STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525273	A. Building B. Wing	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloit Health and Rehabilitation Center	1905 W Hart Rd Beloit, WI 53511

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45695 Based on observation, interview, and record review, the facility did not ensure that each resident received the needed supervision to prevent accidents for 1 of 3 total sampled residents (R6) reviewed for falls. R6 received a bed bath on 11/19/22 with the assist of 1 Certified Nursing Assistant (CNA). R6 rolled out of bed due to R6 missing the grab bar and landed on her back onto the floor. R6 was to be a two-person assist with her bed bath, and staff only used assist of 1. This is evidenced by: The Facility's Policy and Procedure entitled Bath, Bed with a last revised date of 2/18, documents, in part: . Back: a. Instruct the resident to turn on his/her side with his/her back toward you. (Note: Be sure the side rail is up on the opposite side of the bed to prevent the resident from rolling out of bed.) . R6 is a long-term resident of the facility. R6 was admitted on [DATE] with a diagnosis history that indicates: Cerebrovascular Disease, Cerebral Infarction, Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affecting Left Non-Dominant Side, R6's quarterly Minimum Data Set (MDS) assessment on 9/15/22 indicates R6 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired. R6's is indicated as being usually understood and usually understands others. R6's Functional Assessment: extensive assistance with one person for physical assist with bed mobility, dressing and personal hygiene. R6's transfer and toileting require total dependence assistance with two + persons for physical assistance. R6's functional limitation assessment indicates one impairment on one side in the upper and lower extremities. Devices that R6 uses are a wheelchair. The fall assessment for R6 indicates no falls since admission. R6's care plan reviewed by surveyor on 12/13/22, documents the following, in part: ADL (Activities of Daily Living)/Mobility Care Plan-Page 1 . Interventions . Assist/encourage/provide per resident preference . Bed bath, Provide 2A (2 Assist) . Care Delivery Guide . prompt her to use the right side grab bar to assist with positioning, reposition/ assist every 2 hours . (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Note: this document is referred to as the Certified Nursing Assistant Kardex that does not indicate how many staff are required to assist R6.) R6's Fall assessment dated [DATE], R6 scored a 10 indicating moderate risk for falls. R6's Fall report dated 11/19/22 state, in part: . Notes: 11/21/22 Talked with resident regarding her fall. She said that when she rolls over, she grabs the bar, but she felt that she did not grab it hard enough and rolled over the side of the bed. She said that she has not had that problem ever before. Talked with her about having two staff to help and she said that she felt she could still be a one assist. So, we will keep her as a one assist and if in the future we feel she needs to be a two assist we will change at that time. Resident will be prompted to grab the enabler bar when turning over . (R6's paper copy of the care plan in her chart indicates R6 is a 2 assist with bed baths.) On 11/19/22 R6 Nursing Note state, states in part: At 1755 (5:55 PM), this writer was on the phone with another resident's family when CNA came to desk to alert me she needed help right away. Then heard screaming from down the hall. CNA stated that resident rolled out of bed while giving her a bed bath. Resident hit head, elbow, and bottom. DON (Director of Nursing), family and doctor notified . On 11/20/22 R6 Nursing Note, states in part: Resident returned to facility at 0200 (2:00AM). Resident has ace wrap to right arm, requested Norco for pain related to fall. Neuro checks within normal limits. Sleeping comfortably and this time. Call light within reach, able to make needs known. Will continue to monitor. On 12/12/22 at 2:37 PM, Surveyor observed R6's bed does not have siderails but has 2 grab bars. On 12/13/22 at 3:56 PM, Surveyor interviewed DON B. Surveyor asked DON B if any education was provided, DON B replied she did not know. Surveyor reviewed R6's care plan from the chart with DON B, and asked DON B if R6 should have 2 staff assist with a bed bath, DON B replied yes. Surveyor asked DON B if there were 2 staff to assist with R6's bed bath, would R6 have fallen. DON B replied to Surveyor, probably not. Surveyor provided the comparison of R6's care plan from the chart and the provided care delivery guide to DON B. Surveyor asked DON B how staff would know how many staff should assist with the bed bath for R6. DON B replied to Surveyor, They contradict each other. On 12/12/22 at 4:00 PM, Surveyor observed the care plan rack in the nursing station on the wall to be empty. On 12/13/22 at 4:10 PM, Surveyor interviewed LPN E (Licensed Practical Nurse). Surveyor asked LPN E where to look for the care plan, LPN E replied in the resident's chart. Surveyor reviewed R6's care plan in R6's chart. Surveyor asked LPN E how would R6 be assisted with her bed bath. LPN E replied to Surveyor that 2 CNAs would be needed for the bed bath. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/22 at 7:23 AM, Surveyor interviewed CNA C. Surveyor asked CNA C how she would know how to care for R6 for a bed bath. CNA C reported to Surveyor that the care plans are printed out. Surveyor asked CNA C where the care plans are located, CNA C advised the wall rack in the nurses station, and she had asked to have it filled as they have been out of copies. Surveyor asked CNA C to describe the events of R6's fall. CNA C replied to Surveyor that she looked for the other girl to help and she was busy, CNA C further reported that she is aware that R6 is a 2 person assist. CNA C explained to Surveyor that R6 rolled over to reach for the grab bar and rolled off the bed onto the floor landing on her back, hitting her head. CNA C stated to Surveyor she went to obtain a nurse, 911 was called, the paramedics picked up R6 from the floor, and R6 was taken to the hospital. Surveyor asked CNA C if she was provided any education, CNA C replied she did not remember but knows that any time she is taking care of R6 she will have 2 people assist in the cares. (CNA C did not follow R6's care plan by not waiting for a 2nd staff member to come and assist her with R6's bed bath.)

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F 0692 Level of Harm - 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** 42038 Based on interview and record review, the facility did not ensure Residents maintained acceptable parameters of nutritional and hydration status for 1 of 3 Residents (R2) reviewed for nutritional status. R2's nutritional and fluid intakes were not monitored to ensure he was meeting his estimated daily nutritional and fluid needs, resulting in 2 hospitalization s for dehydration. This is evidenced by: Facility policy titled Nutrition and Hydration Guideline dated 10/3/22, states in part, Purpose: The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters for nutritional and hydration status through: Providing nutritional and hydration care and services consistent with the nutritional comprehensive assessment. Recognizing, evaluating, and addressing the needs of every resident, including but not limited to, those at risk or already impaired nutrition and hydration .Process: Accurately and consistently assess a resident's nutritional status on admission and as needed thereafter: Identify a resident at nutritional risk and address risk factors for impaired nutritional status .Obtain weights upon admission, weekly x 4, monthly .Identify, implement, monitor, and modify interventions (as appropriate), consistent with the resident's needs, choices, preferences, goals, and current professional standards of practice, to maintain acceptable parameters of nutritional status. Notify the physician as appropriate in evaluating and managing causes of the resident's nutritional risk and impaired nutritional status. Identify and apply relevant approaches to maintain acceptable parameters of nutritional status, including fluids .Offer sufficient fluid intake to maintain proper hydration and health. Facility policy titled Notification of Change Guideline dated 10/3/22 states in part, .Requirements for notification of resident, the resident's representative, and their physician: A significant change in the resident's physical, mental, or psychosocial status. A significant change includes deterioration in health, mental, or psycho-social status . R2 was admitted to the facility on [DATE] with diagnoses that include right hip fracture with repair, hemiplegia, and hemiparesis following cerebral infarction (stroke) affecting the left side, Major Depressive Disorder, and hypertension. R2's Admission Minimum Data Set (MDS) dated [DATE] states that R2 has a Brief Interview for Mental Status (BIMS) of 3 out of 15, indicating that R2 is severely cognitively impaired. R2 requires extensive 2 person assist for bed mobility and is independent with eating, requiring setup help only. R2's Physician Orders state: Daily weight upon admission x 3 days, then weekly x 4 weeks, then monthly. R2 also had an order dated 11/3/22 for Ensure Clear with meals, changed to Ensure Regular with meals on 11/10/22. There is no documentation showing that R2 received the Ensure or how much he consumed. R2's weights were documented as follows: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/2/22: 147.2 lbs. (pounds). 11/7/22: 156 lbs. 11/18/22: 130.2 lbs. 11/19/22: 131.3 lbs. 11/20/22: 130.0 lbs. 11/21/22: 129.6 lbs. 11/28/22: 129.0 lbs. It is important to note that the facility did not complete daily weights for the first 3 days after admission (11/3 and 11/4), nor did they obtain a re-weigh when documentation showed that R2 had gained 9 lbs. Based on the documented weights, R2 had lost 26 lbs. from 11/7/22 to 11/18/22. Additionally, facility staff only entered the weights from 11/2/22 and 11/18/22 into the Electronic Health Record (EHR), the others were documented on the paper Medication Administration Record (MAR). There is no documentation indicating that the Physician was updated on R2's significant weight loss. R2's meal intake documentation is as follows: 11/2: RU (Resident Unavailable) 11/3: no documentation 11/4: 2 (51-75%), 1 (26-50%), no documentation for supper 11/5: no documentation 11/6: no documentation 11/7: no documentation 11/8: 3 (76-100%), 3, no documentation for supper 11/9: RR (Resident Refused), RR, 2 11/10: RR, 2, no documentation for supper 11/11: 0 (0-25%), 0, 0 (R2 tested positive for Covid-19) 11/12: 0, 2, no documentation for supper 11/13: 0, 0, 0 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/14: 3, 0, 0 11/15: 2, 2, no documentation for supper 11/16: 3, RU, RU (hospital) 11/17: in hospital 11/18: no documentation- R2 returned from the hospital at 4:15 PM 11/19: 0, 0, RR 11/20: 0, RR, 0 11/21: 0, 1, RU 11/22: 0, 3, 0 11/23: 3, no documentation for lunch, 0 11/24: 0, RR, no documentation for supper 11/25: 0, 1, 0 11/26: 0, 0, 0 11/27: 0, RR, RR 11/28: 0, 0, 1 11/29: 2, 1, no documentation for supper 11/30: RR, 1, RR R2's fluid intake (in milliliters) documentation (by shift) is as follows: 11/2: AM: NA (Not applicable) PM: RU (Resident unavailable) NOC: no documentation 11/3: AM: no documentation PM: no documentation NOC: 0 11/4: AM: 300 PM: no documentation NOC: no documentation 11/5: AM: 120 PM: no documentation NOC: 0 11/6: AM: no documentation PM: 120 NOC: NA (Not Applicable) 11/7: AM: no documentation PM: no documentation NOC: NA (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/8: AM: 480 PM: no documentation NOC: 120 11/9: AM: 240 PM: no documentation NOC: 120 11/10: AM: 120 PM: no documentation NOC: 120 11/11: AM: 50 PM: 250 NOC: no documentation (R2 tested positive for Covid-19) 11/12: AM: 600 PM: 240 NOC: 0 11/13: AM:240 PM: 240 NOC: 240 11/14: AM:600 PM: 120 NOC: 150 11/15: AM: 360 PM: no documentation NOC: 200 11/16: AM:240 PM: RU NOC:120 11/17: in hospital 11/18: AM: no documentation PM: no documentation NOC: RU 11/19: AM:120 PM:0 NOC: 200 11/20: AM:480 PM:0 NOC: no documentation 11/21: AM: 120 PM:240 NOC: 0 11/22: AM: 600 PM: 480 NOC: 0 11/23: AM: 240 PM: 360 NOC: NA 11/24: AM: 500 PM: no documentation NOC: 0 11/25: AM: 480 PM: 720 NOC: no documentation 11/26: AM: 480 PM: 480 NOC: 200 11/27: AM: 240 PM: 240 NOC: 200 11/28: AM: 120 PM: 120 NOC: 200 11/29: AM: 240 PM: 120 NOC: 0 11/30: AM: 200 PM: 120 NOC: 120 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed the Nurse's Notes, and there is no documentation stating that the Physician was updated regarding R2's poor appetite or poor fluid intake. Facility staff did not total daily intakes to ensure that R2 was receiving an adequate amount of fluids. On 11/11/22, R2 was positive for Covid-19. On 11/16/22, R2 had an unwitnessed fall and was sent to the emergency department. The hospital's History and Physical (H&P) states in part, On exam, frail elderly male with right sided weakness and expressive aphasia, dry mucous membrane noted. Patient admitted for UTI (Urinary Tract Infection) and AKI (Acute Kidney Injury) in setting of dehydration and recent COVID-19 infection. Plan: continue gentle hydration . Abnormal lab values include Sodium 147 (H), BUN (Blood Urea Nitrogen) 32 (H). R2 received IV (Intravenous) fluids. R2's Discharge MDS dated [DATE] states that R2 now requires supervision - oversight, encouragement or cueing with eating. R2 returned to the facility on [DATE]. Facility did not complete a dehydration assessment on R2. R2's Nutrition Risk Care Plan dated 11/27/22 states in part, At nutritional risk r/t (related to): Consumes <75%, weight loss - down 17 lbs. x 2 weeks. Goal: Weight will remain stable 130 lbs., Resident will be free of dehydration AEB (As Evidenced By) good skin turgor, labs, etc., Resident will meet 75-100% est (estimated) needs. Interventions: Provide diet as ordered .honor food preferences .supplements as ordered: TID (Three Times a Day) Ensure, monitor weights: as ordered, monitor for signs of dehydration. R2's Nutritional assessment dated [DATE] states in part, .Needs staff to cut up food- indicated on meal ticket. Usually requires supervision- at times may need assistance. Est. needs: 1700-2070 kcal/day, 1480-1780 ml/day. Est. needs increased d/t (due to) low BMI (Body Mass Index) and R (Right) hip fx (fracture) with surgical site .No new recommendations at this time. Reweight requested . It is important to note that the facility's Registered Dietician (RD) did not see R2 until R2 had been at the facility for 25 days. R2 went from being independent with set-up to now needing staff to cut up food, requiring staff supervision, and needing assist at times. R2's Quarterly MDS dated [DATE] states that R2 now requires extensive 1 person physical assist for bed mobility, eating, and toilet use. On 12/2/22, R2 went to see his Primary Care Physician (PCP) due to making suicidal remarks and the facility's request to increase his mirtazapine (anti-depressant.) R2 was found to be hypotensive (low blood pressure) with blood pressure readings of 60/40 and 80/52. Clinic notes state that R2 was ill-appearing and pale. The Physician discussed options with family, fluids were started, and R2 was sent to the ED (Emergency Department) and was subsequently admitted to the hospital for 5 days with the diagnoses of dehydration, elevated lactic acid level, hypotension, and failure to thrive. Abnormal lab values include Hemoglobin 8.4 (L), Lactic Acid 3.9 (H), Cortisol 31.0 (H), Creatinine 1.3 (H), and Albumin 3.3 (L). (Albumin test measures the amount of protein in the clear liquid portion of the blood. Low albumin levels can be a sign of malnutrition.) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 12/13/22 at 1:52 PM, Surveyor interviewed CNA J (Certified Nursing Assistant). Surveyor asked CNA J how often residents are weighed? CNA J stated that everyone gets weighed on the 1st of the month, but new admissions are weighed 3 days straight. Surveyor asked CNA J what they do with the weights after they have obtained them? CNA J stated that they give them to the nurse, and they put them in the computer. On 12/13/22 at 1:55 PM, Surveyor interviewed LPN I (Licensed Practical Nurse). Surveyor asked LPN I what do the nurses do with the weights when the CNAs give them to them? LPN I stated that they put them in the computer or on the MAR. Surveyor asked LPN I, how are the nurses alerted to weight loss in a resident? LPN I stated by looking at it and that the computer also updates them when there is weight loss. Surveyor asked LPN I what steps she takes after noticing or being alerted to a weight loss? LPN I stated that they inform the dietician, the doctor, and the family. Surveyor asked LPN I where they would document this communication? LPN I stated in the nurse's notes. On 12/13/22 at 2:40 PM, Surveyor interviewed DON B (Director of Nursing) and ADON F (Assistant Director of Nursing.) Surveyor asked DON B what the facility's policy is for weighing new admissions? DON B stated that they are weighed on admission and then depending on the MD (Medical Doctor) orders. Surveyor asked DON B what her expectations were when a nurse notices a weight loss or gain? DON B stated that she would expect the nurse to let her and ADON F know, and he will update the dietician. Surveyor asked DON B if the MD should be updated; DON B stated yes. Surveyor asked DON B if she would expect that communication to be documented; DON B stated yes. Surveyor asked DON B if by reviewing the documentation, she could tell if the MD was updated on R2's weight loss; DON B stated no. Surveyor asked DON B if she would expect that the RD (Registered Dietician) see R2 before 11/27/22? DON B stated yes, he should have been seen when he was newly admitted . Surveyor asked DON B who is responsible for totaling daily fluid intakes? DON B stated that it is usually dietary. Surveyor asked DON B who reviews the intake totals? DON B stated that before it was dietary, but she is unsure at this time. Surveyor asked DON B if she expected the CNAs to document every day and shift; DON B stated yes. Surveyor asked DON B if staff were aware of R2's poor appetite, would she expect that R2 be weighed more frequently; DON B stated yes. Surveyor asked ADON F if at any point he updated the MD regarding R2's weight loss? ADON F stated he receives and reviews the dietary notes and then sends them to the MD. Surveyor asked ADON F if at any point during the 9 days from when the weight loss was documented, until the RD saw R2 was the MD updated? ADON F stated that he was not sure. On 12/14/22 at 8:25 AM, Surveyor interviewed RN G (Registered Nurse (MD office)). Surveyor asked RN G if they had received any updates from the facility regarding R2's poor appetite and decreased fluid intake? RN G reviewed the clinic documentation and reported that they received faxes on: 11/2 regarding admission paperwork, 11/9 requesting to change Ensure from clear to regular, 11/15 requesting an order for Mucinex and to schedule oxycodone, and 11/18 request orders for an antibiotic for UTI. RN G stated that they also received a call on 12/1 to request an increase to mirtazapine. Surveyor asked RN G if the clinic/MD was made aware the R2 had a 17-pound weight loss? RN G stated that they were not made aware of that. RN G reported to Surveyor that the MD required R2 to come into the clinic to be assessed before increasing his mirtazapine, and then was sent to the hospital for hypotension and dehydration on 12/2/22. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 12/14/22 at 9:35 AM, Surveyor interviewed RD H. Surveyor asked RD H what her timeline is for seeing new admissions? RD H stated 14 days. Surveyor asked RD H if R2 was seen within 14 days of admission? RD H stated no and that she must have been late with that one. Surveyor asked RD H if the facility updated her regarding R2's 17-pound weight loss; RD H stated no, but that she noticed it in the computer and sent an email to the ADON and DON requesting a reweigh. Surveyor asked RD H if a reweigh was completed? RD H stated that she was unsure because some are documented on paper and others are in the EHR (Electronic Health Record.) Surveyor asked RD H if she reviews daily fluid intakes? RD H stated no. Surveyor asked RD H if R2 was meeting his daily fluid intake needs? RD H stated no. Surveyor asked RD H if she knew how much of R2's Ensure he was consuming daily? RD H stated no. Surveyor asked RD H if the dietary staff was documenting how much Ensure is consumed? RD H stated no, nursing should be documenting that. On 12/14/22 at 10:04 AM, Surveyor interviewed DON B. Surveyor asked DON B how they know if a resident is receiving the Ensure if no one is documenting on it? DON B stated that it should be documented on the MAR. DON B reviewed R2's MAR and stated that it's not on there. Surveyor asked DON B how does the nurse know if the Ensure has been given? DON B stated that they would have to check with staff. Surveyor asked DON B if she would expect that to be documented; DON B stated yes. Surveyor asked DON B if they currently have a process to track how much Ensure is being consumed and therefore tracking the calories from the Ensure? DON B stated no. Surveyor asked DON B if they have a Dehydration assessment for R2; DON B stated no. R2 had weight loss due to a decline in fluid and nutritional intake, staff were not monitoring R2's weights or intakes to ensure he was meeting his estimated daily needs. R2 went from being independent to supervision to needing assist of 1 with eating within 28 days of being admitted . R2 became ill with Covid-19 which increased his daily nutritional and fluid requirement while ill. R2 was not assessed for dehydration at any time during his stay by the facility and was hospitalized two times with dehydration. R2 did not return to the facility after his 12/2/22 hospitalization .