would like their nails trimmed. IDON B stated, some ladies like them longer and painted. If they prefer to have them trimmed, I am more than willing to trim their nails. IDON B stated, usually they look at residents' nails on shower day to see if they are in need of being trimmed. Surveyor asked IDON B, would you expect nails to be trimmed on a regular basis and to be well groomed. IDON B stated, yes. Surveyor asked IDON B, would you expect residents with thick toenails to be on the Podiatry list and be seen monthly. IDON B stated, yes. Surveyor asked IDON B, is it acceptable for a resident to go 4 months without having toenails trimmed. IDON B stated, we should have put R4 on the Podiatry list right away and made sure it was done. IDON B stated, resident fingernails and toenails need to be trimmed on a regular basis. IDON B agreed that R4 and R32 should have nails that are trimmed and neatly groom. The facility does not have a system in place to ensure that residents are receiving nail care timely. The facility is not documenting routine nail care aside from Podiatry. Example 5 R55 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/14/22 indicates R55's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 14 out of 15. R55 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] R55's current Physician Orders: Surveyor unable to locate a bathing order, Surveyor asked for orders and no bathing order was provided. R55's current Care plan dated July 2022: ADL: At risk for decrease in ability to perform own ADL's r/t recent hospitalization and increased weakness. Goal- Will be more independent in bathing, dressing, grooming, bed mobility, transfers and ambulation/locomotion by discharge date . Interventions- . Ambulation-no at this time, Bathing- total assist . Dressing- max assist . Toilet use- urinal, bedpan, or hoyer 2 assist to commode. Continent of bowel and mixed continence of bladder. Transfers-hoyer assist of 2. On 7/21/22 at 9:36 AM Surveyor interviewed R55. Surveyor asked R55 how the bathing and showering is going. R55 reports there are only about 4 girls here that clean me up. Surveyor asked R55 how he showers, he replied that he does not take a shower anymore in the shower chair because my butt cheek got caught in the middle seat, so I do a bed bath. Surveyor asked if he has informed any staff, he said he informed PTA GG (Physical Therapy Assistant). On 7/26/22 at 10:30 AM, Surveyor interviewed R55 and PTA GG. Surveyor acknowledged a grievance has been initiated. R55 reviewed with PTA GG about not getting cleaned up after cares. R55 reports that it happened again last night. R55 reports he does not know how well he is cleaned up until the next staff comes in and lets him know he was not cleaned up. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 6 R19 admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R19's most recent MDS completed on 5/9/22 shows that R19 has a BIMS (Brief Interview of Mental Status) of 10/15, indicating that R19's cognitive status is moderately impaired. The MDS also indicates the R19 requires extensive assist from staff for personal hygiene. On 7/21/22 at 11:15 AM Surveyor observed R19 sitting in the dining room coloring a picture. Surveyor observed that R19 had long whiskers on his face, approximately - inch long. Surveyor asked R19 if he liked his long whiskers, R19 stated no, I hate it. On 7/25/22 at 2:49 PM Surveyor observed R19, long whisker stubble still on his face. R19's care plan dated 10/26/21 states in part, Focus ADL (Activities of Daily Living) .Interventions .Hygiene-set up cues and assist of 1 as needed . R19's CNA (Certified Nursing Assistant) Kardex states the same as the care plan; neither document states if or how often R19 should be shaved. On 7/27/22 at 9:25 AM Surveyor interviewed CNA I (Certified Nursing Assistant). Surveyor asked CNA I how often the residents get shaved, CNA I stated that they should be shaved weekly, but it depends on how fast the beards grow. Surveyor asked CNA I if R19 gets shaved weekly, CNA I stated yes and that another CNA works on making sure that everyone gets shaved. Surveyor asked CNA I if she notices that whiskers are getting long, would she then shave the resident, CNA I stated yes. On 7/27/22 at 9:32 AM Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B what her expectations were for shaving men, IDON B stated that it should be done according to the resident's preference and is part of their ADLs. Surveyor asked IDON B to review the Kardex for R19 as it does not indicate a resident preference or a frequency for shaving, IDON B stated that they will have to look into that. It is important to note that there is no documentation of R19 getting shaved on a regular schedule. Example 7 R46 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R46's most recent MDS completed on 6/10/22 shows that R46 has a BIMS of 00/10, indicating that R46 is severely cognitively impaired. The MDS also indicated that R46 requires extensive assist for toileting and personal hygiene, and that R46 is frequently incontinent of urine. On 7/20/22 at 2:36 PM Surveyor interviewed FM II (Family Member). Surveyor asked FM II how things were going in the facility and if she had any concerns, FM II reported to Surveyor that things have been getting better, in regard to R46's care, but she is still concerned that staff is not changing R46's depends and toileting her. R46's care plan initiated on 5/28/22 states in part, Focus: The resident has an ADL self-care deficit r/t Activity intolerance, [CONDITION(S)], Impaired balance, Stroke .Interventions: .Toilet use: mixed continence, toilet before and after meals, check for needs on rounds at night and PRN (as needed) . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed CNA documentation for the last 30 days. The CNA documentation shows that R46 was toileted/ incontinence cares were provided on the following days and times: 6/27/22: incontinent at 3:55 AM and 8:16 PM 6/28/22: incontinent at 1:17 PM 6/29/22: 2:44 AM, 12:39 PM, and 9:59 PM 6/30/22: 12:57 AM, 11:40 AM, and 9:59 PM 7/1/22: 1:07 AM and 9:59 PM 7/2/22: 10:46 AM and 8:33 PM 7/3/22: 11:03 AM and 7:27 PM 7/4/22: 5:59 AM (documented as not applicable), 10:17 AM, 7:06 PM 7/5/22: 3:12 AM, 1:59 PM, and 5:53 PM 7/6/22: 5:32 AM, 12:50 PM, 13:49 PM, 6:42 PM, and 9:52 PM (documented as refused) 7/7/22: 12:24 AM, 12:15 PM, and 9:53 PM 7/8/22: 9:54 AM and 7:49 PM 7/9/22: 9:57 AM and 8:00 PM 7/10/22: 12:21 PM and 6:23 PM 7/11/22: 1:00 PM and 8:22 PM 7/12/22: 1:01 PM and 6:25 PM 7/13/22: 1:23 AM, 1:13 PM, and 7:43 PM 7/14/22: 2:03 AM, 11:24 AM, and 9:47 PM 7/15/22: 4:29 AM, 1:50 PM, and 8:13 PM 7/16/22: 1:55 PM and 8:55 PM 7/17/22: 7:34 AM and 9:38 PM 7/18/22: 3:15 AM, 9:10 AM, 12:54 PM, and 7:49 PM 7/19/22: 2:09 AM, 1:59 PM, and 9:29 PM (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/20/22: 2:18 AM, 12:51 PM, 8:36 PM, and 11:21 PM 7/21/22: 11:03 AM 7/22/22: 12:23 AM and 8:01 PM 7/23/22: 1:33 AM, 1:32 PM, and 6:14 PM 7/24/22: 2:49 AM, 1:34 PM, and 8:23 PM 7/25/22: 12:51 AM and 3:12 PM 7/26/22: 1:42 AM and 1:51 PM On 7/27/22 at 9:25 AM Surveyor interviewed CNA I. Surveyor asked CNA I what the toileting schedule is for residents, CNA I stated that residents are toileted before breakfast, some are toileted before lunch, and they usually toilet residents every 2 hours. Surveyor asked CNA I how often R46 gets toileted, CNA I stated that R46 is supposed to be toileted every 2 hours, but sometimes she refuses and that R46 has to be really wet and then she will let you. Surveyor asked CNA I if staff document R46's refusals, CNA I stated yes. It is important to note that in the last 30 days of documentation, there is only 1 refusal documented. On 7/27/22 at 9:32 AM Surveyor interviewed IDON B. Surveyor asked IDON B what her expectation were for toileting residents, IDON B stated that it depends on the resident's Kardex. Surveyor asked IDON B if staff should be documenting when they toilet a resident, IDON B stated yes. Surveyor asked if staff should be documenting resident refusals, IDON B stated yes. Example 8 R1 was admitted to the facility on [DATE] and has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R1's Admission MDS (Minimum Data Set) Assessment, dated 7/8/22, indicated R1 has a BIMS (Brief Interview of Mental Status) score of 8 indicating R1 has a severe cognitive impairment. R1's Care Plan, dated 7/04/22, with a target date of 7/20/22, states, in part: . Focus: I have an ADL Self Care Performance Deficit r/t (related to) pain and deconditioning .Interventions: Oral Cares: set up and assist as needed with AM and HS (hour of sleep) oral hygiene .Toilet Use: 1 assist with walker to toilet, uses urinal at bedside, staff assist with emptying .Dressing/Hygiene 1 assist . On 7/18/22, at 2:52 PM, Surveyor interviewed R1. R1 indicated his nails need clipping. R1 showed Surveyor both hands. Surveyor observed nails are long on both hands and in need of clipping. On 7/18/22, at 3:49 PM, Surveyor interviewed CNA RR and asked him if R1's nails need to be clipped. CNA RR looked at R1's nails and indicated yes. CNA RR retrieved a nail clipper and clipped R1's nails.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** Based on interview and record review, the facility did not ensure each resident's Advance Directive Preferences, including DNR (Do Not Resuscitate), were signed by the resident's physician for 1 of 21 sampled residents (R19). R19 did not have a signed physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] This is evidenced by: Facility policy titled Do Not Resuscitate Order, reviewed ,d+[DATE] states in part, 1. Do not resuscitate orders must be signed by the resident's Attending Physician on the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . 2. A Do Not Resuscitate (DNR) order form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by state law) and placed in the front of the resident's medical record . Example 1 R19 admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R19's most recent MDS completed on [DATE] shows that R19 has a BIMS (Brief Interview of Mental Status) of , d+[DATE], indicating that R19's cognitive status is moderately impaired. R19 has an activated Health Care Power of Attorney (HCPOA). R19's care plan entry dated [DATE] indicates that R19 and/ or his Power of Attorney have elected for R19 to remain a Full Code and to receive CPR (Cardio-Pulmonary Resuscitation) in the event that his heart stops. R19 also has a care plan entry dated [DATE] stating R19 and/ or responsible party have elected DNR . On [DATE] at 10:30 Am, Surveyor reviewed R19's Electronic Health Record (EHR). R19's EHR stated that R19 was a DNR. Surveyor then reviewed R19's hard chart. R19's hard chart had a document titled CPR Preference in it indicating that R19 was a Full Code. On [DATE] at 8:09 AM Surveyor interviewed LPNM F (LPN Manager). Surveyor asked LPNM F who is responsible for updating code status in resident's charts, LPNM F stated that the nurse working the floor is responsible to get the process started. Surveyor asked LPNM F what the process for changing code status, LPNM F stated that the physician should be notified, the nurse should fill out a new form, and the IDT (Interdisciplinary Team) should be updated. Surveyor asked LPNM F about R19. Surveyor stated that R19's EHR and updated care plan state DNR, but the form in his hard chart indicates full code, Surveyor asked LPNM F if the facility has a signed physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . LPNM F stated that she would look and get back to Surveyor. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:42 AM Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is when a resident changes their code status, DON B stated that it should be entered into the resident's EHR (Electronic Health Record). Surveyor asked DON B when would you expect the physician be notified, DON B reported that typically the physicians are the ones that send the facility a new, signed order. Surveyor asked DON B if she would expect that information regarding a change in code status to be documented, DON B stated yes, she would expect that information to be documented. Surveyor asked DON B if the facility should have a signed physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE] at 1:00 PM Surveyor met with LPNM F. LPNM F provided Surveyor with a CPR preference form signed by R10's POA dated [DATE]. Surveyor asked LPNM F if she was able to find the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] .

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review the facility failed to ensure a qualified activity professional was hired to direct the activities program and to meet the activity needs of residents. This had the potential to affect more than a limited number of residents in the home. The facility's AD E (Activities Director) is not a qualified therapeutic recreation specialist and does not meet the qualifications required to direct the activities program. The facility's AD position has been vacant from February 2022, AD E was placed in the role of AD in April 2022. Evidenced by: Review of the Activity's Director's undated Job Description stated, in part: The primary purpose of your position is to plan, organize, develop, and direct the overall operations of the Activity Department in accordance with current federal, state, and local standards, guideline, and regulations, our established policies and procedures, and as may be directed by the Administrator, and/or the Activity Consultant, to assure that an on-going program of activities is designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident . Qualifications: Must possess, as a minimum, two (2) years of college. Degree preferred by not necessary. Must be qualified therapeutic recreation specialist or an activities professional who is licensed by this state and is eligible for certification as a recreation specialist or as an activities professional; or Must have, as a minimum, two (2) years experience in a social or recreation program within the last five (5) years, on (1) of which was full-time in a patient activities program in a health care setting; or Must be a qualified occupational therapist or occupational therapy assistant; or Must have completed a training course approved by this state. On 7/26/22 at 12:46 PM, Surveyor interviewed AD E. Surveyor asked AD E his job history and education history. AD E replied he has worked at the facility for about 3 years, starting as a dietary aide then an activity assistant, then started filling the role in April 2022 as the Activity Director. Surveyor asked AD E if he has had any formal training or certifications, he replied no. Surveyor asked AD E to describe his duties. AD E replied that he makes the calendars, does daily postings, performs 2 groups per day one in the morning and one in the afternoon, pass out snacks on Friday during socials, passes out menus and helps the residents fill them out, all the charting for activities. Surveyor asked AD E if he assesses for admissions, he replied that he does reassessments and stated, like quarterly assessments, like a change in behavior to keep track if this is permanent or temporary, tries to attend care plans but will prioritize an activity over attending care plans. AD E reports he likes to assess the residents needs, to get to know them, find out what they enjoy and put them into categories and subcategories of what the residents like to do. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/27/22 at 9:46 AM, Surveyor interviewed INHA A (Interim Nursing Home Administrator). Surveyor asked INHA A if there was any certification or training for AD E. INHA A stated, I believe there is some certification required, we are aware, we are looking for courses for him. Surveyor asked INHA A how long the AD position has been vacant, INHA A replied about 60 days maybe.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide care and treatment in accordance with professional standards of practice related to assessment and monitoring for change in condition for 3 residents (R117, R118, R45) reviewed for change of condition out of a total of 21 sampled residents. R117's physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . R118 was not assessed after a [CONDITION(S)] resulting in a fall. R118 had a second [CONDITION(S)] with signifcant injury. R45 had [CONDITION(S)] activity 11 days prior to admission to the facility, the facility failed to implement at risk interventions upon admission. R45 had [CONDITION(S)] activity in the facility, the facility failed to confirm notification resulting in failure for further treatment or diagnostic testing for standards of practice, to allow for clinical interventions and any care plan implementations. R45 had another [CONDITION(S)]. The Nurse Practitioner could not confirm a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . This is evidenced by: Example 1 R117 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] R117's MDS (Minimum Data Set) was not completed. R117 is his own person. R117's hospital discharge orders, signed [DATE], including the following: [CONDITION(S)] (Continuous Positive Airway Pressure) release to patient: Immediate. Settings: As at home; Equipment: Home; [CONDITION(S)] Level: 11; Bleed in oxygen (LPM): 1L; Full mask, Size large; Use at night and when napping; Oxygen administration Mode: Nasal Cannula; Flow: (LPM only): 1; Titrate/Maintain O2 sat equal or great than 88%; Maintain O2 sat less than 94%; Titrate oxygen per facility policy, procedure, or guidelines. Order for DME (Durable Medical Equipment) - Complete as directed Patient transferring care to [provider name] for [CONDITION(S)] and will need all related [CONDITION(S)] supplies. Specify Length of Need: Lifetime Specify Type of Device: Auto [CONDITION(S)] Humidification: Heated Humidifier (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Supplies Needed: Filter (2 per mo.-month), nondisposable filter (1 per 6 mo.), water chamber (1 per 6 mo.), headgear (1 per 6 mo.) Mask Type: Mask of patient preference On [DATE] at 8:12 PM R117's progress notes document the following: Type: Change of Condition What is the resident exhibiting: C/O (complaining of) SOB (shortness of breath), visibly lethargic, spitting pink frothy sputum. Describe current condition and your assessment: Residents' [sic] daughter asked writer what needs to be done to send resident out. Resident seemed tired, spitting up pink frothy sputum, and belly breathing. Vital Signs: Temperature 97.9, Oxygen ,d+[DATE] (NC) (Nasal Cannula), Blood Pressure ,d+[DATE], Pulse: 79, Respirations: 16 Physician and Family notification and response: Daughter was present and requested resident to be sent out, on call Physician gave permission to send resident out. New orders or interventions put into place: No new orders at this time, DON (Director of Nursing) made aware of change in condition, resident sent to ER (emergency room). R117 Hospital Stay: Admit [DATE] and discharged [DATE] R117's hospital information includes the following: Arrival Date/Time: [DATE] 8:35 PM Admission Type: Emergency Means of Arrival: Ambulance Admission Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] Chief Complaint: This patient is a [AGE] year-old male with a history of CHF (Congestive Heart Failure), vocal cord paralysis, aortic valve replacement, [CONDITION(S)] (Chronic Obstructive Pulmonary Disease) and normally on 3L (liters) of oxygen by nasal cannula who presents to the emergency department with increased shortness of breath and generalize weakness. He lives at a local nursing home and staff is concerned that he see [sic] more lethargic today. EMS (Emergency Medical Services) was called, and patient was transported to the emergency department. Oxygen saturation was 100% on his normal 3L of oxygen by nasal cannula. He has a wet sounding cough. Patient otherwise is a poor historian but able to answer yes/no questions. He denies chest pain, abdominal pain. No nausea or vomiting. He has chronic leg swelling which is unchanged. No documented fevers. Lab results reviewed. On recheck, patient remains drowsy, somnolent. Family member is in the room here and states that this is a big change from his normal mentation. Oxygen saturation remains 100% on his normal 3L. However, he does have a lot of gurgling sounds and frequent coughing. Assessment and Plan (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Clinical Impressions: [CONDITION(S)], Dyspnea R117 was treated with IV [MEDICATION(S)] 80 mg (milligrams) and initiation of [CONDITION(S)]. Primary Discharge Diagnoses: [MEDICAL RECORD OR PHYSICIAN ORDER] 1. Acute on chronic HFrEF (Heart Failure with Reduced Ejection Fraction) 2. Acute on chronic hypoxic and hypercarbic resp (respiratory) failure 3. [CONDITION(S)] (Chronic Obstructive Pulmonary Disease) 4. Bronchiectasis 5. CAD ([CONDITION(S)]) 6. [CONDITION(S)] 7. s/p (status post [MEDICAL RECORD OR PHYSICIAN ORDER] 8. CKD (chronic kidney disease) Stage IV (4) 9. Secondary [CONDITION(S)] 10. [CONDITION(S)] 11. DM type II (Diabetes Mellitus Type 2) R117's hospital report documents, in part, the following: .During a prior hospitalization he was on PAP therapy but while at the nursing home some preliminary reports state he has not been on such as initial reports from patient's family member state he has not been on [CONDITION(S)] or [CONDITION(S)]. There are reports that his previous home [CONDITION(S)] machine was 9 years old and covered in mold and thus unusable. (Note, at R117's discharge on [DATE], the hospital ordered the [CONDITION(S)] and all needed parts.) On [DATE] at 5:41 AM, R117's the facility's progress notes document the following: Resident admitted to hospital for Altered mental status, SOB (shortness of breath) and difficulty breathing. Resident put on [CONDITION(S)] (Bilevel Positive Airway Pressure). Hospital nurse states there will be testing done later today, further update will be available then. On [DATE], R117's Discharge Summary includes, in part, the following: Acute on Chronic Hypoxic Hypercarbic Respiratory Failure, [CONDITION(S)] and bronchiectasis: On 2L O2 (oxygen) via nasal cannula at baseline; required [CONDITION(S)] with up to 35% FiO2 (fraction of inspired oxygen). Based on his last admission and work up done, he qualified for a [CONDITION(S)] machine. However, unfortunately, he was not able to get one after his discharge from the SNF (Skilled Nursing Facility). His case was discussed again with his primary pulmonologist, and it was advised that he needs his [CONDITION(S)] machine to keep him stable at home and prevent frequent hospitalization . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The hospital report documents the following: Writer met with R117's family member in patient's room to discuss discharge planning. Last hospitalization patient discharged to the facility and family member will not allow patient to return there due to the care he received. R117 did not return to the facility. The facility submitted a self-report to the State Agency with the following information: Date occurred: [DATE] Date discovered [DATE] Describe the incident: Significant medication error regarding the [sic] an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . Describe the effect that the incident had on the affected person: none known (Note, R117 was hospitalized for 11 days.) Explain what steps the entity took upon learning of the incident to protect the affected person(s) and other from further potential misconduct: See attached summary Summary of Investigation: On [DATE], R117 was admitted to the facility after hospital stay. R117 was admitted with orders for a [CONDITION(S)] to be worn at night. R117's orders were transcribed and faxed over to the Pharmacy. The order for [CONDITION(S)] was omitted. R117's family member was informed of the omitted [CONDITION(S)] order. Resident's family member states she called the facility after resident was admitted and spoke with a nurse, but resident's family member was not able to identify who she spoke with. Family member stated she told the nurse that resident's personal [CONDITION(S)] is moldy and that we need to order one for R117. (Note, there was an admission order for a new [CONDITION(S)] and all needed parts.) Summary: The Regional Consultants were notified of the transcription error by R117's Case Manager. Investigation into error was immediately initiated and a 24-hour self-report to Wisconsin DHS (Department of Health Services) was submitted. Investigation revealed that R117 was admitted to the facility [DATE], after a hospital stay. R117's orders were transcribed and sent to pharmacy. The order for the [CONDITION(S)] was not transcribed and resident was without the [CONDITION(S)] for 6 days. R117's admission orders [MEDICAL RECORD OR PHYSICIAN ORDER] . During the investigation, it was discovered that the family's Admission Department was informed that R117's family member was going to deliver the [CONDITION(S)] to the facility for resident's use. R117 was monitored daily and was stable throughout his stay. (Note, R117 was not stable throughout his stay and was hospitalized for 11 days.) On [DATE], R117 had a change in his respiratory status and was sent to the hospital and admitted with respiratory failure. Conclusion: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The resident was admitted to the facility after hospital stay with an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The [CONDITION(S)] order was not transcribed d/t (due to) being omitted by both the nurse entering orders and 2nd nurse checking orders for accuracy. The nurse the family member spoke with was never identified. R117 was monitored during his stay and was stable from ,d+[DATE]-[DATE]. He had no c/o (complaint of) SOB (shortness of breath) and did not exhibit any outward s/s (signs and symptoms) of respiratory distress. On [DATE], when R117 was exhibiting s/s respiratory distress, the MD (Medical Doctor) was called, and orders received to send resident to the hospital. Resident's family member was present. The facility believes that although there was an omission in transcribing the [CONDITION(S)] order, there was no intent to cause harm to the resident. Steps take to prevent reoccurrence: Education was provided to two staff members involved (1 no longer is employed at the facility) and to DOM W (Director of Marketing) regarding checking orders thoroughly and informing nursing management of needed equipment/devices for new residents. On [DATE] at 1:47 PM, Surveyor spoke with VPO G (Vice President of Operations) regarding this self-report. Surveyor asked VPO G, do you expect staff to follow Physician orders. VPO G stated, Yes. Surveyor stated, R117 had an order a [CONDITION(S)] on admission that was not provided to him. Surveyor asked VPO G, would you expect staff to provide the ordered [CONDITION(S)]. VPO G stated, Yes. Surveyor asked VPO G, did R117 have a [CONDITION(S)] for the 7 days he was at the facility. VPO G stated, No. Surveyor reviewed training documentation for the two (2) staff members involved in this error, DOM W (Director of Marketing) and an RN (Registered Nurse) that is no longer employed at the facility. Surveyor asked VPO G, did you educate all staff. VPO G stated, there was a root cause analysis and R117's [CONDITION(S)] order was not transcribed. When our fairly new employee, DOM W, was told from somebody at the hospital that the resident would be coming with the [CONDITION(S)]. DOM W didn't put that in as something he needed. VPO G stated, We didn't order the ([CONDITION(S)]) and we didn't confirm. VPO G stated, DOM W didn't verify information for admission, and we didn't validate. VPO G stated, the family said he had one but it's molded, that's where the education started, with DME (Durable Medical Equipment) and new admissions. We educated the nursing staff (Note, there is no documentation of this). VPO G stated she does not know where the education sign in sheet is for this training. VPO G stated, those people that are no longer here hold the secrets to where things went. VPO G stated, it is her expectation that all elements of an investigation and training will be kept together and accessible. VPO G stated the facility looked at other residents with CPAPs and ensured they are in functioning order (Note, there is no documentation of this). VPO G stated, we also had the oxygen company come and look at all of our CPAPs (Note, there is no documentation of this). Surveyor asked VPO G, should R117 have had his [CONDITION(S)] while he was at the facility. VPO G stated, Yes. Note, there is no evidence that the facility educated all staff, interviewed other residents with CPAPs, conducted a sweep of the building for other residents with CPAPs to ensure they are in place and orders are being followed. Example 2 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility did not follow DOT OO's (Director of Therapy) recommendation, dated [DATE], Supervision recommended when outside of room - tends to wander and is impulsive. R118 has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE] R118 had two (2) seizures with subsequent falls. The first [CONDITION(S)]/fall occurred at 7:30 AM. The facility did not obtain vitals, complete an assessment, nor monitor R118. R118's second [CONDITION(S)] occurred at approximately 3:00 PM (during shift change). During R118's second [CONDITION(S)]/fall, DOT OO was walking down the hall when he observed R118 falling forward right before hitting the floor. DOT OO reported to Surveyor that no staff were with R118 at the time of his [CONDITION(S)]/fall. Facility staff moved R118 and never consulted with his Physician. R118's APOAHC (Activated Power of Attorney for Health Care) initially told staff to not send R118 to the ED. Staff report to Surveyor they were unable to control R118's bleeding. Approximately two hours later, a family member at the facility took pictures of R118 and sent them to R118's APOAHC. The APOAHC then notified the facility to call 911 and send R118 to the ED (Emergency Department). R118 was admitted to the hospital where with life-threatening injuries including: [NAME] I and II (two facial fractures), SAH (Subarachnoid Hemorrhage), and C7 fracture (7th cervical spinal vertebra). R118 passed away at the hospital on [DATE]. R118 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R118's Admission MDS (Minimum Data Set) dated [DATE] indicates R118 has a BIMS (Brief Interview of Mental Status) of a 5 out of 15, which indicates he is severely cognitively impaired. Section G indicates that R118 is independent for walking in the corridor, locomotion on the unit, supervision and 1 staff assist with transferring. (Note, R1 was independent with transfers at the time of his seizures/falls.) On [DATE] a PTA (Physical Therapy Assistant) documents R118's transfer status as Independent and Assistive Device None. On [DATE] DOT OO (Director of Therapy) documented an Admission Functional Status Form that indicated R118's Transfer Status is Independent, Assistive Devices: None, and Special Instructions Supervision recommended when outside of room - tends to wander and is impulsive. Refuses FWW (four wheeled walker). (Note, the facility did not implement Therapy's safety recommendation.) R118's Comprehensive Care Plan indicates the following focus area: (Date Initiated: [DATE], Date Revised: [DATE]) R118 is at risk/has potential for falls, accidents and incidents r/t (related to deconditioning, generalized weakness, seizures. Resident is able to place self on the floor safely and is able to get off floor safely, however this does increase risk of falls. Goals: Injuries will be minimized through review date. Interventions: Update MD PRN (Medical Doctor as needed). ([DATE]) Follow therapy recommendations for transfers and mobility. Note, R118's last witnessed and documented [CONDITION(S)] is [DATE]. On [DATE] R118 had two (2) seizures with subsequent falls. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	(Note, this is a late entry for a fall that occurred on [DATE] at 7:30 AM.) On [DATE] at 11:21 PM, R118's Progress Notes indicates the following: R118 observed by staff in hallway conversating with another resident when he leaned back and hit his upper back/shoulder area against the wall. Resident then slightly leaned forward and went onto the floor on his butt. When staff member got closer to resident, he was actively having a [CONDITION(S)]. Seizing lasted about 3 minutes, then another 3 minutes in the post-ictal stage, prn (as needed) [MEDICATION(S)] was administered. Resident was agitated after [CONDITION(S)] and repeating tour. hospice updated and APOAHC (Activated Power of Attorney for Healthcare). Of note, the physician was not updated regarding the [CONDITION(S)] and there is no evidence the facility completed a thorough assessment or continued assessments for R118 post [CONDITION(S)]. Subsequently, R118 had another [CONDITION(S)] resulting in signifciant injury. The Fall Report documents the following: Date: [DATE] at 7:30 AM - Same description as above Immediate Action Taken: hospice updated and came to see resident (Note, the hospice nurse did not arrive until R118 was being sent out nearly 2 hours after the 2nd fall at approximately 5:00 PM.) Resident Taken to Hospital: No Level of Pain: 0 Mental Status: Oriented to person Level of Consciousness: Alert Mobility: Ambulatory without assistance Predisposing Environmental Factors: None Predisposing Situation Factors: Ambulating without assist Witness (and writer): No longer employed at facility Agencies/People Notified: Hospice [DATE] at 7:30 AM, Family Member (APOAHC) [DATE] at 11:30 PM (Note, this is a late entry for a fall that occurred on [DATE] around 3:00 PM.) On [DATE] at 6:28 PM, R118's Progress Note indicates the following: Found resident face down on the floor and had [CONDITION(S)] in hallway near nurses station. [CONDITION(S)] lasted for 5 mins (minutes)/assisted R118 to lying position on his side. Resident was bleeding from nose, face, nose swollen and bruises on face. Called hospice, notified on unable to stop bleeding and need of resident to send to hospital/will send nurse ASAP (as soon as possible) to do evaluation for resident per hospice triage nurse. Called resident's APOAHC (Activated Power of Attorney for Health Care), APOAHC said resident's family member is coming to see resident and hospice will come an evaluate resident and do not want resident to send to hospital for evaluation. Res (resident) was bleeding from face, combative with staffs [sic], refusing to do vitals, assessments or take any meds (medication). Received call back from APOAHC at 4:45 PM and APOAHC stated that she wants the resident sent to the hospital for evaluation after a second family member was in the building (family member sent pictures to APOAHC). Called 911 send resident to hospital for evaluation. Hospice nurse was at facility when 911 paramedic took resident to hospital/will update APOAHC per hospice nurse. DON (Director of Nursing) was with writer when res was found on the floor and paramedic took resident to hospital for evaluation. Of note, despite residents significant (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R118's hospital reports documents the following: First documented care in emergency room : [DATE] 5:47 PM admitting diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] Steps to Achieve Goals: Provide supportive care, Pain management Goal review with: Patient and family Admitting Service: Palliative care Brief Summary: R118 is a 73 y/o (year old) man with hx (history) of dementia, [CONDITION(S)], presenting after having a [CONDITION(S)], fall [NAME] I and II (two facial fractures), SAH (Subarachnoid Hemorrhage), and C7 fracture (7th cervical spinal vertebra). C-collar overnight. No invasive cares. Sonorous respirations. Rescinded hospice for trauma eval (evaluation). Talk to trauma/palliative regarding any acute changes. Patient had interim discussions with trauma and palliative and ultimately was admitted to the palliative care service. Code Status: DNR/DNI (Do not Resuscitate/Do not intubate) .While in the ER he experienced 2 subsequent seizures and received 1 mg IV [MEDICATION(S)]. .Briefly R118 was admitted after a fall with facial fractures and found (SAH) (Subarachnoid Hemorrhage), with goals discussed to pursue comfort care. He died [DATE] and was pronounced deceased at 3:44 AM. Surveyor reviewed the facility's self-report. On [DATE] at 6:09 PM, Surveyor spoke with DOM W (Director of Marketing). Surveyor asked DOM W to share with Surveyor what she witnessed the on [DATE] regarding R118. DOM W stated, we were walking from a meeting (later afternoon) a couple colleagues and a couple colleagues and myself saw R118 walking that way. R118 had fallen right onto his face and may have hit the door on the way down. DOM W stated, we immediately went to help him. DOT OO (Director of Therapy) and a CNA (Certified Nursing Assistant) and possibly an RN (Registered Nurse) jumped in to help. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 7:49 AM and 8:57 AM, Surveyor spoke with DOT OO (Director of Therapy). DOT OO stated, he was walking down the hall and heard a noise. DOT OO stated, he saw R118 starting to fall, and he was really close to the ground. DOT OO stated, people gathered to the area. DOT OO stated, R118 was face down with a lot of blood, a pool of blood essentially. DOT OO stated, R118 was basically breathing in blood, there was a gargling sound because his nose and mouth was completely into the ground. DOT OO stated he asked staff to call an ambulance. DOT OO stated, as that gargling action was worse it sounded like he was having a lot of trouble breathing, it was very gargled. DOT OO stated, since he was face down his neck was supported just enough to open his airway, R118 was still having a [CONDITION(S)] but a lot of blood came out of his mouth, and he was able to settle and come out of [CONDITION(S)]. DOT OO stated, we were keeping him positioned like that until the ambulance came. As we were waiting for 911, we were told the POA (Power of Attorney) wanted him to stay in the building. At that point he's in a resting position and started coming out of [CONDITION(S)] (reaching out and kicking trying to get himself up). This was after we were told he was not going out per his POA. Staff were cleaning the blood from his face with warm compresses and trying to stop the bleeding. Staff then transferred R118 to a wheelchair and took him back down to his room. While R118 was on the floor, CNA/Med Tech L (CNA) was wiping R118's face and getting him cleaned up, we were figuring out what the next steps were going to be. The previous DON was present and contacted the family. DOT OO stated the floor nurse may have been there too. DOT OO stated R118 was not sent out until his family member came to the facility and saw him and wanted him to be sent out. DOT OO stated, sometime earlier that same day, between 7:00 AM and 9:00 AM, R118 had a [CONDITION(S)] and ending up on the ground in a sitting position. DOT OO stated the second [CONDITION(S)]/fall was after 3:00 PM. DOT OO stated, R118 was somebody who could walk but was impulsive and would try to get up. DOT OO stated R118 was turned so he could breathe. Surveyor asked DOT OO regarding his assessment on [DATE]. DOT OO stated, Therapy gives recommendations and it's up to Nursing whether they accept (and implement) them. DOT OO stated, that R118 would throw the four wheeled walker that he used to have at the facility. DOT OO stated, R118 was not an assistive device kind of guy, and the walker was more of a detriment to him. DOT OO stated, no staff or other residents were with R118 at the time of his second [CONDITION(S)]/fall that DOT OO witnessed. On [DATE] at 8:40 AM, Surveyor left a message for the RN Q (Registered Nurse) who was on duty at the time of R118's fall. RN Q did not return Surveyor's call. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:41 AM, Surveyor spoke with CNA/MT L (CNA/Medication Technician). CNA L stated, she was in the nurses station getting report when she heard a loud thump. CNA L stated, she got up and ran out to the hall. CNA L stated, R118 was face down and somebody (staff) was by him (she cannot recall who). CNA L stated she does recall that DOT OO, DOM W and RN Q were by R118. CNA L stated, R118 was seizing, and she recalls telling DOT OO he needs to be on his side. CNA L stated, we could see blood and he was still in the middle of a [CONDITION(S)], but he was right in the doorway (just past Therapy and approaching the nurses station). CNA L stated, he fell in the middle of the double doors. Surveyor asked CNA L were there any residents around him at the time. CNA L stated, it was about 3:00 PM so everybody was out. Surveyor asked CNA L, is there any indication that another resident may have hurt or pushed him. CNA L stated, No, no. CNA L stated she has dealt with R118 having a [CONDITION(S)] previously. CNA L stated, R118 goes into fight or flight. CNA L stated, when R118 was coming out of the [CONDITION(S)] he was trying to hit us and when he went to get up, he couldn't get up by himself, so we got him a wheelchair. CNA L stated, R118 doesn't use a wheelchair he walks. CNA L added, we got wheelchair and convinced him to sit down. CNA L stated once he was in the chair staff needed to get him out of everybody's view. CNA L wheeled him into his room in the wheelchair. CNA L stated hospice and family were called immediately before he got up off floor. (Note, there was no Physician notification). CNA L stated, when family member came in to visit R118 and sent pictures to his APOAHC, at that point R118;s APOAHC stated to send him to the ED. CNA L stated, that was, two hours later. CNA L stated, by this time R118 was still bleeding from his nose and we couldn't get the bleeding to stop. CNA L stated, one of his eyes (cannot recall which) was swollen. Surveyor asked CNA L, how many people was R118 care planned to assist him when walking. CNA L stated, R118 was independent. CNA L stated, you could try to help R118, but he was set in his ways and wouldn't accept help. CNA L stated, he was care planned to be independent walking. That day there was staff walking with him. Had people with him that day, it was at shift change. CNA L stated, we did try to keep staff with him. (Note, per interview with DOT OO (above), R118 was walking independently at the time of his fall and no staff were with him.) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:49 AM, Surveyor spoke with VPO G (Vice President of Operations) and INHA A (Interim Nursing Home Administrator). Surveyor asked VPO G, was the Therapy recommendation Supervision recommended when outside of room - tends to wander and is impulsive. Refuses FWW (four wheeled walker). VPO G stated, They're just that, recommendations, some recommendations we get don't add up to care we can provide. VPO G stated, we discontinued R118's walker as it was more of a threat to him (per interview with multiple staff, R118 would throw his walker which was a safety risk.) Surveyor asked VPO G, regarding R118's first [CONDITION(S)]/fall on [DATE], did staff take vitals, complete an assessment and monitoring. VPO G stated, no, there is no documentation of vitals, an assessment, nor monitoring for the first [CONDITION(S)]/fall on [DATE]. VPO G stated, typically when somebody falls, we get vitals and complete an assessment however, we couldn't get vitals or do an assessment due to the resident not cooperating. Surveyor asked VPO G, is there documentation for the first [CONDITION(S)]/fall on [DATE] that R118 refused vitals or an assessment. VPO G stated, no, there is no documentation that R118 refused vitals, an assessment and monitoring for the first fall on [DATE]. Surveyor asked VPO G, if a resident refuses vitals, assessment, and monitoring would you expect this to be documented. VPO G stated, yes. Surveyor asked VPO G why is this important. VPO G stated, to ensure there are no active changes that would require different interventions. Surveyor asked VPO G, would you expect staff to obtain vitals, complete an assessment, and contact the Physician for R118. VPO G stated, yes. Surveyor asked VPO G, was there an SBAR (Situation, Background, Assessment, Recommendations) or any type of change in condition completed for R118's second fall on [DATE]. VPO G stated, an SBAR would not be done in a 911 emergency. VPO G stated, staff should have completed vitals, assessments, and notifications. VPO G stated once the Physician is notified staff should follow the Physician's instructions about what to do next. Surveyor asked VPO G, how often did R118 have seizures. VPO G stated, [DATE] is the last [CONDITION(S)] we witnessed and documented. Surveyor asked VPO G, did the facility provide education to staff following R118's seizures and falls. VPO G stated, yes, we had fall education and she believes there are several educations that stem from this. VPO G stated she will have to look at the education sheets and give that information to Surveyor. Note, no additional information was provided to Surveyor. In summary, the facility failed to do the following: 1. Follow DOT OO's recommendations to ensure R118's safety. 2. 1st [CONDITION(S)]/fall: Did not obtain vitals, complete and assessment, nor monitor R118. 3. 2nd [CONDITION(S)]/fall: Moved R118 and never consulted with the Physician, waited approximately 2 hours before transporting R118 to the Emergency Department when he had uncontrollable bleeding and life-threatening injuries. Example 3 R45 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R45 was admitted to hospital from an Adult Family Home on [DATE]. R45's (EHR) Electronic Health Record reports, sat hard into his chair to eat lunch, took one bite and let out a cry. He then became unresponsive in an unclear manner which was described as suspicious for possible [CONDITION(S)]. He had immediate pain in the hip and inability to bear weight. However, he was then reported to return to his normal cheerful demeanor, imaging revealed the presence of bilateral hip fractures . EEG (Electroencephalogram) was performed given concern for seizures and no focal and no definite epileptiform abnormalities were evident. On [DATE] R45 was then discharged from the hospital and admitted to the facility following hip surgery. R45 was admitted to the facility on [DATE] from a recent hospitalization from ,d+[DATE]-[DATE] for bilateral hip fractures. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of [DATE] indicates R45's cognition is severely impaired with a BIMS (Brief Interview of Mental Status) score of 1 out of 15. R45's Functional Assessment indicates: Bed Mobility, transfer, dressing, toilet use, personal hygiene are 3 indicating extensive assistance. Bowel and bladder assessment indicate always incontinent. Fall assessment history indicated 2 falls since admission of no injury. R45 has an activated POA (Power of Attorney). R45's Care Plan in part states: Focus- Cognition: Alteration in cognition related to diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . Interventions- . Observe for a change in cognition- level of alertnes

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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** Based on observation, interview and record review, the facility did not ensure that each resident with a pressure injury (PI) receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 4 residents (R22) reviewed for PIs out of a sample of 21 residents. R22 was admitted to facility with a chronic PI. R22 did not receive ordered treatments to PI on sacrum 21 times from 4/1/22 through 7/26/22. This is evidenced by: The facility policy, entitled Administering Medications, with a revision date of April 2019, states. In part: . Policy Interpretation and Implementation .22. The individual administering the medication initials the resident's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Topical medications used in treatments are recorded on the resident's treatment record (TAR) . Note: Surveyor asked for facility's policy on treatment administration/pressure injuries. No policies were provided to Surveyor. The facility policy, entitled Policy and Procedure Handwashing, with a revision date of 10/2021, states, in part: . Purpose: To provide guidelines to staff for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. Procedure: Washing Hands with Soap and Water 1. Staff will perform hand hygiene by washing hands for at least fifteen (15) seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following conditions: . c. Before applying gloves and after removing gloves or other PPE (personal protective equipment); . e. After handling items potentially contaminated with blood, body fluids, or secretions; f. Before moving from a contaminated body site to a clean body site during resident care; example: after providing peri-care, before applying moisture barrier or other treatments; g. After providing direct resident care . R22 was admitted to the facility on [DATE] and has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R22's Annual MDS (Minimum Data Set) Assessment, dated 5/11/22, indicated that R22 has a BIMS (Brief Interview of Mental Status) Score of 15, indicating R22 is cognitively intact. R22's Care Plan, dated 7/14/21, with a target date of 7/24/22, states, in part: . Focus: SKIN INTEGRITY: Actual Complications with impaired skin integrity Pressure stage 4 chronic coccyx ulcer present on admit Interventions: . MEDS/LABS/TXS (treatments) AS ORDERED . R22's physician orders, dated 7/19/22, states, in part: . Sacrum: Cleanse with NS (Normal Saline), protect peri wound with skin prep, apply collagen to wound bed, apply alginate with silver to wound bed, cover with ABD, change twice daily and PRN (as needed) every day and evening shift for wound, start date: 6/25/22. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's physician orders, with a start date of 3/15/22 and discontinue date of 6/25/22, states, in part: .To be completed in the AM: Clean with Dove sensitive soap, rinse with SNS, dry with clean washcloth. Gently pack wound with Dakin's moistened gauze followed by fluffed gauze. Apply [MEDICATION(S)] powder to wound edges/creases. Cover with dry gauze or ABD. Secure with tape every day shift for wound care AM order. -To be completed in PM: Clean with Dove sensitive soap, rinse with SNS dry with clean washcloth. Gently pack wound with DRY gauze pads. Apply [MEDICATION(S)] powder to wound edges/creases. Cover with dry gauze or ABD. Secure with tape every evening shift related to Pressure Ulcer of Sacral Region, Unspecified Stage (L89.159) Order for PM TX- No Dakins for PM TX-(changed to AM) Start date: 3/19/22 Discontinue Date: 6/24/22 . R22's July 2022 eTar (electronic treatment administration record) shows the following dates and treatments to be without electronic signatures: On 7/18/22, 7/23/22 and 7/24/22 R22's Treatment: Sacrum: Cleanse with NS, protect peri wound with skin prep, apply collagen to wound bed, apply alginate with silver to wound bed, cover with bordered gauze, change twice daily and PRN every day and evening shift for wound. The EVENING treatments are not signed out. R22's June 2022 eTar shows the following dates and treatments to be without electronic signature: On 6/21/22 R22's Treatment: To be completed in AM: Clean with Dove sensitive soap, rinse with SNS dry with clean washcloth. Gently pack wound with Dakin's moistened gauze followed by fluffed gauze. Apply [MEDICATION(S)] powder to wound edges/creases, cover with dry gauze or ABD. Secure with tape every day shift for wound care. AM wound order. The AM treatment is not signed out. R22's May 2022 eTar shows the following dates and treatments to be without electronic signature: On 5/10/22, 5/23/22 and 5/24/22 R22's Treatment: To be completed in AM: Clean with Dove sensitive soap, rinse with SNS dry with clean washcloth. Gently pack wound with Dakin's moistened gauze followed by fluffed gauze. Apply [MEDICATION(S)] powder to wound edges/creases, cover with dry gauze or ABD. Secure with tape every day shift for wound care. AM wound order. The AM treatments are not signed out. R22's April 2022 eTar shows the following dates and treatments to be without electronic signature: On 4/4/22, 4/14/22, 4/21/22, 4/22/22, 4/24/22, 4/28/22 and 4/30/22 R22's Treatment: To be completed in AM: Clean with Dove sensitive soap, rinse with SNS dry with clean washcloth. Gently pack wound with Dakin's moistened gauze followed by fluffed gauze. Apply [MEDICATION(S)] powder to wound edges/creases, cover with dry gauze or ABD. Secure with tape every day shift for wound care. AM wound order. The AM treatments are not signed out. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/22, at 1:07 PM, Surveyor observed RN (Registered Nurse) LL and LPN (Licensed Practical Nurse) MM perform wound treatment on R22's PI to sacrum. RN LL and LPN BB performed hand hygiene and applied gloves. LPN BB removed old dressing then removed gloves and applied new gloves with no hand hygiene in between. LPN BB cleansed wound with normal saline plastic vials and gauze. LPN BB removed gloves and applied new gloves with no hand hygiene in between. LPN BB then applied skin prep to peri wound, then removed gloves and applied new gloves with no hand hygiene in between. LPN BB applied collagen and alginate to wound bed, then removed gloves and applied new gloves with no hand hygiene in between. LPN BB applied bordered gauze dressing over wound. LPN BB and RN LL removed gloves and performed hand hygiene. On 7/21/22, at 1:18 PM, Surveyor interviewed LPN BB and RN LL and asked when hand hygiene should be performed while doing a dressing change. LPN BB and RN LL both indicated before and after a dressing change, after removing dirty dressing. Surveyor asked if hand hygiene should be performed in between changing dirty gloves to clean gloves. LPN BB and RN LL indicated yes. Surveyor asked LPN BB and RN LL if hand hygiene had been performed in between changing from dirty gloves to clean gloves during dressing change and LPN BB and RN LL indicated no. On 7/21/22, at 4:53 PM, Surveyor interviewed IDON B (Interim Director of Nursing) and asked when should hand hygiene be performed during a dressing change. IDON B indicated before starting the dressing change, every time they remove gloves, every time gloves are changed and every time leaving a resident's room hand hygiene should be performed. On 7/26/22, at 09:12 AM, Surveyor interviewed IDON B and asked what does blanks on the MAR/TAR (Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] ? IDON B indicated the medication was not administered or the treatment was not completed. Surveyor asked IDON B if a treatment or medication was not administered would a progress note be expected for an explanation of that medication or treatment not administered. IDON B indicated yes. Surveyor asked IDON B if it is an expectation that treatments be completed as ordered and IDON B indicated yes. On 7/26/22, at 11:30 PM, Surveyor interviewed LPN HH and asked while looking at MAR/TAR if blanks are noted what that indicate. LPN HH indicated the medication or treatment was omitted. On 07/27/22, at 09:51 AM, Surveyor interviewed R22 regarding his PI and treatments. R22 indicated he is concerned with his treatments/dressing changes being missed. R22 indicated R22 fears R22's wound will worsen and regress backwards.

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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** Based on observation, interview, and record review the facility did not ensure residents that are at risk for fluid deficit, fluid overload, nutrition and hydration received their therapeutic diet for [CONDITION(S)] for 1 of 6 of 21 sampled Residents (R367) reviewed for proper nourishment in preparation for leaving the facility for extended periods of time. R367 goes to [CONDITION(S)] 3 times per week. The facility failed to provide nutritional supplementation during extended time away from the facility to ensure nutritional needs are met prior to going to [CONDITION(S)]. The facility has failed to implement notification to the kitchen when a resident is away during mealtimes. Evidenced by: The facility contract Long Term Care Facility Outpatient [CONDITION(S)] Services Coordination Agreement, dated 11/12/19, states in part: . B. Obligations of Long Term Care Facility and/or Owner . 5. Preparation of [CONDITION(S)] ([CONDITION(S)]) Residents. The Long Term Care Facility shall ensure that [CONDITION(S)] Residents are prepared to spend an extended length of time at the [CONDITION(S)] [CONDITION(S)] Units and have received proper nourishment and any medications prescribed for reasons other than the treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . The facility policy Residents on Leave or Pass, revised April 2022, states in part: Policy Statement The Food Services Department shall be notified when a resident will be away from the facility during scheduled meal times. Policy Interpretation and Implementation 1. Nursing Services will notify the Food Services Department when a resident will be away from the facility during meal times. Notification will be in writing unless times constraints require verbal notification. 2. Such information will include, but is not necessarily limited to: a. Which meal(s) the resident will miss; b. How long the resident will be absent; and c. Which meal the resident will be served upon returning to the facility . R367 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 7/14/22 indicates R367's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 14 out of 15. R367's has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] . R367's has the Physician Ordered Diet: CCHO (Consistent Carbohydrate Diet), Regular Texture and Regular Thin Consistency. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R367's care plan dated 7/12/22 states: Focus- The resident has [CONDITION(S)] requiring [CONDITION(S)], goal- The resident will have no s/sx (signs/symptoms) of complications r/t (related to) fluid deficit through the review date. The resident will have no s/sx of complications related to fluid overload through the review date. Interventions- . Fluids as ordered. Restrict or give as ordered. Monitor s/sx for hypovolemia or hypervolemia. Weight per orders . (Note: No interventions for ensuring nutritional needs before or during [CONDITION(S)], facility has not provided evidence that a weight has been obtained during length of stay at the facility). Focus- The resident has Diabetes Mellitus r/t pancreas removal. Goal- The resident will have no complications related to diabetes through the review date. Interventions- . Offer substitutes for food not eaten . On 7/21/22 at 10:13 AM, Surveyor interviewed R367 outside. Surveyor asked R367 about her [CONDITION(S)] appointments. R367 reports she leaves on Monday, Wednesday, and Friday for [CONDITION(S)], and they last all day. Surveyor asked R367 how early the appointments are and how she maintains her nutrition, she replied that she leaves before 7:00 AM and was informed that they can't even get into the kitchen at that time. R367 elaborates to the Surveyor that it is fine that she does not get anything from kitchen because she would not eat it anyway because it is so awful. Surveyor asked R367 if she eats before she goes and throughout the day, she replied that her family brings her snacks and has some snacks in her room. Surveyor observed a prepackaged oatmeal on R367's bed side table. On 7/27/22 at 9:28 AM, Surveyor interviewed [CONDITION(S)] RN MM (Registered Nurse). [CONDITION(S)] RN MM validated to Surveyor the dates and times of R367's [CONDITION(S)], reports that R367 does not eat during treatment, has not seen her eat, they do not routinely take blood sugars unless a situation would warrant concern, the unit does offer a protein supplement and reports that R367 does not like taking it. [CONDITION(S)] RN MM advised weights: June 21 = 64.3 kilograms, July 13 = 63 kilograms, July 27 = 65.2 kilograms and will remove 4 Liters during [CONDITION(S)] today. On 7/27/22 at 9:57 AM, Surveyor interviewed CNA Z (Certified Nursing Assistant). Surveyor asked CNA Z about R367's meal, snacking and usual intake. CNA Z replied to Surveyor that R367 leaves before breakfast comes, so she eats prepackaged food that her family brings, this morning was a prepackaged oatmeal cup and that she normally will eat around 6:30 AM when she goes to [CONDITION(S)]. On 7/27/22 at 10:11 AM, Surveyor interviewed Cook S. Surveyor asked Cook S if there were any requests for R367 for early breakfast, snacks or alternative lunch. Cook S replied that she was not aware R367 was going to [CONDITION(S)]. Surveyor asked Cook S what the process for a request for early meals or snacks is, she replied that she did not know and there used to be a board in the kitchen that would list people for requests, so I guess it would be nursing to let us know. Surveyor asked Cook S the procedure if one were to refuse snacks, she replies she would ask them what they would eat or like and try to make those arrangements. On 7/27/22 at 10:58 AM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor described R367's nutrition needs and kitchen process for [CONDITION(S)], Surveyor asked what the process was. IDON B replied to Surveyor that she could get the policy and did not know the procedure, I know we prepare to take with, it's usually a packed lunch. Surveyor asked IDON B what the procedure would be if the resident refused nutrition, she replied that she would have to look at the policy. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/22 at 11:03 AM, Surveyor interviewed INHA A (Interim Nursing Home Administrator). Surveyor asked INHA A if early breakfast or food is provided for [CONDITION(S)] residents, she replied they should get a snack. Surveyor asked INHA A how the kitchen is notified of any requests, she replied the nursing department will let the kitchen know.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview and record review the facility did not ensure that a RN (Registered Nurse) was on duty for at least 8 consecutive hours a day, 7 days a week. This has the potential to affect all 67 residents. The facility had 3 dates in the 2 week look back period where they did not have a RN on duty for 8 consecutive hours. This is evidenced by: Census of the facility on the following dates was: 7/11/22- 65, 7/19/22- 68, and 7/20/22- 67. Facility's annual recertification survey began on 7/20/22. It was observed by Surveyors that there was not a RN on AM or PM shifts. Staff postings for 7/11/22, 7/19/22 and 7/20/22 do not have any RN hours listed. Nursing schedules for 7/11/22, 7/19/22 and 7/20/22 do not have any RNs scheduled. On 7/19/22 and 7/20/22 the following is documented, DON B RN DON, however the facility does not have a waiver in place. On 7/26/22 at 10:03 AM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B if there should be a RN staffed for at least 8 consecutive hours per day, 7 days per week, IDON B stated yes, there should be a RN every day. On 7/27/22 at 3:45 PM, Surveyor interviewed INHA A (Interim Nursing Home Administrator). Surveyor asked INHA A if there should be a RN on staff for at least 8 consecutive hours per day, 7 days per week, INHA A said yes. 4

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 4 Facility policy titled Administering Medication, revised 4/2019 states in part, .6. Medication errors are documented, reported, and reviewed by QAPI (Quality Assurance and Performance Improvement) committee to inform process changes and or the need for additional staff training .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication . R47 was admitted to the facility on [DATE] with diagnoses including, but not limited to, [CONDITION(S)], Dysphasia, Hypertension, and Major Depressive Disorder. R47 was sent to the ER (emergency room) on 7/7/21 due to having an unresponsive episode. Hospital records indicate that R47 was admitted to the hospital with septic shock related to CAUTI (Catheter Associated Urinary Tract Infection) On 7/13/22 R47 returned to the facility from the hospital. R47 returned with orders for [MEDICATION(S)] 1gram/10ml (milliliter) in sterile water, 2 gram IV (Intravenous) every 24 hours for 7 days. Upon record review, Surveyor noted that facility staff had entered an order for [MEDICATION(S)] use 20 milliliters intravenously in the evening for [CONDITION(S)] for 7 days 1G(Gram)/10MLs in sterile water injection. Facility staff had signed out that they had administered the [MEDICATION(S)] on 7/13, 7/14, 7/15, 7/16, 7/17, and 7/18. The order was changed to the correct antibiotic on 7/19. On 7/26/22 at 8:15 AM Surveyor interviewed LPNM F (Licensed Practical Nurse Manager). Surveyor asked LPNM F if she had entered the admission orders for R47, LPNM F stated that they facility did have her enter physician's orders, so she had probably entered R47's orders. Surveyor asked LPNM F to review the antibiotic order that she had entered. LPNM F stated that she entered an order for [MEDICATION(S)] and then it was changed to [MEDICATION(S)] on the 19th. Surveyor asked if the facility has a process for double checking medications, LPNM F stated that she would find out. On 7/26/22 at 8:15 AM Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B what the facility's process was for entering admission orders, IDON B stated that one nurse will enter them, and another nurse would double check them. Surveyor asked IDON B if there was any documentation that R47's orders were checked by a second nurse, IDON B stated no. Surveyor asked IDON B to review the IV antibiotics for R47, IDON B reviewed medications and reported that [MEDICATION(S)] was initially ordered and then changed to [MEDICATION(S)] on 7/19; IDON B reviewed R47's orders and stated that the wrong medication was entered. Surveyor asked IDON B what the process is for a medication error, IDON B stated that staff should notify the DON, do an investigation, and notify the family. Surveyor asked IDON B if the physician should be notified of a medication error, IDON B stated yes. IDON B stated that she was calling the pharmacy and would get back to Surveyor with an update. On 7/26/22 at 1:30 PM Surveyor met with IDON B. IDON B provided a pharmacy slip indicating that the pharmacy had sent the correct medication and reported that the medication had been entered incorrectly. Surveyor asked IDON B if she would consider that a medication error, IDON B stated its a transcription error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review the facility did not ensure the provision of pharmaceutical services (including procedures that assure that accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 4 out of 21 sampled Residents (R59, R68, R1, & R47). R68's May 2022 eMAR (electronic medication administration record) indicates R68 did not receive three doses of [MEDICATION(S)] and one dose of [MEDICATION(S)] by blanks on the eMAR. There is no evidence in the nurses' notes indicating whether R68 did or did not receive his medications as ordered. R59's July 2022 eMAR indicates R59 did not receive his [MEDICATION(S)] two times during the month. R59's June 2022 eMAR indicates R59 did not receive his [MEDICATION(S)] one time during the month. R59's May 2022 eMAR indicates R59 did not receive his [MEDICATION(S)] one time during the month. There is no evidence in the nurses' notes indicating whether R59 did or did not receive his medications as ordered. R1 was admitted to the facility 7/1/22. R1's July 2022 eMAR indicates R1 did not receive his ordered daily [MEDICATION(S)] for 8 days after admission. R1's July eMAR indicates R1 did not receive ordered daily [MEDICATION(S)] for 4 days after admission. R1 did not receive his ordered daily [MEDICATION(S)] powder for 4 days after admission. R1 did not receive ordered super B-Complex for 4 days after admission. R1 did not receive ordered acetaminophen for 4 days after admission. R1 did not receive ordered [MEDICATION(S)] Sodium Gel four times a day for three and a half days after admission. Staff transcribed R47's antibiotic incorrectly staff did not complete the 5 rights prior to administering the medication. The correct antibiotic was given however staff were signing out an incorrect order. This is evidenced by: The facility policy, entitled Administering Medications, with a revision date of April 2019, states, in part: . Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .4. Medications are administered in accordance with prescriber orders, including any required time frame .6. Medication errors are documented, reported, and reviewed by QAPI committee to inform process changes and or the need for additional staff training. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy entitled Admission Assessment and Follow UP: Role of the Nurse, with a revision date of September 2012, states, in part: . Purpose: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS (Minimum Data Set) .11. Reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures .Documentation: The following information should be recorded in the resident's medical record: . 5. Orders obtained from the physician . Example 1 R68 was admitted to the facility on [DATE], and has diagnoses that include clostridioides difficile, which is a bacterium that causes severe diarrhea and [CONDITION(S)] (inflammation of the colon), Malignant Neoplasm of Bladder, Essential Hypertension and [CONDITION(S)] Stage 3. R68's Annual MDS (Minimum Data Set) Assessment, dated 6/7/22, indicated that R68 has a BIMS (Brief Interview of Mental Status) score of 15 indicating R68 is cognitively intact. R68's discharge summary medications order, dated 5/13/22, states, in part: . [MEDICATION(S)] hcl (hydrogen chloride) 10 mg (milligram) tablet Take one tablet by mouth 3 times daily. Purpose: Hypertension . -[MEDICATION(S)] HCl 50 MG/ML (milligram per milliliter) solution Take 2.5 mL by mouth 4 times daily for 7 days . R68's May 2022 eMAR shows the following dates, times and medications to be without electronic signature: -On 5/13/22, R68's [MEDICATION(S)] hcl tablet 10 mg- Give 10mg by mouth three times a day. The NOON dose is not signed out. -On 5/13/22, R68's [MEDICATION(S)] hcl solution 50 mg/ml- Give 2.5 mL by mouth four times a day for c-diff for 7 days. The NOON, 4PM and 8PM doses are not signed out. There is no evidence in nurses' notes indicating whether R68 did or did not receive his medications as ordered. On 7/26/22, at 9:12 AM, Surveyor interviewed IDON B (Interim Director of Nursing) and asked when looking at the MAR/TAR (Medication Adminstration Record/Treatment Administration Record) and there are blank spots what does that indicate. IDON B indicated that the medication was not administered. Surveyor asked IDON B if a medication was not administered for whatever reason would you expect a nurses note with explanation and medication not administered. IDON B indicated yes. Surveyor asked IDON B if physician notification is expected if medications such as [MEDICATION(S)] or a blood pressure medication are not administered, and IDON B indicated yes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/22, at 11:30 am, Surveyor interviewed LPN HH (Licensed Practical Nurse) and asked what the process is if a medication is not available to administer. LPN HH indicated if the medication is not in stock check the contingency box. LPN HH indicated if the medication is not in the contingency box LPN HH would call pharmacy to see if the pharmacy had received the order for that medication and let the pharmacy know the medication is needed STAT (right away). The pharmacy will get the medication to the facility in 3-4 hours. LPN HH indicated it is not typical for a medication not to be in the contingency box as the pharmacy restocks it weekly. Surveyor asked LPN HH when looking at the MAR/TAR and there are blank spots what does that indicate. LPN HH indicated that the medication was omitted. Example 2 R59 was admitted to the facility on [DATE] and has diagnoses that include [CONDITION(S)] and Major Depressive Disorder. R59's Annual MDS (Minimum Data Set) Assessment, dated 5/1/22, indicated that R59 has a BIMS (Brief Interview of Mental Status) score of 15 indicating R59 is cognitively intact. R59's physicians orders, dated 6/3/22, states, in part: . [MEDICATION(S)] Sodium Tablet 100 MCG (microgram) Give 1 tablet by mouth every night shift related to [CONDITION(S)] . R59's July eMAR shows the following dates, times, and medications to be without electronic signature: -On 7/15/22 and 7/18/22 R59's [MEDICATION(S)] Sodium 100 MCG- Give 1 tablet by mouth every night. The NIGHT dose is not signed out. R59's June eMAR shows the following dates, times, and medications to be without electronic signature: -On 6/24/22, R59's [MEDICATION(S)] Sodium 100 MCG- Give 1 tablet by mouth every night. The NIGHT dose is not signed out. R59's May eMAR shows the following dates, times, and medications to be without electronic signature: -On 5/3/22, R59's [MEDICATION(S)] Sodium 100 MCG- Give 1 tablet by mouth every night. The NIGHT dose is not signed out. There is no evidence in nurses' notes indicating whether R59 did or did not receive his medications as ordered. On 7/26/22, at 9:12 AM, Surveyor interviewed IDON B and asked when looking at the MAR/TAR and there are blank spots what does that indicate. IDON B indicated that the medication was not administered. Surveyor asked IDON B if a medication was not administered for whatever reason would you expect a nurses note with explanation and medication not administered. IDON B indicated yes. Surveyor asked IDON B if physician notification is expected if medications such as [MEDICATION(S)] DON B indicated yes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/22, at 11:30 am, Surveyor interviewed LPN HH and asked what the process is if a medication is not available to administer. LPN HH indicated if the medication is not in stock check the contingency box. LPN HH indicated if the medication is not in the contingency box LPN HH would call pharmacy to see if the pharmacy had received the order for that medication and let the pharmacy know the medication is needed STAT (right away). The pharmacy will get the medication to the facility in 3-4 hours. LPN HH indicated it is not typical for a medication not to be in the contingency box as the pharmacy restocks it weekly. Surveyor asked LPN HH when looking at the MAR/TAR and there are blank spots what does that indicate. LPN HH indicated that the medication was omitted. Example 3 R1 was admitted to the facility on [DATE] and has diagnoses that include Other Specified Congenital Malformations of Brain, Mild Cognitive Impairment and Calculus of Kidney with Calculus of Ureter. R1's Admission MDS (Minimum Data Set) Assessment, dated 7/8/22, indicated R1 has a BIMS (Brief Interview of Mental Status) score of 8 indicating R1 has a severe cognitive impairment. R1's Discharge Summary, dated 7/1/22, states, in part: . [MEDICATION(S)] (Vitamin D) 25 MCG (1000UT) tablet: Take 1 tablet by mouth once daily for vitamin D deficiency . -acetaminophen 500 mg tablet 1000mg oral every 8 hours scheduled -[MEDICATION(S)] 1 % Gel 2 g (grams) Topical 4 times daily. Apply to low right side back . -[MEDICATION(S)] 17 g packet 17 g oral daily . -[MEDICATION(S)] 10 mg capsule 1 tablet by mouth in the morning . -Super B-Complex tablet 1 tablet by mouth in the morning for supplement . R1's July 2022 eMAR shows the following dates, times, and medications to be without electronic signature: On 7/1/22, 7/2/22, 7/3/22, and 7/4/22, R1's [MEDICATION(S)] Tablet 25 mcg (1000UT)- Give 1 tablet by mouth one time a day for vitamin D deficiency. The 06:00 (6:00AM) doses on those days are not signed out. On 7/1/22, 7/2/22, 7/3/22, and 7/4/22, R1's [MEDICATION(S)] HCL Tablet 10 mg- Give 1 tablet by mouth in the morning for depression. The AM doses are not signed out on those days. On 7/1/22, 7/2/22, 7/3/22, and 7/4/22 R1's [MEDICATION(S)] Powder ([MEDICATION(S)] 1450)- Give 17 grams by mouth in the morning for constipation. Mix with liquid. The AM doses for those days are not signed out. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/22, 7/2/22, 7/3/22, and 7/4/22 R1's Acetaminophen 500 mg- Five 2 tablets by mouth three times a day for pain- Take 2 tablets three times a day. The AM, PM and HS (hour of sleep) doses are not signed out. On 7/1/22, 7/2/22 and 7/3/22 R1's [MEDICATION(S)] Sodium Gel 1%- Apply to low right side of back topically four times a day for pain. The AM (7:00), PM (1:00), EVE and HS (hour of sleep) doses are not signed out. On 7/4/22 R1's [MEDICATION(S)] Sodium Gel 1%- Apply to low right side of back topically four times a day for pain- Take 2 tablets three times a day. The AM (7:00) and PM (1:00) doses are not signed out. On 7/26/22, at 09:12 AM, Surveyor interviewed IDON B and asked when looking at the MAR/TAR and there are blank spots what does that indicate. IDON B indicated that the medication was not administered. Surveyor asked IDON B if a medication was not administered for whatever reason would you expect a nurses note with explanation and medication not administered. IDON B indicated yes. Surveyor asked IDON B if physician notification is expected if medications are not administered, and IDON B indicated yes. On 7/26/22, at 11:30 am, Surveyor interviewed LPN HH and asked what the process is if a medication is not available to administer. LPN HH indicated if the medication is not in stock check the contingency box. LPN HH indicated if the medication is not in the contingency box LPN HH would call pharmacy to see if the pharmacy had received the order for that medication and let the pharmacy know the medication is needed STAT (right away). The pharmacy will get the medication to the facility in 3-4 hours. LPN HH indicated it is not typical for a medication not to be in the contingency box as the pharmacy restocks it weekly. Surveyor asked LPN HH when looking at the MAR/TAR and there are blank spots what does that indicate. LPN HH indicated that the medication was omitted.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 2 R54 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/13/22 indicates R54's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. R54 has the following Diagnosis: [MEDICAL RECORD OR PHYSICIAN ORDER] R54's April Medication orders state in part: ~[MEDICATION(S)] Mix 75/25 Suspension (75-25) 100 Unit/ML (Insulin [MEDICATION(S)] Prot & [MEDICATION(S)]) Inject 38 unit subcutaneously two times a day for diabetes. Start date 3/5/22 ~ [MEDICATION(S)] Solution (Insulin [MEDICATION(S)]) Inject as per sliding scale: If 70-139= 0 140-180= 2 181-240= 3 241-300= 4 301-350= 6 351-400= 8 Call doctor for BS (Blood Sugar) of 400 or higher., subcutaneously two times a day related to Type 2 Diabetes Mellitus without complications. Start Date 4/25/25, Stop date 4/25/25; Start Date 4/26/22, Stop Date 5/4/22 ~ D/C (Discontinue) sliding scale when schedule insulin [MEDICATION(S)] 75/25 back in the facility. R54's May Medication orders state in part: ~[MEDICATION(S)] Mix 75/25 Suspension (75-25) 100 Unit/ML (Insulin [MEDICATION(S)] Prot & [MEDICATION(S)]) Inject 38 unit subcutaneously two times a day for diabetes. Start date 3/5/22 ~ [MEDICATION(S)] Solution (Insulin [MEDICATION(S)]) Inject as per sliding scale: If 70-139= 0 140-180= 2 181-240= 3 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	241-300= 4 301-350= 6 351-400= 8 Call doctor for BS (Blood Sugar) of 400 or higher., subcutaneously two times a day related to Type 2 Diabetes Mellitus without complications. Start Date 4/25/25, Stop date 4/25/25; Start Date 4/26/22, Stop Date 5/4/22. Start Date 5/4/22, Stop Date 5/5/22. ~ D/C (Discontinue) sliding scale when schedule insulin [MEDICATION(S)] 75/25 back in the facility. R54's June Medication orders state in part: ~[MEDICATION(S)] Mix 75/25 Suspension (75-25) 100 Unit/ML (Insulin [MEDICATION(S)] Prot & [MEDICATION(S)]) Inject 38 unit subcutaneously two times a day for diabetes. Start date 3/5/22 ~ D/C (Discontinue) sliding scale when schedule insulin [MEDICATION(S)] 75/25 back in the facility. R54's July Medication orders state in part: ~[MEDICATION(S)] Mix 75/25 Suspension (75-25) 100 Unit/ML (Insulin [MEDICATION(S)] Prot & [MEDICATION(S)]) Inject 38 unit subcutaneously two times a day for diabetes. Start date 3/5/22 ~ D/C (Discontinue) sliding scale when schedule insulin [MEDICATION(S)] 75/25 back in the facility. R 54's MAR (Medication Administration Record) documents on 4/25/22-5/4/22, R54 received sliding scale insulin. On 4/24/22 R54's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . R54's Progress Notes were reviewed and there is no evidence of a Progress Note to explain why R54 did not receive her [MEDICATION(S)] Insulin as ordered. Surveyor requested MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Surveyor was provided one note dated from 6/8/22, not in reference to 4/24/22. Note: There are 18 documentations in the April MAR marked with a 4 and no supporting documentation was provided. R54's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . (Note: The Sliding Scale order reads to D/C when [MEDICATION(S)] is back in the facility, noting resident received both sliding scale and [MEDICATION(S)] insulin. R54's blood sugars remained above 142 during this time frame.) R54's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . Another Sliding scale order was obtained with a start date of 5/4/22 and stop date of 5/5/22 was used and administered for the 11:00 AM and 4:30 PM blood sugars. R54's MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . An order was obtained on 5/21/22 at 11:40 AM for Insulin [MEDICATION(S)] 6 units subcutaneously now one time only for blood sugar 332 until 5/21/22 at 12:00 PM. Pharmacy delivery confirmation for R54's [MEDICATION(S)] Insulin is dated 5/4/22. Surveyor was not provided delivery documentation prior to this date. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/22 at 4:42 PM, Surveyor interviewed LPN EE (Licensed Practical Nurse). Surveyor provided R54's the Sliding Scale insulin order to D/C when [MEDICATION(S)] is in the facility. Surveyor asked LPN EE by looking at this order, what would you do with this order. LPN EE replied to Surveyor, it is unclear and that she would call to make it clear. On 7/27/22 at 16:48 PM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor provided R54's Sliding Scale insulin order to D/C when [MEDICATION(S)] is in the facility to IDON B. Surveyor asked IDON B if the order would need to be clarified. IDON B responded that it should be a new order to be given and there shouldn't be an x, we would mark every time we gave it. Please Note: R54's D/C Sliding Scale when [MEDICATION(S)] Insulin 75/25 comes back in the facility remains on the June and July MAR, indicating the need for clarification.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview the facility did not assist the resident in making transportation arrangements to and from the source of service if the resident needs assistance for 1 of 2 Residents (R22) reviewed for transportation arrangements. R22 had a scheduled appointment at the wound clinic on 7/19/22. The appointment had to be cancelled due to transportation was not equipped to manage R22's wheelchair width. This is evidenced by: The facility policy, entitled Transportation- Social Services Policy, with a revision date of 04/2022, states, in part: . Policy Statement- Our facility shall help arrange transportation for residents as needed. Policy Interpretation and Implementation . 2. Social services will help the resident as needed to obtain transportation . Example 1 R22 was admitted to the facility on [DATE] and has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R22's Annual MDS (Minimum Data Set) Assessment, dated 5/11/22, indicated that R22 has a BIMS (Brief Interview of Mental Status) Score of 15, indicating R22 is cognitively intact. R22's Care Plan, dated 7/14/21, with a target date of 7/24/22, states, in part: . Focus: SKIN INTEGRITY: Actual Complications with impaired skin integrity Pressure stage 4 chronic coccyx ulcer present on admit Interventions: . Wound managed by wound clinic .MEDS/LABS/TXS (treatments) AS ORDERED . On 7/27/22, at 9:51AM, Surveyor interviewed R22. R22 indicated he had to miss a scheduled appointment at the wound clinic for his pressure injury to his sacrum on 7/19/22. R22 indicated the facility had set up transportation with (Company Name) which cannot accommodate to R22's wheelchair width. R22 indicated (Transportation Comapny Name) was tried once before in the past and R22's wheelchair does not fit into the vehicle due to width of wheelchair. R22 indicated the morning of his appointment (Transportation Comapny Name) had phoned facility and discussed the fact that R22's wheelchair does not fit in their vehicle. R22 indicated the facility then placed a call to another transportation company came to facility for R22 and R22's wheelchair did not fit into that companies vehicle. R22 indicated the facility was aware R22 had to use one particular transportation due to this being the only transportation company in the area R22's wheelchair fits into. R22 indicated being upset and informed the facility to inform the wound clinic it was the facility's fault appointment had to be cancelled. (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/22, at 10:33 AM, Surveyor interviewed MRD (Medical Record Director) JJ. MRD JJ indicated MRD JJ is responsible for setting up transportation for the residents to and from appointments. Surveyor asked what transportation R22 uses and MRD JJ looked it up on computer and indicated R22 uses (Company Name) transportation. Surveyor asked MRD JJ if there are certain transportation companies that are not equipped to take wide width wheelchairs. MDR JJ indicated yes and there are 2 residents that are on a list that cannot use this company due to wheelchair width with one resident being R22. Surveyor asked MRD JJ if she recalled R22's appointment on 7/19/22 and transportation issues that day. MRD JJ indicated MRD JJ was not here but recalled setting the transportation up with the company not equiped to take R22's wheelchair. MRD JJ indicated MRD JJ did not know R22 was to use only one particular company until that day. MRD JJ left to check on information and returned to Surveyor and related to Surveyor for residents on Managed Care the facility is to call their case worker regarding appointments and the case worker is to set up the transportation. Surveyor asked MDR JJ if R22 was Managed Care and MRD JJ indicated yes. Surveyor asked MDR JJ if R22's case worker through Managed Care should have been notified of appointment for the case worker could set up the transportation and MDR JJ indicated yes. On 7/27/22, at 2:08 PM, Surveyor asked SW (social worker) KK who is responsible for setting up resident transportation to and from appointments and SW KK indicated MRD JJ.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview, the facility failed to employ a full time Registered Dietician (RD) or a Director of Food and Nutrition Services. This has the potential to affect all 67 residents in the facility. The facility did not employ a qualified dietary manager, which is required when the facility does not employ a full-time dietitian. The dietitian works one day every other week and the facility's Admission/Marketing Director (DOM W), who has no dietary certifications or education, is serving as the facility Interim Dietary Manager. Findings include: The facility's most recent Dietary Manager's last day was prior to the start date of the Interim Dietary Manager start date of April 2021. On 7/20/21 at 9:12 AM, Surveyor interviewed Cook S. She indicated the facility does not have a Dietary Manager. Cook S indicated the Interim Dietary Manager was hired for Admissions and Marketing and is covering the duties of ordering food and scheduling. Cook S reports she does not have any dietary training or certifications. On 7/20/22 at 9:12 AM, Surveyor interviewed DA T (Dietary Aide) and reports she does not have any dietary training or education. On 7/20/22 at 9:12 AM, Surveyor interviewed DA V and reports he does not have any dietary training or education. On 7/26/22 at 10:51 AM, Surveyor interviewed DOM W (Director of Marketing) and indicated she is not a Certified Dietary Manager or a Registered Dietician. DOM W indicated she does the ordering of food and scheduling. DOM W indicated that a Dietary Manager was hired on 7/22/22 and is scheduled to start on 8/6/22. On 7/25/22 at 11:21 AM, Surveyor interviewed RD X. RD X reports starting as a contracted RD and started in June 2022. RD X reports working 8-10 hours per week on Tuesdays and visits the facility every other Tuesday. On 7/27/22 at 7:58 AM, Surveyor interviewed AD E (Activities Director), AD E reports he does not have any dietary training or education. The facility does not have a qualified Dietary Manager or a full time Registered Dietician to ensure there are sufficient, competent staff to carry out the functions of the food and nutrition service for the residents of the facility. Cross Reference: F802, F804 and F812

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility did not employ and provide sufficient staff or support staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. This has the potential to affect all 67 residents residing in the facility. Surveyor interviewed Cook S and indicated she served unpasteurized eggs that were not fully cooked with runny yokes to R3 (Resident) and R 20. Cook S indicated she had not received education regarding pasteurized and non-pasteurized eggs. Surveyor observed dented cans in serving areas and Cook S indicating she does not know what to do. Surveyor observed multiple outdated foods within the kitchen. Dietary staff did not follow appropriate protocols to dispose of expired food per standards of practice. Surveyor observed staffing of no certifications for trained cook and dietary aids. Evidenced by: Example 1- Eggs The facility policy Food Preparation and Service, undated, version 2.1 (H5MAPL0333) states in part . Food Preparation, Cooking and Holding Time/Temperatures .13. Unpasteurized eggs are cooked until all parts of the egg (yolk and whites) are completely firm . According to the 2017 FDA (Food and Drug Administration) Food Code: ,d+[DATE].13 Pasteurized Eggs, Substitute for Raw Shell Eggs for Certain Recipes. Raw or undercooked eggs that are used in certain dressings or sauces are particularly hazardous because the virulent organism Salmonella Enteritis may be present in raw shell eggs. Pasteurized eggs provide an egg product that is free of pathogens and is a ready-to-eat food. The pasteurized product should be substituted in a recipe that requires raw or undercooked eggs. Highly susceptible population means PERSONS who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised; preschool age children, or older adults; and (2) Obtaining food at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney [CONDITION(S)] center, hospital, or nursing home, or nutritional or socialization services such as a senior center. ,d+[DATE].11 Pasteurized Foods, Prohibited Re-Service, and Prohibited Food. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION: (B) Pasteurized EGGS or EGG PRODUCTS shall be substituted for raw EGGS in the preparation of . (2) A partially cooked animal FOOD such as lightly cooked FISH, rare MEAT, soft-cooked EGGS that are made from EGGS, and meringue. On [DATE] at 9:12 AM, During the initial tour of the kitchen Surveyor observed shelled eggs in the facility's walk-in refrigerator, in a box. Surveyor observed that there was no P mark on the eggs, which would indicate the eggs were pasteurized. Surveyor observed no indication on the box the eggs were pasteurized. The box was labeled Item# L3370, Shell eggs Grade AA, packed date [DATE]. On [DATE] at 7:23 AM, Surveyor pointed to box of shell eggs and asked Cook S if she uses those eggs. Cook S stated she sometimes uses them on the Cedar wing and for another resident. Cook S reports she could not think of their name until she would see the name in the tray line and would let me know. Cook S then said to the Surveyor, to be honest, I thought we could do that. I was told that if the resident was able to make their own decisions, we could serve those. Surveyor asked Cook S the procedure of how they were cooked. Cook S said she sprays the pan, cracks the egg, and cooks it. Surveyor asked Cook S how did they like their eggs, Cook S replied sunny side up or over easy. Surveyor asked Cook S how frequently the eggs are made sunny side up, she replied she made them last week. Surveyor asked Cook S if she received any training on pasteurized versus non-pasteurized eggs. Cook S indicated she had not. On [DATE] at 4:48 PM, Surveyor asked NHA A for RD (Registered Dietician) information and was advised will obtain the name of the RD, the position is vacant for the Dietary Manager and have been without one for a couple of weeks. On [DATE] at 11:49 AM, Surveyor interviewed RD X. Surveyor asked RD X if it is appropriate to serve unpasteurized eggs sunny side up or over easy, RD X replied, No. Oder details of facility's food supplier from [DATE]-[DATE]. The Surveyor noted an order for item number L3370 with a description of Egg shell on white Grade AA is the same item number observed on the box of eggs in the walk-in cooler that the cook identified as using for food preparation of over easy eggs. Example 2- Dented Cans On [DATE] at 9:21 AM, During the initial tour, Surveyor asked Cook S what the process is for dented cans. Cook S reports she did not know and just left them in the here, should probably send them back, I don't have a supervisor, so I don't know what to do. Example 3- Outdated Foods/Process (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 09:21 AM, During initial tour with Cook S, Surveyor asked Cook S the process for outdated foods. Cook S stated they should use them by the date indicated. During the tour of the dry storage room with Cook S, Surveyor provided to Cook S 2 bags of hoagie buns from the bread rack. Surveyor asked Cook S what the green substance was in both bags, she replied that it was mold, and we don't get our bread fresh anymore, it's frozen. Surveyor asked Cook S the process of how items are handled once they come from the vendor. Cook S reports she usually puts some away. Surveyor asked Cook S how the dating system works for receiving product. Cook S reports items are dated when they arrive, when opened and when they are to use them by. Surveyor asked Cook S if the country dry sausage 6-pound can should be dated, she said yes. Note: 6 cans are dated received ,d+[DATE], 1 is not dated. Surveyor asked Cook S if the brownie mix should be dated, she replied, yes. Note: 4 total brownie mix boxes, one box is opened and not dated, 3 unopened boxes are not dated. Surveyor asked Cook S if the yellow cake mix boxes should be dated, she replied yes. Note: 5 yellow cake mix boxes are not dated. Surveyor asked Cook S if the 25-pound bag of flour is dated, she replied no. Surveyor asked Cook S to read the date of the flour, she replied manufacturer expiration [DATE]. Note: Flour is expired. Surveyor asked Cook S the 5-gallon container of breadcrumbs of the expiration date, she reports [DATE]. Surveyor asked if the breadcrumbs were outdated, she replied yes. Note: the cover was off the container of breadcrumbs and is expired. Surveyor went to reach in cooler with Cook S. Surveyor asked Cook S what was in a 5-gallon bucket, she replied Chicken base dated ,d+[DATE]. Surveyor asked Cook S to describe the appearance, she replied it is crusted on the top and is probably bad. Surveyor asked Cook S to identify the bowl on the top shelf, she replied a tomato soup bowl with a cover that has spilled down the side with a cracked lid, the date is ,d+[DATE]. Cook S removed tomato soup. Surveyor asked Cook S are the following foods outdated: Applesauce, opened date ,d+[DATE], use by date ,d+[DATE] Pasta salad individual dated ,d+[DATE] Dressing of unknown substance, dated [DATE] good for 3 days Whipped cream squeeze, no date, has a loose baggie on the opened end Cottage Cheese 5 pounds, opened date [DATE] Fruit juice for puree, dated ,d+[DATE], use by [DATE] Folgers coffee opened and crusted in bag, no date, removed by Cook S Cook S agreed the foods were outdated. Initial tour continued into the walk-in freezer with Cook S. Cook S reports the freezer was broke yesterday and was fixed, she was not aware how long it was broke, maybe a few hours Note: freezer temperature log does not have documentation for yesterday. Note: the internal thermometer does not have a glass cover and the needle is crystalized. The freezer was covered with crystallization with frozen water droplets on the ceiling and 4 inches of ice mounded up near the door frame and along the metal shelving. Cook S scratched off the thermometer to move the ice to read it. Cook S scratched off freezer items to read labels. Surveyor asked Cook S if the thermometer is reading correctly, she replied she did not think so. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The following items were dated: Baker boy pastry, use by date [DATE] Mighty Shake Vanilla, low sugar, not dated, suggested manufacturer use by date [DATE] x6 items Mighty Shake Strawberry, not dated, suggested manufacturer use by date [DATE], unopened case. Surveyor asked Cook S if the items were expired Cook S replied yes. Surveyor went into the walk-in cooler with Cook S during initial tour. Surveyor asked Cook S to identify the items on the racks in the trays. Cook S replied, the desserts of pears, pudding with whipped cream and a full sheet of cake. Cook S reports unable to locate dates. Surveyor asked Cook S if the items should be dated, she replied yes. Surveyor asked Cook S to identify the 5-pound bags in the cooler. Cook S was not able to identify the 4 bags of a liquid brown substance and stated, I would not eat this. Note: no identification of the item, no dates. Surveyor asked Cook S the date of the cooked noodles, she replied [DATE] with a use by [DATE]. Surveyor asked Cook S if the noodles are outdated, she replied yes. Surveyor asked Cook S the use of the 6 gray tubs that contained 3 juices, milk, thickener. Cook S reports each wing will get a tub during meals for the beverages. Surveyor asked Cook S if the pitchers should be dated, she replied yes. Note: Pitchers were noted to be topped off after meals and placed back into the cooler. Surveyor asked Cook S to open the BUN juice machine. Surveyor asked Cook S for the dates, she reports I know one was just changed yesterday. Note: dates were not found on the opened juice containers in the BUN machine. Dietary staff including Cook S did not recognize foods were outdated, not labeled and expired and failed to follow dietary standards of practice. Cook S stated she does not have a supervisor and was not sure what to do. Example 4- Staffing On [DATE] at 9:12AM, Surveyor interviewed Cook S, she indicated the facility does not have a Dietary Manager. Cook S indicated the Interim Dietary Manager was hired for Admissions and Marketing and is covering the duties of ordering food and scheduling. Cook S reports she does not have any dietary training or certifications. On [DATE] at 9:12 AM, Surveyor interviewed DA (Dietary Aide) T and reports she does not have any dietary training or education. On [DATE] at 9:12 AM, Surveyor interviewed DA V and reports he does not have any dietary training or education. On [DATE] at 8:06 AM, Surveyor interviewed SSD C (Social Services Director) and asked if she had any formal dietary or cooking training, SSD C replied she had no cooking training we are doing what we can. On [DATE] at 8:50 AM, Surveyor interviewed Registered Nurse LL (RN) (Director of Nursing) and asked if she had any formal dietary or cooking training, she replied no kitchen training. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:51 AM, Surveyor interviewed DOM W (Director of Marketing) and indicated she is not a Certified Dietary Manager or a Registered Dietician. DOM W indicated she does the ordering of food and scheduling. DOM W indicated that a Dietary Manager was hired on ,d+[DATE] and is scheduled to start on , d+[DATE]. On [DATE] at 7:58 AM, Surveyor interviewed Activities Director E (AD) and reports he does not have any dietary training or education. On [DATE] at 1:33 PM, Surveyor interviewed INHA A (Interim Nursing Home Administrator) of kitchen staffing concerns, INHA stated that all the kitchen help has been given a raise and we will continue looking for help. Cross Reference: F801, F804, and F812

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure that each resident receives, and the facility provides food and drink that is palatable, attractive, and at a safe and appetizing temperature for 5 of 12 residents interviewed regarding food (R52, R367, R22, R54 and R4) and 3 of 3 supplemental residents (R35, R43, and R64). 2 of 2 test trays were not palatability. Residents stated that food was served cold and not palatable. Surveyors observed food that was not hot and milk that was not cold on test trays. Residents voiced concerns in Resident Council meetings and Food Committee meetings regarding hot food being served cold. Evidenced by: The Wisconsin Food Code reads that hot foods should be served at 135 degrees Fahrenheit (F) or above. Example 1: R52 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 7/7/22 indicates R52's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 7/21/22 at 2:41 PM, Surveyor interviewed R52. R52 reports the scrambled eggs are not eggs, they are powder eggs and have a bad smell I refuse to eat them. Example 2: R367 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 7/14/22 indicates R367's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 14 out of 15. On 7/21/22 at 10:13 AM Surveyor interviewed R367. R367 reports: Toast was wet because they have powdered eggs that mix with water. The food is always cold. I don't know how they feed these people, its disgusting, it's not right. That is all 3 meals, tasteless, thrown together, cold, and nothing to it. Yesterday was supposed to be meatloaf for dinner, it was a pile of meat, broccoli smelled like it was in the freezer, I don't know how long, it's like they are scraping the bottom of the freezer. The toast is used to absorb all the liquids from the eggs, because the toast is wet and soggy. I was so upset about it this morning, because of people that don't have a choice. Example 3: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R54 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/13/22 indicates R54's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 7/21/22 at 2:28 PM, Surveyor interviewed R54. R54 reports: I didn't eat it today, I didn't like the way the ham looked, there was carrots and peas, I didn't eat it. I would rather have some sandwich, so they brought one. The sandwich was old or something. I didn't say anything. It taste like poison. The food is not always hot, it can be cold and hard. The same with the fries, it can be hard and cold too. I wish they would have a contract. Example 4: R64 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/25/22 indicates R64's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 7/27/22 at 9:25 AM, Surveyor observed R64 served breakfast. R64 reports cream of wheat smelled burnt and gave the cream of wheat back to CNA FF (Certified Nursing Assistant). Surveyor smelled and confirmed the burnt smell. Example 5: R35 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/14/22 indicates R35's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 7/27/22 at 9:25 AM, Surveyor observed R35 served breakfast. R35 reports the cream of wheat is burnt and gave the cream of wheat back to CNA FF. Surveyor smelled and confirmed the burnt smell. Example 6: On 7/21/22 at 1:01 PM, Surveyors performed Resident Council. The following are the voices heard at the meeting: The food is lousy, spicy cheese, don't want spicy food- get anyway, scrambled eggs= runny, grilled cheese not grilled, got potatoes x2 and a biscuit. Example 7: R43 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 5/27/22 indicates R43's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 13 out of 15. On 7/27/22 at 9:25 AM, Surveyor observed R43 served breakfast. R43 reports the cream of wheat is burnt and gave the cream of wheat back to CNA FF. Surveyor smelled and confirmed the burnt smell. Example 8: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22 was readmitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 5/11/22 indicates R22's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 7/20/22 at 9:21 AM, Surveyor was provided the following documentation in writing from R22. R22 reports: (6/21/22) Italian Grinder for lunch had inedible mystery meat mush I was afraid to eat the Red Velvet cake for dinner dessert because the icing was curdled and the grease was separated. I took pictures if anyone is interested. (6/23/22) The eggs had green areas just like a week or so ago. The raisin toast was the dried butt of the loaf. I went to eat the sausage and my fork had something stuck to it, maybe a piece of a napkin, so it wasn't usable. My dirty fingers are cleaner than the utensils. I have pictures for proof. (6/26/22) Dinner was disgusting diced turkey with gravy. (7/1/22) Hearty soup for dinner was cold. (7/2/22) Lunch cheeseburger was good but cold. Example 9: On 7/26/22 at 12:32 PM, Tray cart was delivered to the wing at 12:19 PM. Staff began serving trays from the cart at 12:32 AM. Note: Lunch service is from 11:30 AM to Noon as posted by the dining room including the wing times. At 12:36 PM, Surveyor obtained test tray from the last resident in the hallway near room #118. The temperatures are as follows: Goulash 125.4 degrees Fahrenheit Mixed Vegetable 100.5 degrees Fahrenheit, hardened edges Milk 54.4 degrees Fahrenheit, warm Breadstick 99.5 degrees Fahrenheit Blueberries 68.4 degrees Fahrenheit (This meal was not palatable, served with a disposable spoon) Example 10: On 7/27/22 at 8:07 AM, Surveyor conducted a room tray/test on a different hallway, near room #204 of the Cedar wing. The tray cart arrived to the wing at 8:07 AM. At 8:23 AM Surveyor was informed by RN Y (Registered Nurse) that he was able to get someone to pass trays. Note: Surveyor did not ask for assistance with tray delivery, trays sat in the hallway for 18 minutes prior to the beginning of serving. 8:40 AM Surveyor obtained a test tray. The temperatures and palatability were as follows: Scrambled eggs 104.7 degrees Fahrenheit, runny, spongy Sausage link 95.7 degrees Fahrenheit, very cold in the middle, did not taste warm throughout (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pancake 96.4 degrees Fahrenheit, pancake absorbed the liquid run off and was soggy that it was dough texture Milk 44.4 degrees Fahrenheit, warm, served in a Styrofoam cup (This meal was not palatable, warm foods were served cold. The meal was served on a 3 portioned plate with a cover. No warmer under the plate or a bottom heat protector and a disposable spoon.) Example 11 On 7/20/22 at 3:36 PM, R4 stated to Surveyor the food is often cold. On 7/20/22 at 11:47 AM Surveyor observing lunch tray line. Surveyor asked Cook S how the food stays warm. Cook S replied, the metal plate warmer is broke and have asked maintenance to look at it. Surveyor asked Cook S if the dinner plate warmer worked, she replied, it's okay. 7/26/22 at 8:09 AM Surveyor observing breakfast tray line. Surveyor demonstrated to INHA A (Interim Nursing [NAME] Administrator) disposable spoons being used in the tray line. Surveyor asked NHA A if she was aware of the shortage of the spoons for the residents, she replied she did not know and would order some. DA T (Dietary Aide) replied and informed INHA A that DOM W (Director of Marketing) was informed. On 7/26/22 at 10:51 AM, Surveyor interviewed DOM W. Surveyor asked the temperatures of hot food and colds should be served at, she replied, hot foods at 135 degrees (Fahrenheit) and cold foods at 41 degrees (Fahrenheit). Surveyor asked DOM W if the metal plate warmer worked, she replied no and that she has brought it up in meetings. Surveyor asked DOM W if food grievances been identified, she replied she sometimes reviews food ones of not enough product, not enough taste, smoking or burnt tasting. Surveyor asked DOM W how this concern was addressed, she reports she performed a staff training about a month after she started (started in April 2022) and trained staff of food handling, food storage and temperatures. Surveyor asked DOM W is she has had any formal kitchen or dietary training, she replied no. Cross Reference: 801, 802, and 812

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not provide food that accommodates resident allergies, intolerances, and preferences; appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice for 1 of 21 sampled residents (R55) and 4 of 4 supplemental residents (R43, R35, R64, and R52). Residents were not being served the menu items of their preferences or within parameters of their Physician Ordered Diet. This is evidenced by: Example 1 R52 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 7/7/22 indicates R52's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. R52 has the following diagnoses: Type 2 Diabetes Mellitus, [CONDITION(S)], [CONDITION(S)], Acute Kidney Failure, Acute Pulmonary [CONDITION(S)]. R52's Physician Ordered Diet, is ADA (American Diabetic Association) Diet, Regular texture and regular consistency, prefers to follow heart-healthy, low potassium and iron diet. On 7/21/22 at 2:41 PM, Surveyor interviewed R52. Surveyor asked R52 how the food is. R52 reports he needs to be on a low potassium otherwise his potassium level is high when he goes to the kidney clinic. R52 further reports You need to shake this kitchen, they are killing people and filling them with sugar, and the snacks are always sweet. (Note R52 is Diabetic). R52 reports needing to eat a salad everyday due to being anemic. He reports asking every day for a salad. Sometimes to get a salad he has been told that he needs to give at least a 2 days' notice, then a 1-day notice, he also writes salad on the menu. Today, he reports they do not have salad, so he was brought a peanut butter sandwich and chips by the staff. (Note: R52 requests low potassium and has a history of [CONDITION(S)]). R55 then refused to eat. There is gravy all the time on the menu and has a lot of salt. He reports he writes on the menu everyday no gravy and he gets gravy. He reports feeling always hungry, most of the time. To supplement his intake, his wife brings him lunch every day and leaves snacks for the remaining parts of the day. Surveyor did observe healthy snacks of fresh vegetables in resident's room. R52 stated he was discharging the following day and hopes his concerns can assist others. Example 2 R64 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/25/22 indicates R64's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. R64 has the following diagnosis: [CONDITION(S)], Dysphagia, Muscle Weakness, Muscle Wasting, GERD (Gastro-[CONDITION(S)] Reflux Disease) without Esophagitis. R64's Physician Ordered Diet is Low Salt, Regular Texture, Regular Active Consistency. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/22 at 9:21 AM, Surveyor interviewed R64 during her breakfast, she reports feeling starved. R64's breakfast arrived at 9:21 AM, supper last night was at 5:00 PM, resulting in a 16 hour and 25-minute difference between meals. R64 reports it is a long time between meals and had to call and request a snack last night because they don't normally come around. Surveyor asked if R64's spoon is okay, she replied that it is hard to eat with a disposable spoon and it bends. R55 opened her cream of wheat and gave to the Surveyor stating that is smells bad, like it's burnt. R64 gave item to CNA FF (Certified Nursing Assistant). CNA FF offered a replacement and was not able to replace as the kitchen reported they were out of oatmeal. Example 3 R35 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/14/22 indicates R35's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. R35 has the following diagnosis: Dysphagia, Unspecified Dementia with Behavioral Disturbance R35's Physician Ordered Diet is Regular diet, Pureed Texture, Thin Liquids On 7/26/22 at 9:25 AM, Surveyor interviewed R35 during her breakfast. R35 opened her cream of wheat and stated, this is not oatmeal, I request oatmeal every day. CNA FF offered to return cream of wheat to the kitchen and get oatmeal. CNA FF returned and informed R35 that they were out of oatmeal and offered yogurt. R35 agreed to have yogurt. CNA FF went to the kitchen, returned to the R35 stating they are out of yogurt and offered applesauce in place. R35 stated I guess. R35 informed Surveyor that she does not get pureed diet and was informed by another CNA that she would not need that anymore. R35 informed Surveyor that she does not like eggs and continues to get eggs. Surveyor noted scrambled eggs on R35's plate. Surveyor observed R35's breakfast intake was 2 containers of applesauce. R35 further reports receiving supper the evening before between 4:30 PM- 5:00 PM. Note: The time gap from supper the evening prior and breakfast is approximately 16 hours and 15-45 minutes between meals. R35 reports she did not get a snack and usually is only able to get a snack during a Friday activity. Example 4 R43 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 5/27/22 indicates R43's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 13 out of 15. R43 has the following diagnosis: Unspecified Protein-Calorie Malnutrition, Proteinuria, [CONDITION(S)], Hypo-osmolarity and [CONDITION(S)], Anorexia, [CONDITION(S)], Cachexia. R43's Physician Ordered Diet is Regular Diet, Regular Texture, Thin Liquid Consistency, Supplement MedPass. On 7/26/22 at 9:30 AM, Surveyor interviewed R43 during breakfast. R43 reports receiving supper last evening at 4:30 PM. Note: This is 17 hours between meals. Surveyor asked R43 if she had a snack, she reports they don't serve snacks. Note: diagnosis of Cachexia, [CONDITION(S)] and Malnutrition and resident reports not receiving snacks. Surveyor noted that R43 did not eat her cream of wheat, Surveyor observed her opening the cover and then closing the cover. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 5 R55 was admitted to the facility on [DATE]. Most recent MDS (Minimal Data Set) with ARD (Assessment Reference Date) of 6/14/22 indicates R55's cognition is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 14 out of 15. R55 has the following diagnosis: [CONDITION(S)], [CONDITION(S)] (Chronic Obstructive Pulmonary Disease), [CONDITION(S)], GERD without Esophagitis. R55's Physician Ordered Diet is NAS (No Added Salt) Diet, Regular Texture, Thin Liquid Consistency. On 7/21/22 at 9:32 AM, Surveyor interviewed R55. Surveyor asked R55 how the food is, he replied the quality is sometimes very lousy, he has had to put no vegetables on his menu every time and continues to receive vegetables. R55 further indicated his reasoning is that the vegetables tend to get stingy and get caught when he eats and makes him choke. R55 states he had to finally be very mean on the menu and state dumb ass, no vegetables. R55 reports he has not received any more vegetables since then. On 7/26/22 at 9:10 AM, Surveyor interviewed CNA AA. Surveyor asked CNA AA if she had any difficulty with resident meal concerns, she reports that they complain about the meals normally because they don't like it. On 7/26/22 at 11:18 AM, Surveyor interviewed Cook U. Cook U reports not having items in stock that residents are asking for. Cook U provided examples of ranch dressing and that 99% of residents ask for ranch and we don't have it. Cook U reports that pineapple tidbits are on the menu, and they don't have any pineapple at all. Cook U reports that the facility has been without oatmeal for about 2 weeks. Cook U reports he gives a list to DOM W (Director of Marketing) and it does not get ordered. On 7/26/22 at 8:09 AM, Surveyor observing breakfast tray line. Surveyor demonstrated to NHA A disposable spoons being used in the tray line. Surveyor asked INHA A (Interim Nursing Home Administrator) if she was aware of the shortage of the spoons for the residents, she replied she did not know and would order some. DA T (Dietary Aide) replied and informed INHA A that DOM W was informed. On 7/26/22 at 1:33 PM, Surveyor interviewed INHA A and advised of the situation of residents not getting substitutions and meeting the requests on the menu. INHA A reports that they are over budget now and will look into it.

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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 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, interview and record review the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety to prevent foodborne illness affecting 2 residents (R3 and R20) who were served running yolk eggs. Failure to ensure unpasteurized eggs were fully cooked placed R3 and R20 at risk for becoming infected by Salmonella and created a finding of Immediate Jeopardy (IJ) that started on [DATE]. INHA A (Interim Nursing Home Administrator), VPO G (Vice President of Operations), and RN LL (Registered Nurse) were informed of the Immediate Jeopardy on [DATE] at 2:46 PM. The Immediate Jeopardy was removed on [DATE], when the facility started to implement their removal plan. The deficient practice continues at a scope/severity of an F (potential for harm/widespread) as the facility continues to implement its removal plan and as evidenced, in part, by staff failure to use hairnets and masks in the kitchen, to wash hands/change gloves when indicated while cooking, to check temperatures of the dishwasher, to ensure the dishwasher had detergent, to ensure opened food was dated and not expired, to ensure a fan was not blowing across the steam table, and by the use of plastic dinnerware. This is evidenced by: According to the 2017 FDA Food Code: ,d+[DATE].13 Pasteurized Eggs, Substitute for Raw Shell Eggs for Certain Recipes. Raw or undercooked eggs that are used in certain dressings or sauces are particularly hazardous because the virulent organism Salmonella Enteritidis may be present in raw shell eggs. Pasteurized eggs provide an egg product that is free of pathogens and is a ready-to-eat food. The pasteurized product should be substituted in a recipe that requires raw or undercooked eggs. Highly susceptible population means PERSONS who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised; preschool age children, or older adults; and (2) Obtaining FOOD at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney [CONDITION(S)] center, hospital or nursing home, or nutritional or socialization services such as a senior center. ,d+[DATE].11 Pasteurized Foods, Prohibited Re-Service, and Prohibited Food. In a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION: (B) Pasteurized EGGS or EGG PRODUCTS shall be substituted for raw EGGS in the preparation of . (2) A partially cooked animal FOOD such as lightly cooked FISH, rare MEAT, soft-cooked EGGS that are made from EGGS, and meringue; (continued on next page)

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	525074	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The CDC notes that Salmonella causes 1.2 million cases of illness each year in the United States and 450 deaths. According to Salmonella enteritidis Infection, A bacterium, Salmonella enteritidis, can be inside perfectly normal-appearing eggs, and if the eggs are eaten raw or undercooked, the bacterium can cause illness .A person infected with the Salmonella enteritidis bacterium usually has fever, abdominal cramps, and diarrhea beginning 12 to 72 hours after consuming a contaminated food or beverage. The illness usually lasts 4 to 7 days, and most persons recover without antibiotic treatment. However, the diarrhea can be severe, and the person may be ill enough to require hospitalization . The elderly, infants, and those with impaired immune systems may have a more severe illness. In these patients, the infection may spread from the intestines to the blood stream, and then to other body sites and can cause death unless the person is treated promptly with antibiotics. https://wonder.cdc.gov/wonder/prevguid/p 03/p 03.asp#:~:text=A%20person%20infected%20with%20the, persons%20recover%20without%20antibiotic%20treatment. Because of aging-related changes, older adults have an increased susceptibility to foodborne illness. According to the USDA's Food Safety A Need-to-Know Guide for Those At-Risk, Adults 65 and older are at a higher risk for hospitalization and death from foodborne illness. This increased risk of foodborne illness is because our organs and body systems go through changes as we age. These changes include: The gastrointestinal tract holds on to food for a longer period of time, allowing bacteria to grow. The liver and kidneys may not properly rid our bodies of foreign bacteria and toxins. The stomach may not produce enough acid. The acidity helps to reduce the number of bacteria in our intestinal tract. Without proper amounts of acid, there is an increased risk of bacterial growth. Underlying chronic conditions, such as diabetes and cancer, may also increase a person's risk of foodborne illness. https://www.foodsafety.gov/people-at-risk/older-adults#:~:text=Adults%20age%2065%20and%20older, time%2C%20allowing%20bacteria%20to%20grow. The facility policy Food Preparation and Service, undated, version 2.1 (H5MAPL0333) states in part . Food Preparation, Cooking and Holding Time/Temperatures .13. Unpasteurized eggs are cooked until all parts of the egg (yolk and whites) are completely firm . Food Service/Distribution .6.Gloves are worn when handling food directly and changed between tasks. 7. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. On [DATE] at 9:12 AM, During the initial tour of the kitchen Surveyor observed shelled eggs in the facility's walk-in refrigerator, in a box. Surveyor observed that there was no P mark on the eggs, which would indicate the eggs were pasteurized. Surveyor observed no indication on the box the eggs were pasteurized. The box was labeled Item# L3370, Shell eggs Grade AA, packed date [DATE]. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 7:23 AM, Surveyor pointed to the box of shelled eggs and asked Cook S if she uses those eggs. Cook S stated she sometimes uses them on the Cedar wing and for another resident. Cook S reports she could not think of their name until she would see the name in the tray line and would let writer know. Cook S then said to the Surveyor, To be honest, I thought we could do that. I was told that if the resident was able to make their own decisions, we could serve those. Surveyor asked Cook S the procedure of how they were cooked. Cook S said she sprays the pan, cracks the egg and cooks it. Surveyor asked Cook S how the residents like their eggs, Cook S replied sunny side up or over easy. Surveyor asked Cook S how frequently the eggs are made sunny side up; she replied she made them last week. Surveyor asked Cook S if she received any training on pasteurized versus non-pasteurized eggs. Cook S indicated she had not. Surveyor reviewed the order details of facility's food supplier from [DATE]-[DATE]. Surveyor noted an order for item number L3370 with a description of Egg shell on white Grade AA is the same item number observed on the box of eggs in the walk-in cooler that the cook identified as using for food preparation of over easy eggs. Date: [DATE] Item# L3370 1 CASE/15DOZ EGG SHL ON WHITE XLG GRD AA LOOSE PACK REF Date: [DATE] Item# L3370 1 CASE/15DOZ EGG SHL ON WHITE XLG GRD AA LOOSE PACK REF Date: [DATE] Item# L3370 1 CASE/15DOZ EGG SHL ON WHITE XLG GRD AA LOOSE PACK REF Date: [DATE] Item# L3370 1 CASE/15DOZ EGG SHL ON WHITE XLG GRD AA LOOSE PACK REF Date: [DATE] Item# L3370 1 CASE/15DOZ EGG SHL ON WHITE XLG GRD AA LOOSE PACK REF Date: [DATE] Item# L3370 1 CASE/15DOZ EGG SHL ON WHITE XLG GRD AA LOOSE PACK REF On [DATE] at 7:30 AM, Cook S reported the names of the two residents who received running yolk unpasteurized eggs as the residents names came across in the tray line. Cook S picked up the tray ticket and provided Surveyor both names of: R3 and R20 confirming both residents received sunny side up eggs last week. On [DATE] at 11:31 AM, Surveyor interviewed R20. R20 reports he loves eggs over easy because he loves to dip toast into it. R20 states he cannot remember when he last had one over easy because you don't get what you want when you write it down on the menus, they used to do it all the time. R20 reported to Surveyor he does not eat the scrambled because it is the powder stuff. R20 stated he does not like to eat breakfast anymore because it sits in the hall and it's too cold to eat. On [DATE] at 11:47AM, Surveyor interviewed R3. Surveyor asked R3 if he likes his eggs over easy or sunny side up, R3 replied yep. When Surveyor asked R3 when he last ate eggs that were over easy or sunny side up, R3 replied, Last week. When Surveyor asked R3 if the yolk was runny or liquid, R3 stated, yes. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:48 PM, Surveyor spoke to INHA A regarding the concern the facility served unpasteurized eggs to two residents R3 and R20. INHA A asked Surveyor the difference of the eggs. Surveyor educated the difference of pasteurized and unpasteurized eggs and the ability to use them if cooked completely. Surveyor asked INHA A for RD (Registered Dietician) information and was advised the facility will obtain the name of the RD. INHA A stated the position is vacant for the Dietary Manager and the facility has been without a Dietary Manager for a couple of weeks. On [DATE] at 11:49 AM, Surveyor interviewed RD X (Registered Dietician). Surveyor asked RD X if it is appropriate to serve unpasteurized eggs sunny side up or over easy, RD X replied, No. Surveyor asked RD X what she expected staff to do. RD X replied staff should cook the yolk not soft or runny. Surveyor asked RD X what the process staff should take, RD X replied to remove the item and prepare an egg to be cooked thoroughly, further discuss why it is risky and discuss cooking temperatures with staff. RD X stated she would also advise nursing staff if they saw a runny yolk egg that was not a pasteurized egg nursing should take it back to the kitchen. Serving unpasteurized eggs that were not fully cooked created the potential that residents could contract Salmonella and created a reasonable likelihood for serious harm, thus leading to a finding of Immediate Jeopardy (IJ). The IJ was removed, on [DATE], when the facility began implementing the following: 1. Ad Hoc Meeting QA meeting was held to educate the entire leadership team on our plan and follow up. Completed [DATE] 2. Dietary Cooks educated on the facility policy regarding using unpasteurized eggs, the new order guide that only allows the dietary staff to order pasteurized eggs, how to check the eggs if they are pasteurized, and what to do if the facility receives unpasteurized eggs. Completed [DATE] 3. Current residents at risk for potentially receiving undercooked eggs. The facilities policy and procedures were reviewed to ensure they are based upon current standards of practice. Completed [DATE] 4. Residents that received the undercooked/runny eggs have the potential to be affected: Two residents were identified with no adverse outcome; Education has been completed and it was determined that only one cook was serving residents undercooked eggs. All unpasteurized eggs have been removed from the facility and can no longer be order from the facility food vendor. Completed [DATE] 5. All education completed for all cooks in the facility. Any new cooks hired will have the education at orientation. Dietary Manager/Designee will educate on coming staff. Completed [DATE] 6. IDT revised the Preventing Foodborne Illness-Food Handling policy and procedure. All education completed for all cooks. 7. Unpasteurized eggs have been removed from the ordering guide per the food vendor. Dietary Manager/Designee [NAME] check each order that is delivered that the eggs are label pasteurized eggs on the carton. Any unpasteurized eggs received will be immediately discard. INHA will conduct random audits weekly for four weeks upon food delivery to ensure the facility is not receiving unpasteurized eggs. Audits will be taken to QAPI to review for any concerns addressed immediately and to discuss if audits need to continue. Completion date [DATE]. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The deficient practice continues at a severity/scope of an F (potential for harm/widespread) as evidenced by: INFECTION CONTROL: On [DATE] at 12:28 PM, Surveyor observed CNA Z (Certified Nursing Assistant) to enter the kitchen without performing hand hygiene or wearing a hairnet. On [DATE] at 7:23 AM, Surveyor observed breakfast tray line with Cook S. Cook S left the tray line with her gloves on touching various items within the kitchen. On return to the tray line Cook S did remove her gloves or wash her hands. On [DATE] at 11:34 AM, Surveyor observed DA V (Dietary Aide) with his mask under his chin. Surveyor asked DA V how his mask should be worn, DA V replied on his nose and that he has difficulty breathing with the mask on. On [DATE] at 11:45 AM, Surveyor observed DA T with her mask under nose and asked how her mask should be worn, DA T replied No, it's supposed to be on my nose. On [DATE] at 11:45 AM, Surveyor observed DA T during tray line and was asked by Cook S to take temperatures of the desserts. DA T obtained a thermometer and took temperatures, removed her gloves by curling them in her hand and obtaining another pair of gloves, no hand hygiene performed. After the tray delivery cart was full, DA T delivered the cart to the unit with the same gloves on and returned to the kitchen. Surveyor asked DA T if she has changed her gloves or washed her hands. DA T replied No and washed her hands. On [DATE] at 12:56 PM, Surveyor asked DA T to locate the ice machine. DA T opened the ice machine cover and found a covering of brown spotted substances throughout the cover. Surveyor asked DA T if the machine appears clean and the maintenance schedule. DA T replied that she didn't know what that was, and she does not know the cleaning schedules and that someone comes to clean it. PERSONAL ITEMS: On [DATE] at 12:45 PM, Surveyor observed a personal backpack on a shelf with clean dessert dishes below. The backpack has cords coming out and plugged into an outlet above the clean silverware cart. Surveyor asked DA T if a personal backpack should be on a clean kitchen utility rack. DA T replied, No. WET STACKING: On [DATE] at 9:21AM, During the initial tour with Cook S, Surveyor observed wet substance in a 3L container upside down stacked on top of another alike container. Surveyor asked Cook S what the substance was inside the top container. Cook S pulled the container down from the clean utility rack and touched it. Cook S replied, I don't know what that is, maybe it wasn't cleaned well enough. Surveyor asked Cook S if drying could occur with a wet substance tightly packed inside of another alike size container, she replied, I don't think it can. DISHWASHING: (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:21 AM, During initial tour with Cook S, Surveyor observed the dishwasher spraying out approximately 4 feet of water and an alarm sounding. Surveyor asked Cook S if the dishwasher normally sprays out that far, she replied she didn't know anything about it. Surveyor asked DA V what the alarm was for. DA V reports it goes off all the time. Surveyor asked to read the reason for the alarm. DA V replied, he did not know. Surveyor asked DA V if this was reported, he replied he has informed DOM W (Director of Marketing). On [DATE] at 1:01 PM, Surveyor asked DA V to demonstrate temperature checks on the dishwasher. DA V replied, I don't have time, I am sorry, I am the only one today. On [DATE] at 11:20 AM, Surveyor asked Cook U if he has had any dishwasher training and identified any alarms, he reported, Yes, I talk to DOM W a thousand times every day until I bang my head against the wall. On [DATE] at 1:33 PM, Surveyor asked INHA A and VPO G to come to the kitchen for observations. Surveyor asked INHA A if there should be an alarm on the dishwasher, she replied no. Surveyor asked INHA A if the staff should be wearing an apron, she replied yes. On [DATE] at 4:20 PM, Surveyor asked to come to INHA A's office for the dishwasher service technician staff present. The dishwasher service technician reports he looked at the dishwashing machine and that it is limed up; deliming the machine must be done at least monthly. Surveyor asked dishwasher service technician regarding the alarms going off, dishwasher service technician reported because the machine is out of detergent and that he has demonstrated to Cook U how to add detergent. TEMPERATURES/DOCUMENTATION: On [DATE] at 12:49 PM, Surveyor provided temperature logs on the freezer to Cook S. Surveyor asked Cook S why the boxes from the past few days on the log were not filled out. Cook S replied, I didn't think you would notice. On [DATE] at 1:33 PM, Surveyor provided temperature logs of the freezer and the food to INHA A. Surveyor asked INHA A when the logs should be filled out, INHA A replied on the same day. Surveyor asked INHA A if the logs should always have the same temperatures every day, she replied No. On [DATE] at 5:03 PM, Surveyor observing dinner tray line and asked AD E (Activities Director) if the food had temperatures taking prior to serving. AD E replied he thought Cook S checked everything before she left, we don't normally check. Note: Surveyor observed temperature logbook and no temperatures were documented for dinner meal. SCOOPS: On [DATE] at 9:21 AM, During initial tour with Cook S, Surveyor asked Cook S what was inside the container located on the prep table and what the product of the container was. Cook S reports it is thickener and that is a scoop inside. Surveyor asked Cook S if there should be a label of identification and date, she replied yes and stated, There probably should not be a scoop in there either. Surveyor asked Cook S about the dry cereal for identification and what was the product inside the container. Cook S replied, It was Froot Loops. I will label, and I will take out the scoop. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:09 AM, Surveyor asked INHA A what was inside the container of the thickener, she replied it was a scoop and shouldn't be in there. FAN: On [DATE] at 5:18 PM, Surveyor observed dinner tray line with AD E cooking. Surveyor observed the floor fan on pointing air in the direction of the tray line. Surveyor observed a paper tray card blow into the steam table onto the meatballs. AD E looked at Surveyor and stated, That's not good. On [DATE] at 8:09 AM, Surveyor observed breakfast tray line with INHA A. Surveyor asked INHA A the appearance of the fan that is sitting on the floor. INHA A reports the fan is dirty and should not be in here. DINNERWARE: On [DATE] at 11:47 AM, Surveyor observing lunch tray line. Surveyor asked Cook S how the food stays warm. Cook S replied, the metal plate warmer is broke and I have asked maintenance to look at it. Surveyor asked Cook S if the dinner plate warmer worked, she replied, It's okay. On [DATE] at 12:12 PM, Surveyor observed lunch tray line. Surveyor asked DA V if he was placing plastic disposable spoons on the trays. DA V replied yes, because they do not have enough spoons for all the residents, and they have informed DOM W. On [DATE] at 12:16 PM, Surveyor asked Cook S the reasoning for using lipped plates and portioned plates. Cook S replied because they don't have enough dinner plates for all the residents and have informed DOM W. On [DATE] at 8:09 AM, Surveyor observed breakfast tray line. Surveyor demonstrated to INHA A disposable spoons being used in the tray line. When Surveyor asked INHA A if she was aware of the shortage of the spoons for the residents, she replied she did not know and would order some. DA T stated to INHA A DOM W was previously informed. On [DATE] at 8:50 AM, Surveyor observed breakfast tray line. RN LL was observed asking where more plates are kept. Note: There were no DAs or cooks scheduled at this time. Surveyor informed RN LL of observations with lack of regular plates and dietary staff using lipped or portion plates due to lack of regular plates. Surveyor asked RN LL if it is appropriate to use lipped plates or portioned plates when residents do not require specialized dishes. RN LL replied, the residents should have regular plates. OUTDATED FOOD: (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:21 AM, Surveyor asked Cook S while pointing to the large 3-gallon container on the shelf with white substance to identify, date and if it is covered. Cook S reports I just poured that yesterday, it is flour. I will date it and our covers don't fit well on these containers. During the tour of the dry storage room with Cook S, Surveyor asked what the substances were on the floor under the utility racks. Cook S replied they are spilled brown substance and a peanut butter individual cup. Surveyor provided to Cook S 2 bags of hoagie buns from the bread rack. Surveyor asked Cook S what the green substance was in both bags, she replied that it was mold, and we don't get our bread fresh anymore, it's frozen. Surveyor asked Cook S the process of how items are handled once they come from the vendor. Cook S reports she usually puts some away. Surveyor asked Cook S how the dating system works for receiving product. Cook S reports items are dated when they arrive, when opened and when they are to use them by. Surveyor asked Cook S if the country dry sausage 6-pound can should be dated, she said yes. Note: 6 cans are dated received , d+[DATE], 1 is not dated. Surveyor asked Cook S if the brownie mix should be dated, she replied, yes. Note: 4 total brownie mix boxes, one box is opened and not dated, 3 unopened boxes are not dated. Surveyor asked Cook S if the yellow cake mix boxes should be dated, she replied yes. Note: 5 yellow cake mix boxes are not dated. Surveyor asked Cook S if the 25-pound bag of flour is dated, she replied no. Surveyor asked Cook S to read the date of the flour, she replied manufacturer expiration [DATE]. Note: Flour is expired. Surveyor asked Cook S the 5-gallon container of breadcrumbs of the expiration date, she reports [DATE]. Surveyor asked if the breadcrumbs were outdated, she replied yes. Note: the cover was off the container of breadcrumbs and is expired. Surveyor went to reach in cooler with Cook S. Surveyor asked Cook S what was in a 5-gallon bucket, she replied Chicken base dated ,d+[DATE]. Surveyor asked Cook S to describe the appearance. She replied it is crusted on the top and is probably bad. Surveyor asked Cook S to identify the bowl on the top shelf. She replied a tomato soup bowl with a cover that has spilled down the side with a cracked lid, the date is ,d+[DATE]. Cook S removed tomato soup. Surveyor also observed: Applesauce, opened date ,d+[DATE], use by date ,d+[DATE] Pasta salad individual dated ,d+[DATE] Dressing of unknown substance, dated [DATE] good for 3 days Whipped cream squeeze, no date, has a loose baggie on the opened end Cottage Cheese 5 pounds, opened date ,d+[DATE] Fruit juice for puree, dated ,d+[DATE], use by ,d+[DATE] Folgers coffee opened and crusted in bag, no date, removed by Cook S Initial tour continued into the walk-in freezer with Cook S. Cook S reports the freezer was broke yesterday and was fixed, she was not aware how long it was broke, maybe a few hours. Note: freezer temperature log does not have documentation for yesterday. Note: the internal thermometer does not have a glass cover and the needle is crystalized. The freezer was covered with crystallization with frozen water droplets on the ceiling and 4 inches of ice mounded up near the door frame and along the metal shelving. Cook S scratched off the thermometer to move the ice to read it. Cook S scratched off freezer items to read labels. Surveyor asked Cook S if the thermometer is reading correctly, she replied she did not think so. Surveyor observed the following items: (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Baker boy pastry, use by date [DATE] Mighty Shake Vanilla, low sugar, not dated, suggested manufacturer use by date [DATE] x6 items Mighty Shake Strawberry, not dated, suggested manufacturer use by date [DATE], unopened case Surveyor went into the walk-in cooler with Cook S during initial tour. Surveyor asked Cook S to identify the items on the racks in the trays. Cook S replied, the desserts of pears, pudding with whipped cream and a full sheet of cake. Cook S reports unable to locate dates. Surveyor asked Cook S if the items should be dated, she replied yes. Surveyor asked Cook S to identify the 5-pound bags in the cooler. Cook S was not able to identify the 4 bags of a liquid brown substance and stated, I would not eat this. Note: no identification of the item, no dates. Surveyor asked Cook S the date of the cooked noodles, she replied ,d+[DATE] with a use by , d+[DATE]. Surveyor asked Cook S if the noodles are outdated, she replied yes. Surveyor asked Cook S the use of the 6 gray tubs that contained 3 juices, milk, thickener. Cook S reports each wing will get a tub during meals for the beverages. Surveyor asked Cook S if the pitchers should be dated, she replied yes. Note: Pitchers were noted to be topped off after meals and placed back into the cooler. Surveyor asked Cook S to open the BUN juice machine. Surveyor asked Cook S for the dates, she reports I know one was just changed yesterday. Note: dates were not found on the opened juice containers in the BUN machine. Cross Reference: F801, F802, and F804

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility administration did not ensure residents received care and services to promote residents highest practicable physical, mental, and psychosocial well-being for each resident. This has the potential to affect all 67 residents. Administration team should have known the facility had concerns with F580, F684, F760, F812, F801, F880, F881, F882, F883 and F887. F580 - (3 examples) Example 1 R118 has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . R118's most recent [CONDITION(S)] occurred on [DATE]. On [DATE] R118 had two (2) seizures with subsequent falls. The first [CONDITION(S)]/fall occurred at 7:30 AM. The facility did not notify R118's Physician. R118's second [CONDITION(S)] occurred at approximately 3:00 PM (during shift change). During R118's second [CONDITION(S)]/fall, DOT OO (Director of Therapy) was walking down the hall when he observed R118 falling forward right before hitting the floor. DOT OO reported to Surveyor that no staff were with R118 at the time of his [CONDITION(S)]/fall. Facility staff moved R118 and never consulted with his Physician. When R118 was sent to the ED (Emergency Department) approximately 2 hours later, he was diagnosed with life-threatening injuries including: [NAME] I and II (two facial fractures), SAH (Subarachnoid Hemorrhage), and C7 fracture (7th cervical spinal vertebra). R118 passed away at the hospital on [DATE]. The facility failed to notify R118's Physician of two falls/seizures on [DATE]. The second [CONDITION(S)]/fall resulted in R118's death two (2) days later. On [DATE] DOT OO (Director of Therapy) documented an Admission Functional Status Form that indicated R118's Transfer Status is Independent, Assistive Devices: None, and Special Instructions Supervision recommended when outside of room - tends to wander and is impulsive. Refuses FWW (four wheeled walker). (Note, the facility did not implement Therapy's safety recommendation.) On [DATE] at 10:49 AM, Surveyor spoke with VPO G (Vice President of Operations) and INHA A (Interim Nursing Home Administrator). Surveyor asked VPO G, was the Therapy recommendation Supervision recommended when outside of room - tends to wander and is impulsive. Refuses FWW (four wheeled walker). VPO G stated, They're just that, recommendations,.some recommendations we get don't add up to care we can provide. Example 2 R46 has a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . R46's physician orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE], R46 weighed 203.4 lbs. On [DATE], the resident weighed 191 pounds which is a 6.10 % loss. Facility staff did not reweigh R46, and there is no documentation that the physician or family was updated. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 3 R54 had a [CONDITION(S)] event without a [CONDITION(S)] diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . F 684 (3 examples) Example 1 The facility did not follow DOT OO's (Director of Therapy) recommendation, dated [DATE], Supervision recommended when outside of room - tends to wander and is impulsive. R118 has diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE] R118 had two (2) seizures with subsequent falls. The first [CONDITION(S)]/fall occurred at 7:30 AM. The facility did not obtain vitals, complete an assessment, nor monitor R118. R118's second [CONDITION(S)] occurred at approximately 3:00 PM (during shift change). During R118's second [CONDITION(S)]/fall, DOT OO was walking down the hall when he observed R118 falling forward right before hitting the floor. DOT OO reported to Surveyor that no staff were with R118 at the time of his [CONDITION(S)]/fall. Facility staff moved R118 and never consulted with his Physician. R118's APOAHC (Activated Power of Attorney for Health Care) initially told staff to not send R118 to the ED. Staff report to Surveyor they were unable to control R118's bleeding. Approximately two hours later, a family member at the facility took pictures of R118 and sent them to R118's APOAHC. The APOAHC then notified the facility to call 911 and send R118 to the ED (Emergency Department). R118 was admitted to the hospital with life-threatening injuries including: [NAME] I and II (two facial fractures), SAH (Subarachnoid Hemorrhage), and C7 fracture (7th cervical spinal vertebra). R118 passed away at the hospital on [DATE]. On [DATE] at 10:49 AM, Surveyor spoke with VPO G (Vice President of Operations) and INHA A (Interim Nursing Home Administrator). Surveyor asked VPO G, was the Therapy recommendation Supervision recommended when outside of room - tends to wander and is impulsive. Refuses FWW (four wheeled walker). VPO G stated, They're just that, recommendations,.some recommendations we get don't add up to care we can provide. Example 2 R117 has a diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On [DATE] R117 was admitted to the facility with an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The facility did not transcribe R117's [CONDITION(S)] order. R117 went from [DATE]-[DATE] (7 days) without the ordered [CONDITION(S)]. Subsequently, R117 was transferred to the emergency roiagnom on [DATE] where he was hospitalized from ,d+[DATE] - [DATE] with primary diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Example 3 R45 had [CONDITION(S)] activity 11 days prior to admission to the facility, the facility failed to implement at risk interventions upon admission. R45 had [CONDITION(S)] activity in the facility, the facility failed to confirm notification resulting in failure for further treatment or diagnostic testing for standards of practice, to allow for clinical interventions and any care plan implementations. R45 had another [CONDITION(S)]. The Nurse Practitioner could not confirm a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F760 Example 1 R4 has an order [MEDICATION(S)] [CONDITION(S)] Solution - Administer 60 milliliters by mouth two times a day for [CONDITION(S)] of the liver. The facility ran out of R4's [MEDICATION(S)] and did not administer three (3) consecutive doses: [DATE] (HS-bedtime) [DATE] (AM and HS-bedtime dose). The facility did not consult with R4's Physician or Nurse Practitioner regarding running out of [MEDICATION(S)]. On [DATE] LPN EE (Licensed Practical Nurse-Agency) noted a change in R4's demeanor (using inappropriate language and name calling) and that he had two (2) falls on [DATE]. LPN EE stated she notified an RN (Registered Nurse) that is no longer employed at the facility regarding her concerns. There is no documentation that the RN assessed R4, obtained vitals, nor consulted with R4's Physician or Nurse Practitioner. R4 was hospitalized from [DATE] - [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . This relieves the pressure of blood flowing through the diseased liver and can help stop bleeding and fluid back up.), cognitive impairment, and [CONDITION(S)]. Example 2 R54 Continued to receive sliding scale insulin due to order to stop sliding scale after scheduled [MEDICATION(S)] Insulin is back into the facility resulting in medication errors. F812 Failure to ensure unpasteurized eggs were fully cooked placed R3 and R20 at risk for becoming infected by Salmonella and created a finding of Immediate Jeopardy (IJ) that started on [DATE]. INHA (Interim Nursing Home Administrator) A, VPO G (Vice President of Operations) and RN LL (Registered Nurse) was informed of the Immediate Jeopardy on [DATE] at 2:46 PM. The Immediate Jeopardy was removed on [DATE], when the facility started to implement their removal plan. The deficient practice continues at a scope/severity of an F (potential for harm/widespread) as the facility continues to implement its removal plan and as evidenced, in part, by staff failure to use hairnets and masks in the kitchen, to wash hands/change gloves when indicated while cooking, to check temperatures of the dishwasher, to ensure the dishwasher had detergent, to ensure opened food was dated and not expired, to ensure a fan was not blowing across the steam table, and by the use of plastic dinnerware. F801 The facility failed to ensure their Contracted Registered Dietician worked full time in the building while they were recruiting a new Director of Food and Nutrition Services. The facility Admission/Marketing Director is serving as the facility Interim Dietary Manager and has no dietary certifications or education. F880 Resident surveillance of infection control does not include S/Sx (signs and symptoms), organism, or colony count for [DATE]-[DATE] reviewed. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility is not accurately identifying if an infection meets criteria. Infection control program is not being tracked daily. Facility is not ensuring that new admissions are reviewed thoroughly to ensure all infection control data is obtained. Many infection control Policies and Procedures have not been reviewed annually. Facility does not have infection control rates for [DATE]-February 2021, [DATE], or [DATE]. Staff surveillance for infection control is only present for June-[DATE] and this only includes COVID. The Facility has little to no information for COVID outbreaks in [DATE] or [DATE]. Infection control mapping is not being completed contemporaneously to track and trend infections. F881 Residents either had no supporting documentation for antibiotic use or the supporting documentation did not support antibiotic use. F882 IDON B (Interim Director of Nursing) is designated as the IP (Infection Preventionist) and has not had any specialized training in infection prevention and control. F883 R55, R1 and R65 had no documentation of influenza or pneumococcal immunizations in their medical record. F887 R55, R1, R65, R4, and R31 had no documentation of COVID-19 immunizations in their medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not establish and maintain an infection prevention and control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has the potential to affect 67 of 67 residents. Resident surveillance of infection control does not include S/Sx (signs and symptoms), organism, or colony count for April 2022-July 2022 reviewed. Facility is not accurately identifying if an infection meets criteria. Infection control program is not being tracked daily. Facility is not ensuring that new admissions are reviewed thoroughly to ensure all infection control data is obtained. Many infection control Policies and Procedures have not been reviewed annually. Facility does not have infection control rates for July 2021-February 2021, May 2022, or June 2022. Staff surveillance for infection control is only present for June-July 2022 and this only includes COVID. The Facility has little to no information for COVID outbreaks in May 2022 or July 2022. Infection control mapping is not being completed contemporaneously to track and trend infections. This is evidenced by: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Surveillance for Infections Policy and Procedure dated April 2022, documents in part: The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) .1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections .7. When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures . Gathering Surveillance Data 1. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data .2. The surveillance should include a review of any or all of the following information to help identify possible indicators of infections: a. Laboratory records . e. Infection documentation records .3. If laboratory reports are used to identify relevant information, the following findings merit further evaluation .b. Positive wound cultures that do not just represent surface colonization c. Positive urine cultures (bacteriuria) with corresponding signs and symptoms that suggest infection .Data Collection and Recording 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate .b. Diagnoses; c. admitted , date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test) .e. Pathogens .g. Pertinent remarks (additional relevant information, i.e. temperatures, other symptoms of specific infection, white blood cell count, etc.) .h. Treatment measures and precautions (interventions and steps taken that may reduce risk .4. For targeted surveillance using facility-created tools, follow these guidelines: a. DAILY (as indicated): Record detailed information about the resident and infection on an individual infection report form . Calculating Infection Rates 1. Obtain the month's total resident days from business office. The following data is used as the denominator to calculate the monthly infection rate .Interpreting Surveillance Data 1. Analyze the data to identify trends . Resident Surveillance April 2022 has two different line lists; one includes more information than the other but neither list documents S/Sx. (Signs or symptoms) for any of the 10 infections listed for the month. Organism is identified on 4 of 7 infections. Colony count is identified for 2 of 7 infections. R66 has conflicting data; on the line list he is listed for LRI (lower respiratory infection) but on the SHEA form it is listed as pneumonia. R15 does not have enough S/Sx documented to meet criteria for pneumonia. R22 has no S/Sx documented. May 2022 line list does not document any S/Sx, organism or colony count for any of the 4 infections listed for the month. R22 does not have enough S/Sx documented to meet criteria for an infection, and it is documented in a concern for R22 that he must quit drinking on 5/24/22 due to staff's inability to meet his needs to use the urinal. R28 was treated for [MEDICAL RECORD OR PHYSICIAN ORDER] . R30 has no S/Sx documented. June 2022 line list does not document any S/Sx, organism or colony count for any of the 6 infections listed for the month. R50 has conflicting data; on line list and SHEA form it says he's being treated for [MEDICAL RECORD OR PHYSICIAN ORDER] . R34 has no S/Sx documented. R48 has no S/Sx documented. R28 has no S/Sx documented. R30 has no S/Sx documented. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	July 2022 (reviewed data from July 1-20) line list does not document any S/Sx, organism or colony count for any of the 7 infections list for the month, thus far. R63 has no S/Sx documented. R21 has no S/Sx documented and there is documentation that says R21 has no S/Sx. All resident line lists are only for those residents that are being treated with antibiotics not residents with S/Sx of potential infection. Identification of meeting criteria of infection For April 2022 through July 20, 2022, the Facility is utilizing a SHEA (Society for Healthcare Epidemiology) document to identify if an infection meets criteria but states they are using CDC (Centers for Disease Control) as their standard of practice for infection control. These two organizations do not align therefore their identification is not accurate. It is important to note that the SHEA form is not complete and, in some cases, inaccurate. Daily infection control Per interview with IDON B (Interim Director of Nursing) staff are reviewing the 24-hour report log and reviewing orders for antibiotics daily. S/Sx are not tracked daily. New admissions The Facility does not currently have a process to ensure they receive all the appropriate data for infection control for new admissions. Policies and Procedures The following Policies and Procedures have not been reviewed annually: Pneumococcal Vaccine dated October 2019 Legionella Surveillance and Detection dated July 2017 COVID-19 Vaccination Policy is undated (It is important to note that this policy only addresses staff, not residents) The Facility could not locate Policies/Procedures for: Staff Illness, Outbreak Infection Control Rates The Facility does not any documentation for infection control rates for July 2021-February 2021, May 2022, or June 2022. Staff Surveillance Staff surveillance for infection control is only present for June-July 2022 and this only includes COVID. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Outbreaks Facility only has a resident line list and map for May 2022 COVID outbreak. There is no documentation of what interventions were put into place or when notification to Public Health or the Facility's Medical Director took place. Facility only has staff and resident line list for July 2022 COVID outbreak. There is no documentation of what interventions were put into place when notification to Public Health or the Facility's Medical Director. Infection Control Map Maps are completed at the end of the month for QA (Quality Assurance) purposes not in real time to manage potential trend or outbreak in facility. On 7/27/22 at 2:56 PM, Surveyor interviewed IDON B. Surveyor asked IDON B what standard of practice the facility uses for infection control. IDON B stated, I don't know which standard of practice is used. Surveyor asked IDON B how the facility determines if an infection meets criteria. IDON B said they mainly look at those put-on antibiotics and pull the antibiotic log. Surveyor asked IDON B if the infection control program is conducted daily. IDON B replied that the 24-hour report log and orders for antibiotics are reviewed daily. Surveyor asked IDON B what if a resident is having S/Sx of an infection but hasn't been put on an antibiotic, is that tracked somewhere; IDON B said should be documented in the progress notes. Surveyor asked IDON B if the infection control log should be accurate. IDON B stated yes. When Surveyor asked IDON B how often the infection control Policies and Procedures are reviewed, IDON B said, I'm not sure, possibly yearly. Surveyor asked IDON B if the facility doesn't have the surveillance on the SHEA form or the line list, where it is; IDON B stated, we need to put all that on the log. Surveyor asked IDON B how the facility ensures that they have all pertinent infection control data for new admissions. IDON B replied that the admitting nurse puts the orders in notes if they are on an antibiotic. Surveyor asked IDON B who ensures that the facility has the data, for example a urine culture that isn't resulted yet; IDON B said they should be putting a note on the chart or in the MAR (Medication Administration Record)/TAR (Treatment Administration Record) to follow up on that. When Surveyor asked IDON B if there were any other records for staff illness besides June-July 2022, IDON B stated they could not locate any other records. Surveyor asked IDON B if the infection control map is updated in real time. IDON B said you'll have to ask the ED (Executive Director/NHA (Nursing Home Administrator) how she does that. Surveyor asked IDON B if there were any infection control rates for July 2021-February 2022 or May 2022 or June 2022. IDON B said what is in the binder is what I could find. When Surveyor asked IDON B if there was any further documentation for the COVID outbreak in May or July, IDON B stated, not that I could find. It is important to note that IDON B was indicated to be the IP (Infection Preventionist) for this facility. On 7/27/22 at 3:33 PM, Surveyor interviewed INHA A (Interim Nursing Home Administrator). Surveyor asked INHA A if she knew what standard of practice the facility is using for infection control. INHA A stated CDC. Surveyor asked INHA A if she would expect the infection control program to be conducted daily. INHA A said yes it should be done daily.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This affected 4 of 21 sampled residents (R4, R47, R22, R48) and 4 supplemental residents (R166, R15, R43, and R50). Residents either had no supporting documentation for antibiotic use or the supporting documentation did not support antibiotic use. This is evidenced by: The Facility's Antibiotic Stewardship Policy and Procedure, dated December 2021, documents in part: .4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements . f. Indications for use. 5. When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. 6. Discharge or transfer medical records must include all of the above drug and dosing elements .8. When a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the following information available: a. Signs and symptoms; b. When symptoms were first observed .11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued . April 2022 R4 was on an antibiotic upon admission; however the facility did not provide supporting documentation to support the use of the antibiotic. R166 is listed on line list for [CONDITION(S)]. His C/S (culture and sensitivity) grew out 1000-9000 cfu/ml (colony-forming unit per milliliter) of mixed flora and documented on C/S is the following: .**Cultures that show greater than three different species including potential uropathies are suggestive of contamination or colonization. No further workup. Recommend repeat specimen to determine significance. ** . R166's Discharge Summary documents, in part: .CT abdomen obtained and shows bladder wall thickening consistent with [CONDITION(S)] (urinary tract infection) and bilateral lower lung field infiltrates which could be 2/2 (secondary to) chronic aspiration .blood cultures only one if (should be of) 4 with staph epi (staphylococcus epidermis which is normal human skin flora) =>contaminant .) R166 was treated with [MEDICATION(S)] (a broad-spectrum antibiotic) from 4/4/22-4/13/22. There is no documentation that the facility followed up with R166's Provider. R47 was hospitalized [DATE]-[DATE] due to proteus mirabilis catheter associated urinary tract infection and bacteremia. The facility could not provide the UA (urinalysis), C/S, or blood cultures. The hospital documentation was not present in R47's medical record it was printed from the Carelink portal on 7/26/22. R47 was treated with [MEDICATION(S)] from 4/20/22-4/30/22. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15 did not have any S/Sx of infection documented at facility. R15 was treated with [MEDICATION(S)] from 4/26/22-5/6/22. R22 had no S/Sx of infection documented. R22's C/S grew >100,000 cfu/ml E. coli (Escherichia coli) and 5, 000 cfu/ml mixed skin/[CONDITION(S)] flora. R22 was treated with [MEDICATION(S)] ([MEDICATION(S)]) 4/29/22-5/6/22. May 2022 R22's C/S results dated 5/19/22 document culture urine- further incubation required and handwritten on lab result it says, Call MD (Medical Doctor) in morning again did not call back. C/S dated 5/20/22 grew out >100, 000 cfu/ml mixed flora and documented on C/S is the following: .**Cultures that show greater than three different species including potential uropathies are suggestive of contamination or colonization. No further workup. Recommend repeat specimen to determine significance. ** . R22 was treated with [MEDICATION(S)] ([MEDICATION(S)]) 5/21/22-5/26/22. There is no documentation that the facility followed up with R22's Provider. June 2022 R43's CxR (chest x-ray) documents .radiograph of chest showed no pneumonia .No acute cardiopulmonary disease. Features of [CONDITION(S)] (Chronic Obstructive Pulmonary Disease) . R43 was treated with [MEDICATION(S)] 6/30/22-7/4/22. There is no documentation that the facility followed up with R43's Provider. R50 had no S/Sx of infection documented at facility. The facility could not provide the UA (Urinalysis) or C/S. R50 was treated with [MEDICATION(S)] 6/27/22-7/3/22. R48 had no S/Sx of infection documented at facility. The facility could not provide the UA or C/S. R48 was treated with [MEDICATION(S)] and [MEDICATION(S)] 6/13/22-6/22/22. July 2022 R47 had no S/Sx of infection documented at facility. The facility could not provide the UA or C/S. R47 was treated with IV (intravenous) [MEDICATION(S)] through PICC (peripherally inserted central catheter- IV access that can be used for a prolonged period of time) line 7/13/22-7/20/22. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/27/22 at 2:56 PM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B what standard of practice the facility uses for infection control. IDON B stated, I don't know which standard of practice is used. Surveyor asked IDON B how the facility determines if an infection meets criteria. IDON B said they mainly look at those put-on antibiotics and pull the antibiotic log. Surveyor asked IDON B if the infection control log should be accurate. IDON B stated yes. When Surveyor asked IDON B how the facility ensures that they have all pertinent infection control data for new admissions, IDON B replied that the admitting nurse that puts the orders in notes if they are on an antibiotic. Surveyor asked IDON B who ensures that the facility has the data, for example a urine culture that isn't resulted yet; IDON B said they should be putting a note on the chart or in the MAR (Medication Administration Record)/TAR (Treatment Administration Record) to follow up on that. Surveyor asked IDON B if a C/S doesn't meet criteria should there be a conversation with the Provider. IDON B said yes, and it would be documented in the residents' medical record. Surveyor asked IDON B if the C/S shows contamination, should that be treated or re-collected. IDON B replied it should be re-collected. Surveyor asked IDON B if a C/S shows < 100,000 cfu/ml is that indicative of treatment. IDON B said they should notify the Provider of the findings and document if they don't hear back. It is important to note that IDON B was indicated to be the IP (Infection Preventionist) for this facility. On 7/27/22 at 3:33 PM, Surveyor interviewed INHA A (Interim Nursing Home Administrator). When Surveyor asked INHA A if she knew what standard of practice the facility is using for infection control, INHA A stated CDC (Centers for Disease Control).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay at Belmont Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview, the facility failed to designate an individual as the infection preventionist that has completed specialized training in infection prevention and control. This has the ability to affect all 67 residents. IDON B (Interim Director of Nursing) is designated as the IP (Infection Preventionist) and has not had any specialized training in infection prevention and control. This is evidenced by: Upon the entrance conference on 7/20/22 that was held with Surveyors and IDON B, the question was asked who the IP was. IDON B said she wasn't sure, but she would find out and get back to Surveyors. A short time later, a Regional Staff Member entered, and she was asked who the IP was. This Regional Staff Member stated IDON B was. Surveyors alerted her that the IDON B was not aware that the role of the IP was hers at this time. On 7/27/22 at 2:56 PM, Surveyor interviewed IDON B. Surveyor asked IDON B what training she has had in infection control. IDON B stated she has not had any. Surveyor asked IDON B if she completed the CDC (Centers for Disease Control) infection control training or any training by APIC (Association for Professionals in Infection Control). IDON B replied no.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	07/27/2022

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility did not ensure the resident's medical record includes documentation that indicates, at a minimum, the following: that the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza and/or pneumococcal immunization; and that the resident either received the influenza and/or pneumococcal immunization or did not receive the influenza/pneumococcal immunization due to medical contraindications or refusal, this affected 3 of 5 residents (R55, R1 and R65) reviewed for immunizations. R55, R1 and R65 had no documentation of influenza or pneumococcal immunizations in their medical record. This is evidenced by: The Facility's Influenza Vaccine Policy and Procedure, dated April 2022, documents in part: All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives) .4 .Provision of such education shall be documented in the resident's . medical record. 5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's .medical record. 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record . The Facility's Pneumococcal Vaccine Policy and Procedure, dated October 2019, documents in part: All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections .2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. 3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine .5. Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 6. For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record . Surveyors requested documentation for R55, R1 and R65 for administration of or declination of influenza and pneumococcal immunizations several times with no documentation being provided. On 7/27/22 at 2:56 PM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B if the facility had any influenza or pneumococcal immunization documentation for R55, R1 or R65. IDON B said I don't see any. Surveyor asked IDON B if R55, R1 and R65 should have documentation of either the administration of the vaccine or the declination of the vaccine. IDON B stated yes, it should be documented, I'm unsure if they were offered or given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay at Belmont Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility did not ensure the resident's medical record includes documentation that indicates, at a minimum, the following: that the resident or resident's representative was provided education regarding the benefits and potential side effects of COVID-19 immunization; and that the resident either received the COVID-19 immunization or did not receive the COVID-19 immunization due to medical contraindications or refusal. This affected 5 of 5 residents (R55, R1, R65, R4 and R31) reviewed for immunizations. R55, R1, R65, R4, and R31 had no documentation of having received or declined COVID-19 immunizations in their medical record. This is evidenced by: The Facility did not have a COVID-19 Vaccination Policy and Procedure for Residents. The Facility provided Surveyors with a Resident COVID-19 vaccination log. On this log, R55, R1, R65, R4 and R31 were listed as refused, not vaccinated. Surveyors requested documentation for R55, R1, R65, R4 and R31 for administration of or declination of COVID-19 immunizations several times with no documentation being provided. On 7/27/22 at 2:56 PM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B if the facility had any COVID-19 immunization declination documentation for R55, R1, R65, R4, and R31. IDON B said I don't see any. Surveyor asked IDON B if R55, R1, R65, R4 and R31 should have documentation of the declination of the vaccine. IDON B stated yes, it should be documented.