STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not investigate, resolve, and/or record resolution of grievances for 1 resident (R14) of 23 sampled residents. The facility did not have a grievance form for a concern expressed by R14 and family. Findings include: The facility's Grievance policy, with an implementation date of 3/1/19, states: It is the policy of this facility that each resident has the right to voice grievances to the facility .Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay. The facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed through the investigation and resolution process. Voice Grievances - is not limited to a formal, written grievance process but may include a resident's verbalized complaint to facility staff. G. Response - Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved, the employee shall escalate that complaint to their supervisor and the facility Grievance official. Upon receipt of a grievance or concern, the Grievance official will review the grievance and determine immediately if the grievance meets a reportable complaint. R14 was admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus with diabetic chronic kidney disease, chronic pain, fibromyalgia and peripheral vascular disease. R14's 11/17/22 Minimum Data Set (MDS) contained a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R14 was cognitively intact. R14 did not have an activated decision maker. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/22, Surveyor investigated a complaint that stated on Sunday 12/4/22, a nurse advised R14 to bundle up and keep warm and R14 would be fine. R14's family reported to Director of Nursing (DON)-B that a nurse made the statement when R14 was ill and needed to go to the hospital. The complaint indicated the family did not receive a resolution to the grievance. On 12/14/22, Surveyor reviewed the facility's grievances and noted a grievance form for R14. The grievance was related to a concern by R14's family that nothing was done regarding R14's cough. The grievance was dated 12/6/22; however, when Nursing Home Administrator (NHA)-A provided the grievance to Surveyor on 12/13/22, NHA-A indicated the timeline attached to the grievance was completed by DON-B on 12/13/22. Surveyor did not note any grievances from R14 or R14's family related to a comment made to R14 by a nurse on 12/4/22. On 12/14/22 at 11:28 AM, Surveyor asked DON-B about the statement of concern on the complaint that indicated a nurse told R14 to drink something warm and bundle up when R14 did not feel well and needed to go to the hospital. DON-B stated DON-B did not recall that R14's family mentioned the incident on 12/4/22. DON-B stated someone brought the concern to DON-B's attention on Monday (12/5/22) or Tuesday (12/6/22); however, DON-B could not recall who. DON-B stated R14's nurse on 12/4/22 was Licensed Practical Nurse (LPN)-G. DON-B stated DON-B spoke with LPN-G regarding the concern and LPN-G stated LPN-G didn't mean any ill intent behind the comment. DON-B stated DON-B felt it was a misinterpretation of communication and there was no paperwork or write-up regarding the incident. On 12/14/22 at 12:10 PM, Surveyor interviewed NHA-A who indicated NHA-A was not aware of the comment before last night (12/13/22) when family came in to collect R14's belongings since R14 was not returning to the facility following R14's hospital stay. NHA-A stated if DON-B was aware of the comment, DON-B should have filled out a grievance form to ensure the concern was properly investigated. NHA-A stated grievances were something the facility needed to work on and verified staff education was needed. NHA-A stated grievance forms don't seem to be readily available; however, NHA-A thought the forms were located at the nurses' station. On 12/14/22 at 3:06 PM, Surveyor interviewed LPN-G who stated LPN-G was an agency staff and rarely worked on the unit on which R14 resided. LPN-G denied LPN-G said anything of that nature to R14 and stated DON-B did not speak to LPN-G regarding the concern. LPN-G stated LPN-G would not say that to anyone and was able to correctly indicate what to do if LPN-G witnessed or was informed about a concern. On 12/14/22 at 3:09 PM, Surveyor interviewed Anonymous Staff (AS)-F who stated AS-F frequently worked with R14. AS-F recalled R14 complained R14 did not feel well, was cold and wanted to go to the hospital; however, AS-F could not recall the date. AS-F stated that an unknown agency nurse was working at the time. AS-F stated the agency nurse took R14's vitals and said R14's vital signs were better than the nurse's. AS-F stated the nurse covered R14 with a blanket and told R14 to eat some soup to warm up. AS-F verified R14 told AS-F about the incident with the nurse. AS-F stated AS-F didn't know what to tell R14 and indicated AS-F did not want to go above the nurse's head.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure 2 Residents (R) (R14 and R31) of 2 residents reviewed for hospitalization received the proper notice to include date of transfer, reason for transfer, location of transfer, appeal rights and contact information for the State Long-Term Care Ombudsman. R14 was transferred to the hospital on 12/6/22. The facility did not provide R14 with a transfer notice. R31 was transferred to the hospital on 11/19/22. The facility did not provide R31's guardian with a transfer notice. Findings include: 1 R14 was admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus with diabetic chronic kidney disease, hypertension, chronic pain, fibromyalgia and peripheral vascular disease. R14's Minimum Data Set (MDS), dated [DATE], contained a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R14 had intact cognition. R14 did not have an activated decision maker. On 12/14/22, Surveyor reviewed R14's medical record and the facility's grievance file as part of a complaint investigation conducted with the facility's annual recertification survey. R14's medical record indicated R14 did not feel well, had a cough and requested to go to the hospital on 12/6/22. R14 was sent to the emergency room and diagnosed with a pulmonary embolism. R14 was admitted to the hospital and remained in the hospital at the time of the investigation. An element of the complaint stated R14's family was not notified of R14's hospitalization . Surveyor reviewed R14's medical record and was unable to locate a transfer notice related to R14's hospital transfer. 2. R31 was admitted to the facility on [DATE] and had diagnoses to include constipation, Alzheimer's disease and dementia. R31's MDS, dated [DATE], contained a BIMS score of 4 out of 15 which indicated R31 was severely cognitively impaired. R31 had a guardian for decision making. On 12/14/22, Surveyor reviewed R31's medical record and noted R31 was hospitalized on [DATE] related to a bowel perforation. Surveyor reviewed R31's medical record and was unable to locate a transfer notice related to R31's hospital transfer. On 12/14/22 at 2:25 PM, an interview with Regional Director of Clinical Operations (RDCO)-D confirmed the facility was unable to locate transfer notices for R14 and R31's hospitalization s. RDCO-D confirmed RDCO-D expected transfer notices to be completed for each hospitalization .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure 2 Residents (R) (R14 and R31) of 2 residents reviewed for hospitalization received the proper bed hold notice when transferred to the hospital. R14 was transferred to the hospital on 12/6/22. The facility did not provide R14 with a bed hold notification. R31 was transferred to the hospital on 11/19/22. The facility did not provide R31's guardian with a bed hold notification. Findings include: 1. R14 was admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus with diabetic chronic kidney disease, hypertension, chronic pain, fibromyalgia and peripheral vascular disease. R14's Minimum Data Set (MDS), dated [DATE], contained a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R14 had intact cognition. R14 did not have an activated decision maker. On 12/14/22, Surveyor reviewed R14's medical record and the facility's grievance file as part of a complaint investigation completed with the facility's annual recertification survey. R14's medical record indicated R14 did not feel well, had a cough and requested to go to the hospital on 12/6/22. R14 was sent to the emergency room and diagnosed with a pulmonary embolism. R14 was admitted to the hospital and remained in the hospital at the time of the investigation. Surveyor reviewed R14's medical record and was unable to locate the required bed hold notification. 2. R31 was admitted to the facility on [DATE] and had diagnoses to include constipation, Alzheimer's disease and dementia. R31's MDS, dated [DATE], contained a BIMS score of 4 out of 15 which indicated R31 had severe cognitive impairment. R31 had a guardian for decision making. On 12/14/22, Surveyor reviewed R31's medical record and noted R31 was hospitalized on [DATE] related to a bowel perforation. Surveyor was unable to locate the required bed hold notification in R31's medical record. On 12/14/22 at 2:25 PM, an interview with Regional Director of Clinical Operations (RDCO)-D indicated the facility was unable to locate bed hold notifications for R14 and R31's hospitalization s. RDCO-D verified RDCO-D expected staff to complete bed hold notifications for both hospitalization s. 45942 Resident #31 hospitalization

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42248 Based on observation, staff interview and record review, the facility did not provide the necessary care and services to maintain the highest practicable physical well-being in accordance with professional standards of practice for 2 Residents (R) (R24 and R14) of 2 sampled residents. R24 had a diagnosis of type 2 diabetes mellitus (adult-onset diabetes characterized by high blood sugar and insulin resistance) with diabetic neuropathy (weakness, numbness and pain from nerve damage usually in the hands and feet). The facility did not monitor and assess R24's feet according to R24's plan of care and the facility's foot care and wound management policies which resulted in a scheduled surgical amputation of the second toe on R24's left foot. Failure to monitor and assess a diabetic resident's feet created a finding of Immediate Jeopardy that began on 10/28/22. Regional Field Operations Supervisor (RFOS)-UU notified Nursing Home Administrator (NHA)-A of the Immediate Jeopardy on 12/15/22 at 3:43 PM. The Immediate Jeopardy was removed on 12/16/22; however, the deficient practice continues at a scope/severity level D (Potential for Harm/Isolated) as the facility continues to implement its action plan. The facility did not monitor, assess or notify the physician timely when R14 complained of a cough on 11/28/22. Findings include: The facility's undated Wound Management policy states: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse . 5. Treatments will be documented on the Treatment Administration Record .7. The effectiveness of treatments will be monitored throughout ongoing assessment of the wound. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Skin Integrity-Foot Care policy, dated 10/1/22, states: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. Policy Explanation and Compliance Guidelines: 1. The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions .b. If necessary, the facility will assist the resident in making appointments with a qualified person and arranging for transportation to and from such appointments. 2. Assessment of Risk: a. Licensed nurses will conduct pressure injury risk assessments and skin assessments in accordance with facility policy for those assessments c. The comprehensive assessment will include an assessment of the feet for disorders which may require treatment, including, but not limited to, corns, neuromas, calluses, bunions, hammertoes, heel spurs, and nail disorders .d. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task .3. Interventions for Prevention and to Promote Healing. A. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and assessment of any foot ulcers (e.g., impaired sensation, immobility, foot deformity, wound characteristics) .iii. Referrals to podiatrists, vascular or orthopedic surgeons, or wound care physicians will be made when appropriate. The facility will arrange for transportation to and from any appointments .4. Modifications of Interventions: a. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any foot ulcers, or any changes in a resident's medical condition. B. Interventions will be modified in a resident's plan of care as needed. The facility's Notification of Changes policy, with an implementation date of 3/1/19, states: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the representative, according to their authority, and reported to the attending physician to delegate. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident. R24 was admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus with diabetic neuropathy, end stage renal disease (a chronic kidney disease causing the kidneys to no longer work), dependence on renal dialysis (requiring dialysis to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform those functions naturally), other abnormalities of gait and mobility and venous stasis dermatitis (when blood pools in the lower legs and puts pressure on the skin leading to skin discoloration, pain, itching and sores). R24's Quarterly Minimum Data Set (MDS) assessment, dated 10/20/22, documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R24 was cognitively intact. The MDS further indicated R24 required partial/moderate assistance for activities of daily living (ADLs). The MDS also indicated R24 was at risk for pressure injuries and had one stage two pressure injury. R24's plan of care stated Focus: Assessment of skin condition weekly by licensed nurse. Apply skin moisturizer as needed for dry, itchy skin, initiated 4/13/22 due to alteration in kidney function due to End Stage Renal Disease (ESRD) .Conduct weekly skin inspection, initiated 4/13/22. Diabetic foot monitoring, initiated 04/13/22. Skin assessment to be completed per (facility policy), initiated 5/16/22. Treatment completed as Medical Doctor (MD) ordered followed by wound nurse as appropriate, initiated 5/6/22. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/22 at 2:40 PM, Surveyor observed R24 in bed with bare feet and both heels directly in contact with the mattress. Surveyor observed an undated bandage on the bed next to R24's left foot. R24 did not know when the bandage was applied. R24 stated dressings were sporadically changed by Director of Nursing (DON)-B and other nurses. The bandage was soaked with what appeared to be brownish, yellow dry drainage. Surveyor noted R24's left second toe contained what appeared to be yellow and black crust around the tip of the toe as well as in between the toe. Surveyor also noted the appeared be encrusted with black eschar (dead tissue) around the circumference of the tip and approximately mid-toe in length. R24 stated R24 asked Nurse Practitioner (NP)-II to look at the toe since no one had looked at the toe for a while. R24 was sent to the Emergency Department (ED) on 10/27/22 due to sudden onset of black discoloration of the toe. R24 had no recollection of a toe injury. R24 reported no pain in the toe or foot due to neuropathy. R24 stated to Surveyor the whole experience really frightened me and still does. R24 was unsure of the treatment plan for the toe wound and trusted the nurses with care of the toe. Surveyor also noted R24's right and left feet had visibly cracked and peeling/flaking dry skin. R24 stated nursing staff did not regularly apply lotion to R24's feet as they should. On 12/12/22 at 2:26 PM, Surveyor informed Anonymous Staff (AS)-F that R24's bandages were removed from the left heel and left second toe by NP-II. AS-F stated AS-F would inform DON-B. On 12/12/22 at 2:57 PM, Surveyor interviewed DON-B who verified R24's left second toe wound was discovered on 10/27/22 during weekly care for R24's left heel pressure injury. DON-B was unsure when the toe wound originated despite the fact R24 received scheduled wound care for the pressure injury, weekly skin assessments and bathing. DON-B stated MD-JJ was notified of the toe wound on 10/27/22. MD-JJ ordered staff to send R24 to the ED and follow-up with MD-JJ upon R24's return. DON-B stated DON-B believed the toe injury went undiscovered because DON-B and nursing staff did not remove R24's sock during wound treatments to the left heel. DON-B stated, You just don't always pull the whole sock off, not saying that is right, just playing devil's advocate. DON-B stated the toe wound contained eschar that was resolving because R24's left second toe was all black. On 12/12/22 at 3:07 PM, Surveyor observed DON-B complete wound care for R24's left second toe. Surveyor observed DON-B remove an old dressing that was around R24's left ankle. R24 stated the dressing slid off and was unsure when that occurred. During wound care, DON-B did not cleanse the wound. DON-B stated cleansing the would cause more harm than good because we don't know what is under it. DON-B then stated DON-B was not a doctor the wound needed to be looked at by a podiatrist. DON-B used gloved hands to pick dried, crusty drainage from in between R24's toes. Surveyor noted blood and drainage coming from the wound which was verified by DON-B. DON-B stated DON-B did not want to manipulate the drainage and crust. DON-B applied iodine to the wound edges and wrapped the toe with Kerlix (a woven gauze used in wound care). DON-B stated DON-B wanted to leave the eschar open to air. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/22 at 3:30 PM, Surveyor interviewed DON-B who stated DON-B completed wound rounds on Wednesdays, unless otherwise ordered in residents' treatment plans. DON-B stated the facility had an agency Wound Registered Nurse (WRN)-KK who previously completed wound rounds; however, WRN-KK no longer worked in the facility. DON-B verified R24's plan of care did not contain treatment orders for the left second toe. DON-B stated DON-B was doing the best with what (DON-B) had and had not touched (R24's toe wound) for some time. DON-B confirmed DON-B observed the wound and believed the wound was improving; however, DON-B did not document the observations or wound treatments. DON-B verified DON-B was not wound care certified, but stated DON-B can care for any wounds and is just not able to make up treatment plans. DON-B verified NP-II observed the wound on 12/12/22 and ordered a STAT (immediate) appointment with podiatry. DON-B stated the facility was awaiting further treatment orders. DON-B acknowledged R24's plan of care included daily checks of the left heel, foot checks, weekly skin assessments and orders for ointment to R24's feet. On 12/12/22 at 4:00 PM, Surveyor reviewed a faxed copy of an order, dated 12/12/22 and by signed by NP-II, that stated, (R24) Referral to .Podiatrist (MD-LL) STAT. DX (diagnosis) L (left) 2nd toe wound. Increase wound care to daily to L 2nd toe. On 12/12/22 at 4:03 PM, Surveyor reviewed R24's electronic health record (EHR) and found the following progress notes regarding R24's left second toe: 10/27/22 at 3:43 PM: Writer updated (MD-JJ) and (resident representative) .in regard to BLE (bilateral lower extremities) needing possible further medical attention. (MD-JJ) agreed and was ordered to update when (R24) returned if needed. 10/27/22 at 4:08 PM: (R24) great toe and second toe ruddy in color with absence of pedal pulse to palpation with +3 weeping edema noted at foot. (MD-JJ) called with orders received to send (R24) to hospital. (R24) stated it doesn't hurt if second toe has some black eschar 0.2 cm (centimeters) in circumference. 10/27/22 at 9:50 PM: (R24) returned from hospital in stable condition. NNO (no new orders) at this time. Continue with wound care. 10/28/22 at 8:27 AM: Writer placed call to (MD-JJ) for wound consult/referral. Writer informed (MD-JJ) out for the day. Writer left message with nursing staff. Writer informed will deliver message to have (MD-JJ) call back upon return. Progress note selected to display on 24 hour and shift report. R24's EHR contained the following orders: 1. Ointment (Emollient): Apply to bilateral feet topically every day and evening shift for skin concerns, dated 4/12/22. 2. Complete COMS (Core Outcome Measurement Set) skin evaluation weekly on shower day every day shift every Friday, dated 4/13/22. Surveyor reviewed documentation for R24's COMS skin evaluations and noted the last weekly skin review was completed on 9/12/22. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R24's Treatment Administration Record (TAR) and noted an order, dated 4/11/22, to check R24's heels on the evening shift, every evening shift. R24's TAR indicated the heel checks weren't completed on 10/15/22, 10/19/22, 10/21/22, 11/5/22 and 12/2/22. Surveyor noted R24's EHR and TAR contained no treatment orders for R24's left second toe. Surveyor reviewed R24's weekly wound impairment and wound evaluations, dated 11/2/22, 11/9/22, 11/17/22, 11/23/22, 11/25/22, 12/3/22 and 12/7/22. The wound evaluations indicated R24 had a left heel wound identified on 4/17/22. R24's wound/skin impairment was documented as improving. The evaluations stated R24 did not have any other skin or wound impairments that needed evaluation. On 12/13/22 at 10:36 AM, Surveyor reviewed R24's EHR for updated orders, treatments and care plan interventions. Surveyor noted R24's care plan was updated on 12/13/22 at 9:29 AM with the following intervention: Left foot second toe to be assessed for skin integrity to begin on 12/13/22. R24's TAR was also updated and contained the following interventions: Paint second toe on left foot with iodine every Monday, Wednesday and Friday one time a day related to End Stage Renal Disease, dated 12/13/22; Skin assessment daily on second toe on Left foot monitor for increase in redness, drainage and smell if any changes (notify) (NP-II). Complete in the afternoon related to End Stage Renal Disease, dated 12/13/22. On 12/13/22 at 12:27 PM, Surveyor again interviewed R24 who again stated nursing staff did not apply lotion or check R24's feet daily. R24 verified R24 had an appointment with podiatry on 12/14/22. R24 stated R24 was still nervous, afraid of losing the toe and hoped the wound be resolved. On 12/13/22 at 2:38 PM, Surveyor interviewed DON-B regarding documentation of treatments completed by WRN-KK for R24's left second toe. DON-B stated DON-B spoke with (named contracted wound care agency) several times regarding documentation of care provided to R24's toe. DON-B stated (named contracted wound care agency) verified R24's left second toe was not assessed or treated by WRN-KK and there was no documentation of wound care assessments or treatments. On 12/14/22 at 8:45 AM, Surveyor reviewed R24's Treatment Administration Record (TAR) and noted the following new order: Change the bandage on the left foot 3 times per week. Apply Betadine-soaked gauze directly to the wound bed/incision site. Cover the wound with dry gauze. Wrap the foot with rolled gauze can incorporate heel bandage. Secure with tape, avoiding directly on the skin. Complete in the evening every (Monday), (Wednesday), (Friday) for wound care, dated 12/14/22. Surveyor also reviewed documentation in R24's TAR for completion of the following intervention: Skin assessment daily on second toe on left foot monitor for increase in redness, drainage, and smell if any changes (notify) (NP-II) . On 12/3/22, Surveyor noted RN-OO documented 7 and initialed the treatment as completed. Surveyor reviewed the TAR key chart codes/follow up codes and noted code 7 is listed as Other/See Nurses Notes. Surveyor reviewed R24's EHR which contained no documentation related to the code 7 on 12/3/22. (continued on next page)

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	525338	A. Building B. Wing	12/19/2022

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/14/22 at 9:07 AM, Surveyor interviewed NP-II. NP-II stated NP-II completed a routine visit with R24 on 12/12/22 and advised Surveyor to view the visit note contained in R24's medical record. Surveyor noted the visit note was not in R24's EHR at the time of the interview. NP-II stated R24 asked NP-II to look at R24's left second toe. NP-II stated NP-II removed bandages from R24's left heel and left second toe. NP-II verified NP-II was not aware of R24's toe wound. NP-II verified NP-II notified MD-JJ who ordered R24 be sent to the ED. NP-II stated that was the last communication the facility had with NP-II and MD-JJ regarding R24's toe wound. NP-II stated NP-II provided verbal orders to DON-B immediately after viewing R24's toe and faxed orders to the facility. NP-II stated NP-II expected the facility to follow-up with orders after R24 returned from the ED. A visit note, dated 12/12/22 and signed by NP-II, stated R24 requested NP-II look at R24's second toe. The note stated (R24) thought the wound developed approximately a month ago and stated no one looked at R24's foot for a few days now. The note further stated, Staff denies any concerns regarding (R24) .Exam: skin: 2nd toe dry crusted with serosanguineous drainage (drainage containing either blood or clear liquids), foul smelling gauze removed from 2nd toe Skin ulcer of toe of left foot with necrosis of muscle .No dressing/monitoring orders in (R24's EHR) for left toe area .Plan: Emergent referral to (named podiatry clinic) placed. Left second toe to be painted with iodine M-W-F. Skin checks daily-update (NP-II) with any increase in drainage, redness, worsening. If access to podiatry an issue, needs wound clinic or (named podiatry clinic) podiatry (appointment) (as soon as possible) .Note from ER visit on 10/27/22 (attached to visit note): Wound to left second toe. Patient is receiving wound care for heel wound to this foot. Today sock was fully removed and wound noted. Toe is reddened, purulent drainage, no nail to toe noted .Examination of left lower extremity: nail avulsion over left second toe but no signs of infection. No red streak or warmth .(X-ray) toes left (10/27/22). Findings: Degenerate changes in the forefoot .Medical decision making: Patient stable for discharge at this time and encouraged close follow-up with primary care. Patient will return to the ED with new or worsening symptoms .Assessment and Plan: Toenail avulsion. Ordered: Discharge patient .Patient instructions: Return for redness, swelling or pain over affected toe. On 12/14/22 at 11:32 AM, Surveyor interviewed R24 regarding foot care. R24 stated nursing staff did not apply lotion, cleanse wounds or check either foot on 12/13/22. R24 stated R24 informed DON-B that nursing staff did not completed foot care and DON-B stated DON-B would get to it. R24 stated foot care and checks were last completed on 12/12/22. R24 stated this whole ordeal of having to go to the hospital in an ambulance scared R24 and R24 was fearful of losing the toe since the toe was completely purple in color. On 12/14/22 at 1:12 PM, Surveyor interviewed agency RN-OO. RN-OO stated RN-OO did not know what code 7 meant on R24's TAR documentation for 12/13/22. RN-OO verified through the TAR chart/follow-up codes that code 7 indicated See Other Notes/Nurses Notes. RN-OO verified R24's EHR did not contain a note for the treatment. RN-OO verified RN-OO did not complete R24's foot care on 12/13/22, but marked the treatment as completed. RN-OO stated RN-OO intended to complete the treatment; however, RN-OO did not do so. RN-OO stated R24's toe was kinda rotten. RN-OO also stated prior to the treatment orders initiated on 12/12/22, RN-OO cleansed the wound with normal saline and rebandaged the wound when R24's dressing was soiled. On 12/14/22 at 1:13 PM, Surveyor again interviewed NP-II. NP-II stated if the facility would have updated NP-II after R24's ED visit, NP-II would have seen R24 in person or referred R24 to wound care or podiatry. NP-II stated R24's toe wound was not infected, but contained necrosis/eschar and NP-II was waiting for results from R24's podiatry appointment on 10/24/22. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/14/22 at 1:30 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-CC regarding bathing and weekly skin observations for R24. CNA-CC stated the process was to take a warm towel in a bucket and clean R24's body, including R24's feet. CNA-CC stated CNAs do not remove dressings during bathing or skin observations and if there is a soiled dressing, they inform the nurse. On 12/14/22 at 1:34 PM, Surveyor interviewed CNA-PP regarding R24's foot care. CNA-PP stated lotion was applied to R24's feet in the morning and at night and was unsure if R24 had foot wounds. On 12/14/22 at 1:24 PM, Surveyor interviewed CNA-I regarding R24's foot care. CNA-I stated CNA-I completed R24's foot care daily. CNA-I stated CAN-I never removed bandages as bandages stayed on during foot care and were only removed by nurses. On 12/14/22 at 2:12 PM, Surveyor observed DON-B complete wound care for R24's left second toe. DON-B cleansed the wound, applied Betadine to the tip of the toe and then bandaged the wound. Surveyor observed crust around the sides of the toe. DON-B measured the wound and recorded the following dimensions: 2.7 cm (centimeters) (length) by 1.6 cm (width) by 6.7 cm (circumference). On 12/15/22 at 9:10 AM, Surveyor reviewed a note from R24's podiatry appointment on 12/14/22. Surveyor noted the progress note contained new orders for pre and post op amputation of R24's left second toe. The failure to monitor and assess a diabetic resident's feet resulted in a scheduled surgical amputation of the second toe on the left foot and led to serious harm for R24 which created a finding of Immediate Jeopardy. The facility removed the Jeopardy on 12/16/22 when it completed the following: 1. Conducted a skin sweep of all residents. 2. Educated staff on notification of changes in condition, skin assessments, wound prevention and treatment and documentation. 3. Daily documentation audits and review of the wound log with facility staff and weekly review of the wound log with regional staff. 43361 2. R14 was admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus with diabetic chronic kidney disease, congestive heart failure, atrial fibrillation and history of COVID-19. R14's Minimu Data Set (MDS), dated [DATE], contained a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R14 was cognitively intact. R14 did not have an activated decision maker. On 12/14/22, Surveyor reviewed a facility grievance, dated related to a concern from R14's family that the facility was not doing anything about R14's cough. The grievance contained a timeline by Director of Nursing (DON)-B that stated: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~On Monday 11/28, DON-B spoke with R14 regarding R14's cough over the weekend. DON-B spoke with an unnamed nurse and asked them to call R14's physician and get an order for cough syrup. R14's cough was dry at that time. DON-B left the facility for a personal matter after the conversation and was out of work the remainder of the week. On 12/14/22, Surveyor reviewed R14's medical record which did not contain progress notes or monitoring for R14's cough between 11/28/22 and 12/3/22. R14's medical record also did not contain an order for cough syrup or documentation of physician notification regarding the cough on or around 11/28/22. Progress notes indicated: ~12/3/2022 at 12:04 PM, Received call from (R14's family member) concerned about (R14's) breathing. Assessed VS (vital signs): BP (blood pressure): 152/74, (O2 saturation): 93-90, P (pulse): 82, T (temperature): 97.4, R (respirations): 20. LS (Lung Sounds): Wheezes Bilaterally T/O. Called on call: Ordered CDB (cough deep breathing) Q (every) shift. If (O2 sats) go below 89% on RA (room air), call back. ~12/3/2022 at 5:09 PM, (R14) cleared upper bilateral airway with CDB. Sats 93% on NC (nasal cannula). 3 LPM (liters per minute). ~12/4/2022 at 11:57 AM, (R14) continues with cough today although states that it seems much better today. (R14) alert and oriented per usual. O2 sat 92-94% on check today. Will continue to monitor. ~12/4/2022 at 1:27 PM, (R14) called stating feeling worse this afternoon than this (AM) .has had a few fits of coughing .isn't feeling SOB (short of breath) currently, but states is SOB with activity. LS are diminished with some rhonchi scattered that clear some with coughing. VS obtained and stable at this time. Encouraged po (oral) fluids. Will continue to monitor. Call bell in reach. ~12/4/2022 at 8:01 PM, (R14) alert/oriented x 3. Skin warm and dry. No SOB. No resp(iratory) distress. No cough noted. VSS (vital signs stable). Fluids encouraged. Will continue to monitor this shift. ~A chest X-ray was ordered on 12/5/22 at 3:29 AM. ~~12/5/2022 at 9:28 PM, (R14) cont(inues) to complain of not feeling well. Plan to have CXR (chest X-ray) tonight. Has not been having as much coughing noted. Will (continue) to monitor. ~12/6/2022 at 10:35 AM, R14 had a chest X-ray and the results were reported at 12:03 PM. Findings of the chest X-ray included: Left basilar airspace disease and small left pleural effusion (pleural effusion occurs when fluid builds up in the space between the lung and the chest wall. This can happen for many reasons, including pneumonia or complications from heart, liver, or kidney disease). Clinical correlation, recommend follow-up examination to confirm resolution of findings. ~12/6/2022 at 9:30 PM, (R14) requested to go to the hospital because was coughing a lot and was concerned about X-ray. On-call gave order to send out. 911 called. Came and picked (R14) up to take to the ED. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/14/22, Surveyor reviewed R14's vital signs and noted oxygen levels were documented from 2-4 times per day throughout that time period; however, Surveyor noted R14's temperature, respiration rate, heart rate, and blood pressures were documented intermittently. ~Temperature - 11/30 and 2 times on 12/4/22 - all were within normal range ~Blood Pressure -11/30 and 2 times on 12/4/22 - all were within R14's historical ranges ~Heart Rate - 11/30 and 2 times on 12/4/22 - all were within normal range ~Respirations - 11/30 and 2 times on 12/4/22 - all were within normal range On 12/14/22 at 3:09 PM, Anonymous Staff (AS)-F stated AS-F frequently worked with R14. AS-F stated every shift report AS-F participated in during that time frame, AS-F stated R14 needed something for R14's cough. AS-F stated the cough was noticeable and not normal for R14. AS-F stated there was nothing done initially; however, days and days later something was finally done. On 12/14/22 at 11:28 AM, DON-B stated on 12/5/22 when DON-B returned to work, DON-B checked on R14 who stated R14 was not good. DON-B confirmed there was no monitoring of R14's cough, no order for cough syrup and no physician contact between 11/28/22 (when DON-B was aware of the cough) and 12/3/22 when the physician was notified and ordered coughing and deep breathing every shift. DON-B verified things were missed during the week DON-B was off and stated the facility used a lot of agency staff. DON-B also stated prior to 11/28/22 when DON-B spoke with R14 and discovered R14 had a cough over the weekend, DON-B expected weekend staff to note a cough and contact the physician or DON-B. DON-B acknowledged that vital sign documentation was missing and stated DON-B told staff if it's not documented, it did not happen. DON-B stated DON-B expected vital signs be completed more frequently for a resident who didn't feel well. 47248 Resident #24 FTag Initiation

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44862 Based on staff interview and record review, the facility did not ensure medical records contained accurate and complete information for 1 Resident (R) (R218) of 16 sampled residents. R218's medical record contained missing documentation related to abdominal wound treatments. Findings include: R218 was admitted to the facility on [DATE] with diagnoses to include laceration of sigmoid colon and received negative pressure wound therapy (also known as a wound vac) to the abdominal surgical site. R218 was their own decision maker. R218's 11/14/22 Minimum Data Set (MDS) contained a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R218 was not cognitively impaired. R218 was discharged to the hospital on 12/9/22 and was not at the facility during the survey. On 12/14/22, Surveyor reviewed R218's treatment administration record (TAR) which included the following order: Change wound vac Monday-Wednesday- Friday. Cleanse wound bed with 1/4 Dakins solution (used to prevent and treat skin and tissue infections). Place Santyl ointment (used to remove dead tissue from wounds) on slough tissue at base of wound. Apply skin protective wipes to intact skin surrounding wound and staple incision for protection. Place Eakin seal (used to seal and protect against leaks) along perimeter of open wound incision. Apply VAC drape around peri-wound, place black granufoam cut to size into open wound beds and cover all foam with drape. Wound vac setting 125 mmHg (millimeters of mercury). Start date of 11/28/22. On 12/14/22, Surveyor reviewed R218's medical record and noted missing documentation for 3 of 5 wound vac treatments. The dates missing documentation were as follows: 12/2/22, 12/5/22 and 12/7/22. On 12/14/22 at 9:55 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-QQ who stated DON-B was responsible for weekly wound documentation; however, nurses do any assigned treatments daily and sign them out in the TAR. On 12/14/22 at 10:05 AM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B performed weekly wound rounds on Wednesdays. DON-B stated weekly wound documentation was documented under wound assessments. DON-B stated nurses signed out wound care in the TAR and if the wound care was not signed out, the wound care was not done. DON-B stated nurses were not expected to document after wound changes or treatments with the exception of their initials in the TAR. DON-B stated DON-B was not aware of the facility's non-pressure wound monitoring protocols. DON-B's expectation was that staff did the treatments as ordered. DON-B stated DON-B performed weekly wound rounds; however, DON-B did not have time to document everything. DON-B provided Surveyor with a copy of DON-B's personal notes that contained a weekly wound round completed on 12/7/22 that was not part of R218's medical record. In addition, DON-B did not document the completed treatment in R218's TAR or on the wound assessment.