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

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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) (R18 and R17) of 5 residents reviewed for unnecessary medications had documentation to indicate the resident or resident's legal representative was informed of the risks and benefits of the prescribed psychotropic medications. R18 was prescribed Seroquel (an antipsychotic medication with a black box warning). (A black box warning is the strictest and most serious type of warning the FDA (Food and Drug Administration) gives a medication. A black box warning is meant to draw attention to a medication's serious or life-threatening side effects or risks). R18 did not have a current medication consent form on file. R17 was prescribed Seroquel and Sertraline (an antidepressant with a black box warning) and did not have current medication consent forms on file. Findings include: Department of Health Services (DHS) Form F-24277 (,d+[DATE]) Informed Consent for Medication states on page 3 at number 8: This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature . 1. R18 was admitted to the facility on [DATE] with diagnoses to include behavioral symptoms of dementia, unspecified dementia and depression. R18 had an Activated Power of Attorney for Healthcare. R18's Minimum Data Set (MDS), dated [DATE], contained a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R18 was severely cognitively impaired. On [DATE], Surveyor reviewed R18's medical record and noted R18 was prescribed 25 mg (milligrams) of Seroquel two times daily for behavioral symptoms of dementia. Surveyor also noted R18 had been taking Seroquel since [DATE]. Surveyor was unable to locate a consent form for Seroquel in R18's medical record. 2. R17 was admitted to the facility on [DATE] with diagnoses to include unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, hallucinations and dementia with agitation. R17 had an Activated Power of Attorney for Healthcare. R17's MDS, dated [DATE], contained a BIMS score of 5 out of 15 which indicated R17 was moderately cognitively impaired. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], Surveyor reviewed R17's medical record which indicated R17 was prescribed the following: ~25 mg of Seroquel two times daily for unspecified psychosis not due to a substance or known physiological condition. ~50 mg of Sertraline by mouth at bedtime for depression. On [DATE], Surveyor reviewed R17's medical record and noted DHS Form F-24277 Informed Consent for Medication signed by R17's Power of Attorney for Healthcare on [DATE]. Surveyor noted the consent was expired by approximately two months. On [DATE] at 2:20 PM, Regional Director of Behavioral Health Services (RDBHS)-E stated the facility did not have an updated consent form for R17. RDBHS-E also verified R18 did not have a signed consent form for Seroquel. RDBHS-E stated RDBHS-E expected facility staff to maintain current medication consent forms on file. RDBHS-E stated the facility's Social Worker, who was new to the facility, was tasked with ensuring medication consent forms were current. RDBHS-E also stated medication consent forms should be reviewed quarterly for each resident.

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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. 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. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42423 Based on resident and staff interview and record review, the facility did not ensure all allegations of abuse and neglect were reported to the facility's Administrator/designee and/or the State Survey Agency (SSA) for 4 Residents (R) (R12, R20, R54 and R56) of 5 residents reviewed for abuse. On 12/12/22, Surveyor observed R20 call R12 a name and tell R12 to shut up. Surveyor reported the resident-to- resident altercation to staff. Staff did not report the resident-to-resident altercation to Nursing Home Administrator (NHA)-A or a designee. On 12/5/22, R54 eloped from the facility through a window. The facility did not report the incident to the SSA. On 12/8/22, R56 told staff when R56 requested pain medication on the 12/7/22 night shift, Licensed Practical Nurse (LPN)-MM said to R56, You eat these things like candy. You don't have any pain. You just want the pills. You're an addict. R56 asked staff inform NHA-A; however, staff did not report the incident to NHA-A or a designee. Findings include: The facility's Abuse, Neglect and Exploitation policy, with a revision date of 10/01/22, reads as follows: Definitions:Verbal Abuse: Means use of oral, written or gestured communication or sounds 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. Neglect: Means failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Reporting: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury or b. No later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The facility's Compliance With Reporting Allegations of Abuse/Neglect/Exploitation policy, with a revision date of 10/1/22, reads as follows: Reporting/Response: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. 1. On 12/12/22 at 11:45 AM, Surveyor heard yelling coming from the lounge area on the Acute Care Unit (ACU). Surveyor entered the area and observed five residents seated in wheelchairs in the lounge. Surveyor observed R20 yell at R12, tell R12 to shut up! and call R12 an old fart. Surveyor observed R20 maneuver R20's wheelchair toward R12 while R20 continued to tell R12 to shut up and call R12 names. No staff were present in the area. R12 waved Surveyor over and told Surveyor R20 called R12 names and told R12 to shut up. R12 stated, (R20) will hit you right in the back or in the knees. R12 stated R20 yelled at R12 before and R12 did not know why R20 did that. Surveyor observed Certified Nursing Assistant (CNA)-CC pass by and alerted CNA-CC of the resident-to-resident altercation. CNA-CC removed R20 from the lounge and brought R20 to the dining room. On 12/14/22 at 6:11 AM, Surveyor reviewed R20's medical record which indicated on 12/12/22, R20 displayed no behaviors. On 12/14/22 at 8:59 AM, Surveyor interviewed agency CNA-N. After Surveyor described the incident Surveyor observed between R12 and R20, CNA-N stated that was pretty normal behavior for (R20). CNA-N stated staff redirect R20, tell R20 that is not nice to say and R20 should be more respectful. When asked if the incidents were reported to anyone, CNA-N stated, Truthfully no, that's just something (R20) will say. CNA-N verified R20's comments were targeted at both staff and other residents. On 12/14/22 at 9:23 AM, Surveyor interviewed NHA-A who stated NHA-A did not have a resident-to-resident incident decision tree for the incident between R20 and R12 on 12/12/22. NHA-A stated NHA-A was not aware of the incident and verified staff did not report the incident to NHA-A. When Surveyor provided details of the incident, NHA-A stated if R20 called R12 names and told R12 to shut up, NHA-A expected staff to report the allegation of abuse to the Unit Manager who would then report to NHA-A. 2. On 12/12/22, Surveyor reviewed R54's medical record which indicated R54 had a history of elopement from the facility. On 12/5/22, R54 again eloped from the facility through R54's window and traveled approximately .7 to 1 mile on foot. A staff who was off-duty saw R54 walking and contacted the facility. On 12/13/22 at 8:42 AM, Surveyor interviewed NHA-A who confirmed R54's elopement. NHA-A stated R54 was on 30 minute checks at the time of the elopement and verified R54's elopement was not reported to the SSA. 45942 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/12/22 at 2:47 PM, Surveyor interviewed R56 who stated during the night shift on 12/7/22, R56 requested pain medication from LPN-MM. R56 was offended when LPN-MM stated to R56, You eat these things like candy. You don't have any pain. You just want the pills. You're an addict. R56 stated R56 informed Housekeeping Staff (HS)-RR on 12/8/22. HS-RR left R56's room, returned a few minutes later and stated HS-RR reported R56's allegation to NHA-A. R56 also informed Certified Occupational Therapist Assistant (COTA)-Y of the incident. Surveyor reviewed R56's medical record and noted the incident was not documented. On 12/13/22 at 12:24 PM, Surveyor interviewed HS-RR who verified R56 informed HS-RR of the incident. HS-RR stated HS-RR informed NHA-A that R56 requested to speak to NHA-A to report an allegation regarding a nurse. HS-RR confirmed R56 was updated. On 12/13/22 at 12:29 PM, Surveyor interviewed COTA-Y who verified R56 informed COTA-Y of the incident. COTA-Y stated COTA-Y did not report the incident to anyone, but told R56 to report the incident to nursing staff and NHA-A. COTA-Y verified COTA-Y should have reported the allegation to NHA-A. On 12/13/22 at 12:38 PM, Surveyor interviewed NHA-A who denied knowledge of the incident and stated HS-RR talked about discharge only.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 42423 Based on resident and staff interview and record review, the facility did not ensure all allegations of abuse were thoroughly investigated for 4 Residents (R) (R12, R20, R54 and R56) of 5 residents reviewed for abuse. On 12/12/22, Surveyor observed R20 call R12 a name and tell R12 to shut up. Surveyor reported the resident-to- resident altercation to staff. The facility did not complete an investigation of the altercation. On 12/5/22, R54 eloped from the facility through a window. The facility did not conduct a thorough investigation of the elopement. On 12/8/22, R56 reported to staff that when R56 requested pain medication from Licensed Practical Nurse (LPN)-MM on the 12/7/22 night shift, LPN-MM said, You eat these things like candy. You don't have any pain. You just want the pills. You're an addict. The facility did not complete an investigation of the allegation of abuse. Findings include: The facility's Abuse, Neglect and Exploitation policy, with a revision date of 10/01/22, reads as follows: Definitions: Verbal Abuse: Means use of oral, written or gestured communication or sounds 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. Neglect: Means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Investigation of Alleged Abuse, Neglect or Exploitation: A. An immediate investigation is warranted when suspicions of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 4 Identifying and interviewing all involved persons, include the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent and the cause; and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Providing complete and thorough documentation of the investigation. The facility's Compliance With Reporting Allegations of Abuse/Neglect/Exploitation policy, with a revision date of 10/1/22, reads as follows:Reporting/Response: 2. The Administrator or designee will: b. Obtain statements from direct care staff . f. Within 5 working days of the incident, report sufficient information to describe the results of the investigation and indicate any corrective actions taken if the allegation is verified. 1. On 12/12/22 at 11:45 AM, Surveyor heard yelling coming from the lounge area on the Acute Care Unit (ACU). Surveyor entered the area and observed five residents seated in wheelchairs in the lounge. Surveyor observed R20 yell at R12, tell R12 to shut up! and call R12 an old fart. Surveyor observed R20 maneuver R20's wheelchair toward R12 while R20 continued to tell R12 to shut up and call R12 names. R12 waved Surveyor over and told Surveyor that R20 called R12 names and told R12 to shut up. R12 stated, (R20) will hit you right in the back or in the knees. R12 stated R20 yelled at R12 before and R12 did not know why R20 did that. Surveyor observed Certified Nursing Assistant (CNA)-CC pass by and alerted CNA-CC of the resident-to-resident altercation. CNA-CC removed R20 from the lounge and brought R20 to the dining room. On 12/14/22 at 6:11 AM, Surveyor reviewed R20's medical record which indicated on 12/12/22, R20 displayed no behaviors. On 12/14/22 at 8:59 AM, Surveyor interviewed CNA-N. After Surveyor provided details of the incident Surveyor observed between R12 and R20, CNA-N stated that was pretty normal behavior for (R20). CNA-N stated staff redirect R20 and tell R20 that is not nice and R20 should be more respectful. When asked if these incidents were reported to anyone, CNA-N stated, Truthfully no, that's just something (R20) will say. CNA-N stated R20's comments were targeted at both staff and other residents. On 12/14/22 at 9:23 AM, Surveyor interviewed NHA-A who stated NHA-A did not have a resident-to-resident incident decision tree or an investigation for the altercation between R12 and R20. 2. On 12/12/22, Surveyor reviewed R54's medical record which indicated R54 had a history of elopement from the facility. On 12/5/22, R54 again eloped from the facility through R54's window and traveled approximately .7 to 1 mile on foot. A staff who was off-duty saw R54 walking and contacted the facility. On 12/13/22 at 8:42 AM, Surveyor interviewed NHA-A who verified the elopement. NHA-A stated R54 was on 30 minute checks at the time of the elopement. NHA-A provided Surveyor with a Concerns Form. The Investigation Findings portion of the form was not completed nor was the Summary of Investigation. NHA-A confirmed NHA-A did not have a timeline of the elopement or documented interviews with staff. The Surveyor's interviews with staff noted inconsistencies with regard to details of the elopement. NHA-A was unable to verify the inconsistencies due to the lack of an investigation and investigation documentation. 45942 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/12/22 at 2:47 PM, Surveyor interviewed R56 who stated when R56 requested pain medication from LPN-MM on the 12/7/22 night shift, R56 was offended when LPN-MM said, You eat these things like candy. You don't have any pain. You just want the pills. You're an addict. R56 stated R56 informed Housekeeping Staff (HS)-RR on 12/8/22. HS-RR left R56's room, returned a few minutes later and stated HS-RR informed NHA-A of the allegation of verbal abuse. R56 also informed Certified Occupational Therapist Assistant (COTA)-Y about the incident. Surveyor reviewed R56's medical record and noted the incident was not documented. On 12/13/22 at 12:29 PM, Surveyor interviewed COTA-Y who verified R56 informed COTA-Y of the incident. COTA-Y stated COTA-Y did not report the incident to anyone, but told R56 to report the incident to nursing staff and NHA-A. COTA-Y verified COTA-Y should have reported the allegation to NHA-A so an investigation could have been initiated. On 12/13/22 at 12:38 PM, Surveyor interviewed NHA-A who denied knowledge of the incident and stated HS-RR talked about discharge only. NHA stated, I would have DNR'd (do not return) (LPN-MM) to not come back. Well, I would first call agency to let them know what happened and have the agency educate on how nurses should talk to residents will give another chance, then will DNR. NHA-A stated if NHA-A had knowledge of the incident, an investigation would have been conducted immediately.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on staff interview and record review, the facility did not ensure 4 Residents (R) (R31, R12, R20 and R45) of 23 sampled residents met the PASRR (Pre-Admission Screen and Resident Review) requirements. R31's Level I PASRR on admission indicated serious mental illness, a current major mental disorder diagnosis and psychotropic medications. Evidence of referral to the Screening Agency was not located or provided. R12's Level I PASRR on admission indicated R12 had a serious mental illness, a current major mental disorder diagnosis, psychotropic medications and severe cognitive deficits. Evidence of referral to the Screening Agency was not located or provided. R20's Level I PASRR on admission indicated the use of psychotropic medications. Evidence of referral to the Screening Agency was not located. A new Level I screen, dated 12/14/22, which indicated a serious mental illness, a major mental disorder diagnosis and no psychotropic medications was sent for screening on 12/14/22. R45's Level I PASRR on admission indicated R45 had a suspected serious mental illness, a current major mental disorder diagnosis and psychotropic medications. Evidence of a Level II PASRR and referral to the Screening Agency was not located or provided. Findings include: PASRR information requires that all applicants to Medicaid-certified nursing facilities must be assessed to determine whether they have an intellectual disability or mental illness; that is a Level I screen. The purpose of a Level I screen is to identify individuals whose total needs require that they receive additional services for their intellectual disability or serious mental illness. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an intellectual disability or mental illness for PASRR purposes; this is a Level II screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care. 1. On 12/12/22, Surveyor reviewed R31's medical record. R31 was admitted to the facility on [DATE]. R31's diagnoses included unspecified dementia mild without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R31's medication list included Seroquel (an antipsychotic medication) which was started on 1/24/18 and discontinued on 6/20/19 and Lorazepam (a benzodiazepine) which was started on 1/25/18. A PASRR Level I screen, dated 1/24/18, indicated R31 had a serious mental illness, a current major mental disorder and took medications listed as Seroquel, Alprazolam (a sedative medication) for anxiety PRN (as needed) and Trazadone (an antidepressant and sedative medication) for sleep. The Level I screen box which read Referral to the screening agency contained the date 1/24/18. Upon review of R31's medical record, Surveyor was unable to locate the Screening Agency's response and requested documentation from the facility. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 12/12/22, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE]. R12's diagnoses included psychosis related to dementia. R12's medications included Seroquel which was started on 2/24/20, discontinued on 6/18/20 and restarted on 9/1/22. A PASRR Level I screen, dated 1/30/20, indicated R12 had a serious mental illness, a current major mental disorder and took Seroquel and Trazadone. The Level I screen also indicated R12 had a severe cognitive deficit. The Level I screen box which read Referral to the screening agency contained the date 1/30/20. Upon review of R12's medical record, Surveyor was unable to locate the Screening Agency's response and requested documentation from the facility. 3. On 12/12/22, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE]. R20's diagnoses included hallucinations and Alzheimer's disease. R20's Level 1 PASRR, dated 5/10/21, indicated R20 did not have a serious mental illness or diagnosis, but was prescribed Seroquel. The Level I screen box which read Referral to the screening agency contained the date 5/11/21. Upon review of R20's medical record, Surveyor was unable to locate the Screening Agency's response and requested documentation from the facility. On 12/14/22 at 12:54 PM, Nursing Home Administrator (NHA)-A provided Surveyor with a fax cover sheet, dated 12/14/22, addressed to (named Screening Agency) that indicated the fax was urgent and requested Level I and II screens for R20 as well as Level II screens for R12 and R31. NHA-A confirmed the documents were not in the residents' medical records. On 12/14/22 at 2:50 PM, Surveyor interviewed Regional Director of Behavioral Health Services (RDBHS)-E who stated R31's psychotropic medications were taken for comfort, therefore, R31 did not need a PASRR screen referral. Surveyor reviewed the admission Level I screen with RDBHS-E who confirmed the Level I screen indicated mental illness and medication for such as well as a date the screen was to be sent for. For R12 and R20, RDBHS-E verified the facility did not have documentation to or from the Screening Agency. RDBHS-E verified the Level I screens should should have been sent to the Screening Agency for further determination and review. 45942 4. On 12/13/22 at 8:12 AM, Surveyor reviewed R45's medical record and was unable to locate R45's Level II PASRR. R45 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (a mental health condition that causes extreme mood swings) and mood disorder. R45's current medication list included bupropion (an antidepressant medication), duloxetine (an antidepressant medication) and lamotrigine (an anticonvulsant medication) used to treat bipolar disorder. An undated Level I PASRR was completed for R45 and scanned into R45's electronic health record (EHR) on 5/16/21. The Level I screen indicated R45 had a suspected serious mental illness, a current major mental disorder and received psychotropic medication in the last six months. In section A, number 2, under the heading: Medications, Wellbutrin (the brand name for bupropion) was marked. The drug class antidepressant which Wellbutrin falls under was not marked. Other was marked and the following medications were handwritten: Lamictal (brand name for lamotrigine), Lyrica (a nerve pain medication) and Cymbalta (brand name for duloxetine). R45 did not have further evaluation for a Level II PASRR screening. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/13/22 at 12:06 PM, Surveyor interviewed Social Worker (SW)-P. SW-P confirmed a Level II PASRR document was not in R45's medical record and there was no evidence of referral to the Screening Agency. SW-P stated SW-P just spoke with (named screening agency) and faxed R45's Level I PASRR to be screened on 12/13/22 after Surveyor requested the document.

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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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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 42423 Based on observation, staff interview and record review, the facility did not ensure 1 Resident (R) (R54) of 1 resident reviewed for accidents and supervision received adequate supervision to prevent elopement. R54 had a history of elopement from the facility. After R54's most recent elopement on 12/5/22, R54's location and attire were to be checked every 15 minutes by staff. Surveyor observed checks were not completed in 15 minutes increments and all staff working with R54 did not know to check R54's attire. In addition, staff documented 15 minute checks were completed when they were not. In addition, prior to R54's elopement on 12/5/22, R54 was on 30 minute checks. Documentation of 30 minute checks was inconsistent and missing information, including staff initials to indicate who checked R54 prior R54's elopement. The facility's failure to implement safety interventions and adequately supervise a resident with a history of elopement created a finding of Immediate Jeopardy that began on 12/5/22. Regional Field Operations Supervisor (RFOS)-UU notified Nursing Home Administrator (NHA)-A of the Immediate Jeopardy on 12/14/22 at 4:30 PM. The Immediate Jeopardy was removed on 12/13/22; however, the deficient practice continues at a scope/severity level D (Potential for Harm/Isolated) as the facility continues to implement its action plan. Findings include: The facility's Elopement policy reads as follows: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. 3. The facility is equipped with door locks/alarms to help avoid elopements. 4. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/22, Surveyor reviewed R54's medical record. R54 was admitted to the facility on [DATE] with diagnoses to include hemiplegia (paralysis/immobility of one side of the body) and hemiparesis (muscular weakness or partial paralysis restricted to one side of the body) following unspecified cerebrovascular disease (a variety of medical conditions that affect the blood vessels of the brain, often resulting in what is commonly known as a stroke) affecting right dominant side and aphasia (an inability to comprehend or formulate language because of damage to specific brain regions). R54's Minimum Data Set (MDS) assessment, dated 11/1/22, contained a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R54 was severely cognitively impaired. R54's medical record contained Court Ordered Guardianship and Protective Placement documents, dated 3/7/22, that indicated R54's Guardian was responsible for R54's healthcare decisions. R54's medical record contained Elopement Evaluations, dated 2/17/22, 4/7/22, 5/6/22 and 8/16/22 that indicated R54 was at risk for elopement. The 4/7/22, 5/6/22 and 8/16/22 Elopement Evaluations each indicated .History of or attempted leaving the facility without informing staff . R54's medical record also included prior elopements on 6/20/22 and 8/6/22. R54's medical record contained a Social Service Care Plan Meeting note, dated 2/24/22, that stated, .(R54) seems to lack the insight of what is going on/happening or what exactly happened to (R54) .The stroke has affected the brain cognitively--language and understanding; (R54) is not able to communicate effectively verbally . On 12/13/22 at 8:43 AM, Surveyor interviewed NHA-A who confirmed R54 eloped through R54's window on 12/5/22 and a staff who was not in work status found R54 walking on a sidewalk that was .7 to 1 mile from the facility. Surveyor requested the facility's investigation of R54's elopement. On 12/13/22 at 8:45 AM, Surveyor reviewed R54's care plan which stated: 1 on 1 supervision will add what (R54) is wearing and where (R54) is at .Window 4 inch stops modified to prevent (R54) from removing and opening the window independently (initiated 12/5/22) .When I am noted to have blue jeans, tennis shoes, and a baseball hat, I am more prone to wanting to leave and require increased supervision (initiated 6/21/22) . R54's medical record included the following progress notes regarding R54's elopement on 12/5/22: 12/5/2022 at 3:15 PM: Writer spoke with POA (Power of Attorney) and caseworker to update that (R54) did elope and is on 15 minute checks as well as (1 on 1 supervision). No concerns or changes at this time and will update as needed. Writer also faxed (physician) to update. 12/5/2022 at 3:56 PM: Writer heard the code for a missing resident and went looking. A staff member not working today had called and let the facility know that (R54) was in town walking by self. (R54's) window was open in their room. (R54) did come back to the building. All windows checked for the 4 inch clearance. (R54) continues to be on 15 (minute) checks and is on 1:1 as of now. 12/6/2022 at 1:03 PM: Skin Only Evaluation: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal. No current skin issues noted at this time. Right knee 2 cm (centimeter) x 4 cm blister with right shin scrape superficial left open to air 1 cm x 5 cm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed facility-provided check forms that staff utilized to confirm R54's checks were completed. A form, dated 12/5/22, stated R54 was to have 30 minute checks completed. The form included columns for the time (pre-filled in 15 minute increments), R54's location, activity/observations and staff initials. A staff entry at 6:00 AM noted R54 was in bed and included staff initials. Surveyor noted there was a line drawn down each column until 7:45 AM in which the same staff's initials noted R54 was in R54's room eating breakfast. The same initials noted at 8:00 AM that R54 was on R54's bed. Surveyor again noted a line drawn down each column until 10:00 AM when the form indicated R54 was in bed; however, the 10:00 AM entry was not initialed. The form contained a line drawn down the columns to 11:30 AM; however, there was no documentation at 11:30 AM where the line ended. The next row with a time of 11:45 AM was left blank. The 12:00 PM row contained a short line drawn through (R54's) location block only; the activity/observations and staff initials column were blank (no line drawn). There was no documentation of R54's whereabouts at 12:00 PM except for the short line drawn in the location column. The 12:15 PM row read: Got out, Code Green and was initialed by Certified Nursing Assistant (CNA)-N. The columns/rows were then blank until 2:00 PM. On 12/13/22 at 10:55 AM, Surveyor noted R54's room door was approximately one-fourth open. R54 could be seen in R54's bed when looking in the cracked door. No staff were noted in the hallways. There was a nurse within an enclosed nurses' station which was several rooms away and not within sight of R54 or R54's doorway. At 11:06 AM, Surveyor observed staff transport residents to the dining room in the hallway prior to R54's room. Staff were not within visual contact of R54 or R54's doorway. At 11:22 AM, Surveyor observed a CNA deliver R54's lunch tray. Surveyor noted no staff checked on R54 during the observation time of 10:55 AM to 11:22 AM which was a total of 27 minutes. On 12/13/22 at 12:14 PM, Surveyor observed R54 on R54's bed. R54's door was approximately one-third open. Surveyor was able to see R54 when looking through R54's door. Surveyor did not observe staff in the hallway on the unit. Surveyor remained outside R54's door until 12:37 PM which was 23 minutes. When Surveyor departed the area, Surveyor noted there were no staff in the unit hallway and no staff checked on R54 during that time frame. On 12/13/22 at 1:27 PM, Surveyor interviewed Social Worker (SW)-P who was unsure if R54 was on 15 minute checks or 1 on 1 supervision at the time of the interview. When asked how staff knew how to supervise R54, SW-P stated there would be an end date on R54's care plan if 1 on 1 supervision was discontinued. Surveyor reviewed R54's care plan with SW-P who confirmed there was not an end for 1 on 1 supervision. When asked about the intervention related to R54's clothing, SW-P stated in the past, R54 stated if R54 was wearing jeans and tennis shoes, then R54 was leaving. SW-P stated staff were supposed to watch and redirect R54. SW-P stated staff check on R54 at least every 15 minutes. On 12/13/22 at 1:43 PM, Surveyor interviewed NHA-A who stated R54's 1 on 1 supervision was discontinued on 12/12/22 and R54 was currently on 15 minute checks. NHA-A confirmed the care plan still indicated 1 on 1 supervision and indicated R54's care plan should be updated to 15 minute checks. NHA-A stated staff are to observe R54's attire and document it on the check forms. NHA-A stated R54's attire was monitored as a potential elopement red flag because R54 usually wore sweatpants and no shoes. NHA-A stated R54 made comments in the past that if R54 was wearing jeans, tennis shoes and a hat, R54 may plan to leave the facility. NHA-A stated there was a form on the unit for staff to document the time, R54's location and R54's attire. When asked NHA-A's expectation of 15 minutes checks, NHA-A stated NHA-A expected staff to walk by R54's room, check if R54 was in bed and check if R54 was safe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the same interview, NHA-A stated residents' windows contained screws to prevent them from opening fully, but they are old screws. NHA-A located the window screws in R54's dresser drawer following R54's elopement on 12/5/22 and stated, (R54) took (the screens) out. NHA-A stated Maintenance staff (MS)-Q installed longer screws in R54's window frame after the 12/5/22 elopement so they were harder to get out. NHA-A stated NHA-A believed R54 hit the smaller screws previously installed in the window and loosened the screws. NHA-A also stated staff indicated R54 opened the window in the past wide enough to place a can of soda in the opening and R54 must have worked on (the window) for a couple days. NHA-A stated MS-Q checked other facility windows after R54's elopement and noted not all windows needed installation of the longer screws. NHA-A stated NHA-A was made aware of R54's elopement of 12/5/22 when NHA-A heard an overhead page on the loud speaker that stated, (R54) (named Doctor) is here to see you. NHA-A stated the page was the facility's code for an elopement or elopement drill. NHA-A stated, I jumped up and thought, I did not know we were having a drill. I went to the back parking lot (to conduct a search). NHA-A stated the facility then received a call from Hospitality Aide (HA)-S who saw R54 walking down a street in town. NHA-A G googled the location and noted it was .7 miles from the facility. NHA-A was unsure if the weather was documented; however, NHA-A recalled it snowed on the morning of 12/5/22. NHA-A stated the direction R54 was headed was the direction to the highway to get to (town where R54 resided prior). NHA-A stated, Another 1.5 miles, (R54) would have been almost to the highway. NHA-A stated facility staff knew R54 exited R54's window because there was a foot mark in the mud outside the window. NHA-A indicated R54 was wearing jeans, tennis shoes, a hat, a sweatshirt and a flannel when found. NHA-A verified R54 was on 30 minute checks at the time of the elopement. NHA-A believed R54 returned to the facility between 1:30 PM and 1:40 PM on 12/5/22; however, NHA-A verified it was not documented when R54 returned or how long R54 was gone. NHA-A stated there was coaxing done to get R54 to return and that took some time. NHA-A stated NHA-A reviewed the check-off document for 30 minute checks and noted R54 was checked on at 12:15 PM. NHA-A stated CNA-N was the last staff to see R54 during the 30 minute checks and indicated CNA-N last checked on and visualized R54 when CNA-N picked up lunch trays. NHA-A stated upon R54's return to the facility, management began education with staff which included the prior intervention regarding what to do when R54 was wearing jeans, tennis shoes, etc. NHA-A stated an emergency care conference was held because R54 had no skilled need, NHA-A also stated the facility was trying to place R54 at another facility since R54's last elopement. (continued on next page)

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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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NHA-A provided Surveyor with the facility's investigation related to R54's elopement. A Grievance/Concern Form stated, (R54) elopement out window: Date of Occurrence: 12/5/22. Individual completing form: Acute Care Unit (ACU) Director, Registered Nurse (RN)-R. Description of Concern: (R54) removed screws from window and crawled through the window leaving facility. Investigation Findings: Was blank. Summary of Investigation: Was blank. Resolution: (R54) placed on 15 minute checks, 1 on 1 staff, emergency care conference. All windows checked for the 4 inch clearance. Two 3 inch long screws placed to restrict window from opening all the way preventing (R54) from exiting facility through window. SW (Social Worker) put in a call to psychologist. The form was signed by NHA-A and Director of Nursing (DON)-B on 12/6/22. NHA-A stated there was a soft file which included staff education for what to do when R54 was wearing jeans, tennis, shoes, etc. Educations documents provided to Surveyor included staff signatures on educational post-tests related to R54's supervision, including how often staff were to review care plans (before their shift), how often care plans should be updated (when there was a change in orders, treatment or condition), what to do if staff saw R54 in jeans, a baseball hat and tennis shoes (notify the ACU Director), that windows are not required to open completely and the importance of documentation. On 12/13/22 at 2:39 PM, Surveyor noted R54's door was opened approximately 1 foot. Surveyor was not able to see into R54's room without opening the door further to look inside. Surveyor observed one staff on the opposite end of the hall who took a resident into the shower room and was not seen afterward. Surveyor observed CNA-U enter the unit, but noted CNA-U did not go down R54's hallway. At 2:55 PM, Surveyor observed Administrator-in-Training (AIT)-GG enter the unit and interact with staff. Following the interaction, two staff members walked directly to R54's room. Prior to staff entering the room, Surveyor noted R54 was not checked for 16 minutes. On 12/13/22 at 3:00 PM, Surveyor interviewed CNA-CC who verified staff were to check on R54. CNA-CC stated staff were to check R54's location and if R54 needed anything. When asked if staff were to check anything else, CNA-CC stated, No. When asked if staff should check R54's attire, CNA-CC said, That (clothing) does not matter because (R54) changes own clothing. We check if (R54) needs anything and where (R54) is. CNA-CC verified CNA-CC worked the unit on which R54 resided the day prior (12/12/22) as well. On 12/13/22 at 3:11 PM, Surveyor interviewed RN-O who started work at 2:00 PM. When asked the location of R54's 15 minute check form, RN-O stated, Well, there was question if they were going to do them. RN-O stated RN-O was recently off work and was not sure if R54 was still on 15 minute checks. Medication Tech (MT)-J, who was in the nurse's station at that time, stated, (R54) is 15 minute checks. We are seeing if (R54) went in (R54's) room and that (R54) didn't climb out the window. RN-O then stated, Oh, and then we look for a certain outfit (R54) likes to wear. Apparently (R54) wore jeans and tennis shoes when (R54) escaped out the window. RN-O also stated R54 was observed pushing the window back and forth prior to 12/5/22 and that was likely how the screw became loose enough to remove. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/13/22 at 3:30 PM, Surveyor reviewed the 15 minute check forms for 12/13/22 which contained documentation for the above-noted times when Surveyor's observations confirmed staff did not check on R54 within 15 minutes. The observation time from 10:55 AM to 11:22 AM contained documentation at 11:00 AM that R54 was in R54's room eating and wearing sweats, tee (T-shirt) and socks. (Of note, R54's lunch tray was not delivered until 11:22 AM). There was a line drawn from the 11:00 AM entry to an 11:45 AM entry. During the observation time of 12:14 PM to 12:37 PM, staff documented a check was completed at 12:15 PM and R54 was watching TV in room and wearing sweats, tee and socks. Documentation at 12:30 PM indicated the same. There were no staff initials for those checks. On 12/14/22 at 8:04 AM, Surveyor interviewed MS-Q who stated MS-Q looked at every window in the facility following R54's elopement on 12/5/22. MS-Q stated R54's window was the only window that had a machine screw installed in the window track to restrict the window from opening more than 4 inches. MS-Q stated the machine screw had minimal threading, was non-tapered and easy-out (meaning easier to get out than a threaded screw). MS-Q stated the rest of the windows in the facility had sheet metal screws in the window tracks. MS-Q installed a 3 inch screw in R54's window track as a means to restrict the window from opening more than 4 inches and stated, It would take days for (R54) to get (the screw) out. Surveyor noted the screw in R54's window track was different than other screws observed in other resident' windows. The screw in R54's window had a head with a straight line in both directions that formed an X. All other windows observed in residents' rooms had hex-head screws placed in the window tracks. On 12/14/22 at 8:12 AM, Surveyor interviewed HA-S who verified HA-S found R54 walking on a sidewalk in town on 12/5/22. HA-S stated HA-S was off work that day and saw R54 quite a ways from (the facility) while driving down the street. HA-S stated staff were not sure which path R54 took to get where R54 was found. HA-S lived near the area in which R54 was found and stated it took HA-S 20 minutes to walk from home to the facility. HA-S stated it would have taken R54 at least 45 minutes to get that far. HA-S stated R54 was wearing a pull-over sweatshirt, jeans and green tennis shoes. HA-S indicated R54 was shaky and unsteady and walking with one shoulder slumped more than usual. HA-S lowered R54 down to the sidewalk to sit and gave R54 HA-S' sweatshirt when R54 would not get in the car to warm up. HA-S stated the weather was cold and rainy like today but with less wind. (The temperature on 12/14/22 was approximately 30 degrees, damp air, misting with wind). HA-S stated HA-S then called the facility and spoke with Medical Records Clerk (MR)-EE to ask if R54 was supposed to be released from the facility. MR-EE stated, No. HA-S stayed with R54 until staff arrived. HA-S believed HA-S found R54 between 12:30 PM and 1:00 PM. HA-S stated MR-EE and RN-R picked up R54 approximately 15 minutes later. HA-S verified R54 complained about getting in the car, but got in without delay. HA-S stated HA-S was not interviewed by NHA-A or management after the incident and was not asked what time R54 was found. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/14/22 at 8:27 AM, Surveyor interviewed MR-EE who confirmed MR-EE received a call from HA-S on 12/5/22. MR-EE thought MR-EE received the call at approximately 12:00 PM. MR-EE said HA-S stated, I think I (saw) (R54). Can you go to (R54's) room and check? MR-EE checked R54's room with RN-R and noted R54 was not in the room. MR-EE stated CNA-N and CNA-U were working on the unit and both stated R54 was there for lunch. MR-EE stated R54 was likely served lunch around 11:00 AM because R54 had a room tray and was served lunch from the first meal cart that went out. At the time of the interview, Central Supply Clerk (CS)-FF was in the same office as MR-EE and stated that was when CS-FF called an elopement code via the paging system. MR-EE and RN-R then met HA-S in town and picked up R54. MR-EE stated R54 was wearing tennis shoes, a sweatshirt and a baseball cap. MR-EE stated R54 seemed agitated; however, RN-R talked to R54 and then R54 got in the car. MR-EE confirmed MR-EE and RN-R told CNA-N and CNA-U that R54 was not in R54's room and a building search was initiated. MR-EE stated no one noticed R54 went out the window at that time. Upon R54's return, staff saw R54's curtain pulled out the open window and a foot print outside the window in the dirt. MR-EE stated, If (R54) wants to get out, (R54) will keep finding a way to get out. On 12/14/22 at 8:53 AM, Surveyor interviewed CNA-N who confirmed CNA-N and CNA-U were the last to see R54 on 12/5/22 prior to R54's elopement. CNA-N stated CNA-N and CNA-U were assisting with lunch when they discovered R54 eloped. CNA-N stated RN-R entered the dining room and let CNA-N and CNA-U know R54 was missing. CNA-N stated CNA-N and CNA-U told RN-R they did not see R54 come out of R54's room. CNA-N could not recall the time but stated, We had picked up (R54's) tray after R54 was done eating. CNA-N stated CNA-N last saw R54 wearing a T-shirt and sweatpants. When asked if CNA-N was the last to see R54, CNA-N stated, We (CNA-N and CNA-U) were both going back and fourth within the time of meals to see (R54). When asked if CNA-N and CNA-U completed a check and visualized R54, CNA-N said, It wasn't me that saw (R54) last. (CNA-U) (saw) (R54) last. CNA-N verified R54 was currently on 15 minute checks. When Surveyor stated Surveyor observed three instances of missed checks the day prior (12/13/22), CNA-N responded, Yes, it gets busy, especially during meals and getting people up in the morning. On 12/14/22 at 9:18 AM, Surveyor interviewed NHA-A who stated NHA-A did not have written statements or documented interviews with CNA-N or CNA-U. NHA-A confirmed not all staff were educated to check R54's attire during 15 minute checks, including CNA-CC. The failure to adequately supervise a resident with a history of elopement resulted in the resident leaving the facility through a window and created a reasonable likelihood for serious harm for R54 which led to a finding of Immediate Jeopardy. The facility removed the Jeopardy on 12/14/22 when it completed the following: 1. Reviewed all residents for elopement risk score and appropriate care plans. 2. Elopement education for staff, including the importance of completing checks. 3. All residents' windows were checked and secured to prevent them from opening more than 4 inches.

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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. 42423 Based on staff interview and record review, the facility did not ensure 1 Resident (R) (R17) of 1 resident reviewed for weight loss received the necessary care and services to meet nutritional goals and prevent continued weight loss. R17 had a 16 pound or 12.62% unintended weight loss within six months. The facility did not follow orders to provide R17 with a dietary supplement or to weigh R17 on a weekly basis. Findings include: On 12/12/22 at 1:30 PM, Surveyor reviewed R17's electronic health record (EHR) which included a dietary progress note, dated 12/7/22 and electronically signed by Registered Dietician (RD)-C, that stated the following: .CBW (current body weight) 112.4 (pounds), height 60, and BMI (body mass index) 21.9. (R17) triggered for a significant weight loss of 11.8% in the past 6 months. This is not desirable given (R17's) low BMI and variable intakes. (R17's) weight has been stable 112-114 (pounds) for the past 2 months. Discussed with IDT (interdisciplinary team), recommend increasing fortified pudding to BID (twice daily) Recommendations: Continue NAS (no added salt) dysphagia (disorder related to difficulty swallowing) level 3 advanced texture thin consistency diet, fortified cereal once daily, fortified pudding (increase to BID), house supplements TID (three times daily), 60 cc (cubic centimeters) 2 cal (calorie) supplement TID monitoring weight and intakes. Nutrition goal: resident will meet >/=50% of estimated needs and gain to BMI >/= 23 kg (kilograms)/2m^ (A person's weight in kilograms (or pounds) divided by the square of height in meters. Calculated Healthy weight for the height of R17) .Increase (R17's) fortified pudding due to significant weight loss. R17's EHR did not include the above new order for fortified pudding increased to BID. R17's EHR contained an order for fortified pudding once daily. Upon further review, Surveyor noted R17's care plan indicated R17 was at risk for altered nutrition related to diagnoses of dementia with behavioral disturbance, chronic respiratory failure (a chronic condition that damages the airways that carry air to the lungs), hallucinations, major depressive disorder, hypertension, anemia (not enough red blood cells in the body), vitamin D deficiency, malaise (a general feeling of being unwell), chronic kidney disease (a disease of the kidneys that causes moderate or severe kidney damage and prevents the kidneys from filtering waste from the blood), h/o (history of) weight changes and significant weight loss. R17's care plan contained an intervention for weights per orders. R17 had a physician's order for weekly weights dated 3/16/22. On 12/14/22 at 8:30 AM, Surveyor completed a review of R17's weight record. R17's EHR contained eight missing weights for R17 which indicated R17's weekly weight order was not consistently implemented: 12/07/2022 110.8 Lbs. (pounds) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/01/2022 112.4 Lbs. 11/30/2022 no weight documented 11/23/2022 no weight documented 11/16/2022 114.4 Lbs. 11/11/2022 no weight documented 11/04/2022 113 Lbs. 10/26/2022 no weight documented 10/19/2022 113.8 Lbs. 10/12/2022 116.8 Lbs. 10/02/2022 116.9 Lbs. 09/28/2022 117 Lbs. 09/28/2022 no weight documented 09/14/2022 118.2 Lbs. 09/07/2022 117.2 Lbs. 09/03/2022 117.4 Lbs. 08/31/2022 118.5 Lbs. 08/24/2022 117.6 Lbs. 08/21/2022 118.6 Lbs. 08/17/2022 118.6 Lbs. 08/10/2022 119.4 Lbs. 08/03/2022 117.4 Lbs. 07/27/2022 126 Lbs. 07/20/2022 no weight documented 07/13/2022 no weight documented (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/06/2022 125.2 Lbs. 06/29/2022 no weight documented 06/22/2022 128.4 Lbs. 06/15/2022 126.4 Lbs. 06/08/2022 126.8 Lbs. On 12/13/22 at 12:21 PM, Surveyor interviewed RD-C. RD-C stated RD-C documented new orders for dietary changes in weekly dietary notes, discussed them weekly with the team and emailed all orders to Director of Nursing (DON)-B to ensure residents' orders were updated in the EHR. RD-C stated the facility began talking about how to have RD-C que orders so that when an order was prescribed it was immediately added to the orders to be implemented. In the facility's current practice, RD-C stated DON-B was responsible for entering new orders. RD-C stated RD-C followed up weekly on the orders RD-C made to ensure they were entered in residents' EHRs. RD-C confirmed R17's last order, dated 12/7/22, was to increase R17's fortified pudding to twice daily. RD-C stated RD-C followed up on R17's fortified pudding increase order multiple times via the facility's Monday nutritional meetings as well as several emails to DON-B to ensure the order was entered in R17's EHR. RD-C confirmed the order was not entered in R17's EHR at that time. On 12/14/22 at 7:49 AM, Surveyor interviewed DON-B who indicated weights were to be completed on residents as ordered in their care plan/orders. DON-B stated if there was a new dietary order, DON-B was responsible for entering the new order in the resident's EHR by the end of the week in which the new order or change was made. DON-B stated new dietary orders from last week should be already implemented and updated. DON-B stated the task of updating orders was delegated yesterday to someone to work on and get all orders updated. DON-B stated DON-B had not confirmed that all new orders were updated. On 12/14/22 at 8:11 AM, Surveyor reviewed R17's EHR and confirmed the order for fortified pudding BID, dated 12/07/2022, was entered in R17's EHR on 12/13/22 at 3:45 PM.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on staff interview and record review, the facility did not ensure ongoing communication with the dialysis facility was consistent with professional standards of practice for 1 Resident (R) (R24) of 1 resident reviewed for dialysis care and services. R24 obtained dialysis services from a dialysis center outside the facility. There was no evidence of written communication between the dialysis center and the facility following R24's dialysis appointments. Findings include: R24 was admitted to the facility on [DATE] with diagnoses to include 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), anemia in chronic kidney disease (common complication of chronic kidney disease causing iron deficiency), essential hypertension, type 2 diabetes mellitus and hyperkalemia (a high potassium level in the blood). The facility's Dialysis policy, implemented 3/1/19, states: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving dialysis. Policy Explanation and Compliance Guidelines: 1. Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures. 2. The care plan will reflect the coordination between the facility and the dialysis provider and will identify nursing home and dialysis responsibilities. 3. Interventions will include, but not limited to: a. Documentation and monitoring of complications. b. Pre-and post-weights. c. Assessing, observing, and documenting care of access sites, as applicable. d. Nutrition and hydration, including the provision of meals and snacks on treatment days. e. Lab tests. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Vital signs. g. Provision of medication on dialysis treatment days, such as which medications are: -Administered during dialysis -Held prior to dialysis -Given prior to dialysis -Administered by dialysis staff h. Transportation arrangements. i. Addressing any identified psychosocial needs. 4. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treat day, and as needed. 5. If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report. 6. Changes in condition following a dialysis treatment will be reported immediately to the physician. 7. The care plan will be reviewed routinely and as needed for effectiveness and revised as needed. On 12/13/22 at 3:15 PM, Surveyor reviewed the Long-Term Care Facility Outpatient Dialysis Services Coordination Agreement signed by the Facility Administrator, dated 1/7/20, and (Named Dialysis Company/End Stage Renal Disease (ESRD) Dialysis Unit), dated 2/12/20. The document indicated the agreement was the facility's current dialysis contract and would be renewed annually. The agreement included under section B titled Obligations of Long-Term Care Facility and/or Owner: 3. Interchange of Information. The Long-Term Care Facility shall provide for the interchange of information useful or necessary for the care of ESRD residents, including a contact person at the Long-Term Care Facility whose responsibilities include assisting with the coordination of Renal Dialysis Service for ESRD residents. The agreement further included under section E titled Mutual Obligations: 11. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Long-Term Care Facility and ESRD Dialysis Unit From 12/12/22 through 12/14/22, Surveyor reviewed R24's medical record and found no ongoing communication between the facility and the dialysis center. Surveyor was also unable to locate a communication binder or notes transmitted between the facility and R24's dialysis center. In addition, R24's electronic health record (EHR) did not contain pre-and post-weights per facility policy. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/22 at 12:31 PM, Surveyor interviewed Registered Nurse (RN)-H. RN-H verified the facility does not have a book for dialysis and stated R24 sometimes returned from the dialysis center with a note. RN-H was unable to locate progress notes that contained communication between the dialysis center and the facility in R24's EHR. RN-H stated RN-H was unaware of where the notes were kept or who documented that information. RN-H stated the process would be to look for an envelope when (R24) would return from dialysis; however, RN-H stated RN-H was not sure if the facility kept dialysis notes. On 12/13/22 at 2:12 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility should have a policy for how to communicate with the dialysis center. NHA further stated NHA-A did not believe the facility had a notebook or communication book to share information with the dialysis center. On 12/14/22 at 7:49 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated there was no formal documented communication between the dialysis center and the facility. DON-B verified there was not a communication binder or notebook that traveled between the facility and the dialysis center. DON-B stated DON-B knows that is a huge hole being a former dialysis nurse and stated DON-B asked residents how much fluid was taken off them after they returned from dialysis. 47248 Resident #24 Dialysis 12/13/22 12:31 PM [NAME] Schaw RN how do they communicate with dialysis-doesn't know but she would look for the envelope but she isn't sure that they keep them they would be in medical records 12/13/22 02:12 PM [NAME] NHA- asked for dialysis communication policy-she stated that they should have one the last place they worked they had a notebook but she doesn't believe they do have that here they just bring notes back if there is anything that needs to be communicated. 12/14/22 07:49 AM DON [NAME] states that there is no formal communication between dialysis and the facility and he knows that is a gap being a former dialysis nurse and states that usually he asks the patient how much fluid was taken off of them. No weights before and after dialysis, no communication or documentation of communication between the dialysis center and the facility per facility policy and coordination agreement.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42248 Based on observation, resident and staff interview and record review, the facility did not ensure the accurate acquisition and administration of medication for 1 Resident (R) (R33) of 9 residents reviewed for pharmacy services. The facility did not ensure R33's Combivent Respimat inhaler (medication inhaled to help open the airways in the lungs) was refilled timely resulting in thirteen missed doses between 12/10/22 and 12/13/22. Findings include: R33 was admitted to the facility on [DATE] and had a primary diagnosis of acute respiratory failure with hypoxia (low levels of oxygen in tissues) on 2/22/22. R33's active orders included Combivent Respimat Aerosol Solution 20-100 microgram (MCG/ACT) 1 puff inhale orally four times daily related to acute respiratory failure with hypoxia, dated 8/25/22. On 12/12/22 at 11:53 AM, Surveyor observed Registered Nurse (RN)-T perform medication administration for R33. RN-T looked at R33's Combivent Respimat inhaler dose indicator which showed 0 for number of doses remaining. RN-T asked R33 about the empty inhaler. R33 stated the inhaler was dead and staff could not get the inhaler until 12/20/22 due to insurance. R33 stated it was discovered three to four days ago that staff accidentally threw out R33's new inhaler. R33 stated it was not R33's fault and felt the facility should pay for a new inhaler and not submit a claim through R33's insurance. Following the conversation with RN-T, Surveyor interviewed R33 who stated it was more difficult to breath and to clear R33's lungs. R33 stated R33 used the inhaler for approximately three months. R33 stated once R33 begins taking the inhaler, R33 will feel fine. R33 stated staff have not monitored R33's oxygen saturation or performed an assessment. RN-T was not aware R33's inhaler was unavailable because RN-T had not worked in a couple weeks. According to R33's medication administration record (MAR), R33's Combivent Respimat inhaler was first documented as not administered for the 8:00 PM dose on 12/10/22. The next two doses were documented as administered, then the inhaler was documented as not administered through the 8:00 PM dose on 12/13/22. On 12/12/22 at approximately 12:30 PM, Surveyor reviewed R33's medical record which did not include nursing notes, assessments, or provider notification regarding R33's inhaler. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/22 at 12:15 PM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B called in the inhaler refill to R33's pharmacy today (12/12/22). DON-B stated DON-B performed morning medication pass on 12/12/22 for R33. DON-B stated when DON-B went to administer the inhaler to R33, R33 stated there were no doses left and the inhaler was discovered to be empty sometime during the most recent weekend. DON-B stated DON-B and R33 believed the new Combivent Respimat inhaler was misplaced and the nurse who worked that weekend stated to R33 the inhaler could not be refilled until 12/20/22. DON-B stated DON-B was taking this info second hand. DON-B stated DON-B called R33's pharmacy earlier that morning and was told the inhaler could not be refilled until 12/20/22. DON-B stated DON-B was going to call the pharmacy back to expedite the refill because it was not R33's fault the inhaler was missing. DON-B verified R33 was prescribed the Combivent Respimat inhaler for acute respiratory failure with hypoxia. Surveyor asked DON-B if DON-B performed an assessment on R33. DON-B stated, (R33) is breathing fine. (R33) did not appear to be in any distress. Not like (R33) was saying, 'I can't breath. I need my medicine.' (R33) can be very over dramatic. On 12/12/22 at 12:35 PM, DON-B stated DON-B called R33's pharmacy and the pharmacy will be send R33's Combivent Respimat inhaler on 12/12/22 with the night-time shipment. DON-B verified there should have been more urgency regarding the inhaler, which is why DON-B followed up to get the inhaler expedited to the facility. On 12/14/22 at 1:34 PM, Surveyor interviewed RN-W from Medical Doctor (MD)-X's office. RN-W verified MD-X was not aware R33 missed doses of the Combivent Respimat inhaler. RN-W stated MD-X was now aware and did not provide additional orders other than MD-X called in a new Combivent Respimat inhaler to the pharmacy in case prior authorization was needed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure pharmacy recommendation reports were acted on by a physician for 3 Residents (R) (R12, R18 and R6) of 5 residents reviewed for unnecessary medications. R12 had 3 pharmacy recommendations. No physician acknowledgement or follow through was noted. R18 had 1 pharmacy recommendation. No physician acknowledgement or follow through was noted. R6's medication regimen was not reviewed monthly by a pharmacist. Findings include: The facility's Addressing Medication Regimen Review Irregularities policy, with an implementation date of 3/1/19, states: Policy Explanation and Compliance Guidance: 2. The medication regimen of each resident must be reviewed by a licensed pharmacist at least once a month (or more frequently, as indicated by the resident's condition). 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and the director of nursing, and the reports must be acted upon. 4d. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. 1. R12 was admitted to the facility on [DATE] and had diagnoses to include diabetes, hypertension and dementia. On 12/14/22, Surveyor reviewed R12's chart and noted the following: ~6/30/22 - Consultant Pharmacist Recommendation to Physician noted: (R12) currently receives the following pertinent medications: Saccharomyces (a Probiotic) 250 mg (milligram) capsule BID (twice daily). In an effort to reduce pill burden, please consider the following: Discontinue Saccharomyces (no currently administered antibiotic therapy); or Decrease Saccharomyces to 1 capsule QD (every day). Surveyor noted the Physician/Prescriber response was not filled out. ~7/28/22 - Consultant Pharmacist Recommendation to Physician indicated R12 is currently receiving the following pertinent medications: Lantus (insulin) 10 units BID; Losartan (a medication used to treat high blood pressure and help protect the kidneys from damage due to diabetes) 50 mg BID. In an effort to reduce medication pill and pass burdens; please consider the following: Change Lantus to 20 units QD (duration of action greater than 24 hours; Discontinue other order); and change Losartan to 100 mg (manufacturer recommends once daily dosing). Surveyor noted the Physician/Prescriber response was not completed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~10/30/22 - Consultant Pharmacist Recommendation to Medical Director/Director of Nursing (DON) indicated R12 has the following pertinent medication orders: Nystatin cream (used to treat fungal infections of the skin) - apply to affected area Q8H (every 8 hours) PRN (as needed). Please consider the following clarification to therapy: 1. Update order to include application site. Surveyor noted the Follow Through column on the sheet did not contain any comments or signatures. 2. R18 was admitted to the facility on [DATE] with diagnoses to include behavioral symptoms of dementia, unspecified dementia and depression. R18 had an activated Power of Attorney for Healthcare. R18's Minimum Data Set (MDS), dated [DATE], contained a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R18 had severe cognitive impairment. On 12/14/22, Surveyor reviewed R18's medical record and noted a Consultant Pharmacist Recommendation to Medical Director/DON, dated 8/31/22, which indicated: (R18) receives the following pertinent medications: Quetiapine (an antipsychotic medication) 25 mg BID (started 4/12/22); Duloxetine (an antidepressant and nerve pain medication) 60 mg QD (started 1/28/22); Mirtazapine (an antidepressant medication) 15 mg QHS (every evening) (started 1/27/22); Trazadone (an antidepressant and sedative medication) 50 mg QHS (started 12/31/21). BIMS = 7 (severe cognitive impairment); PHQ-9 = 04 (minimal symptoms of depression) *concerns with sleep, feeling tired/little energy. Federal regulations require dose reductions for all medications given to affect mood/sleep. These reductions are intended to determine the lowest, most optimal dose for each medication given. To keep the facility compliant with these regulations please consider the following: Decrease Quetiapine to 12.5 mg QAM (every morning) and 25 mg QHS; or Decrease Duloxetine to 40 mg QD; or Decrease Mirtazapine to 7.5 mg QHS; or Continue Quetiapine, Duloxetine, Mirtazapine and Trazodone as ordered for depression. There is a Follow Through section with a typed comment that indicated Note written to physician; however Surveyor did not note a physician's signature or response. Surveyor also reviewed R18's medication prescription history and did not note a reduction in any of the medications after the pharmacist review. 3. R6 was admitted to the facility on [DATE] with diagnoses to include diabetes mellitus, personal history of adult physical and sexual abuse, conversion disorder with seizures or convulsions, other specified anxiety disorders, pulmonary hypertension and major depressive disorder (recurrent). On 12/14/22, Surveyor reviewed monthly medication regimen reviews for R6 and noted that there was no pharmacy review for R6 in September of 2022. The facility provided a list titled Psychotropic & Sedative/Hypnotic Utilization by Resident, dated 11/30/22. The report indicated the following: ~R6 was taking an antipsychotic medication (Risperdal .5 mg QD and 1 mg QHS) for major depression. The medication was ordered on 3/18/21 and last gradual dose reduction (GDR) was on 3/18/22. The report indicated the next evaluation would be in September of 2022. ~R6 was taking an anxiolytic medication (Xanax .25 mg QHS) for anxiety. The medication was ordered on 9/16/21 and the last GDR was on 9/16/21. The report indicated the next evaluation would be in September of 2022. ~R6 was taking an antidepressant medication (Zoloft 100 mg QD) for depression. The medication was ordered on 4/18/19 and there was no date indicated in the GDR column. The column for next evaluation indicated September of 2022. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/22 at 10:20 AM, Surveyor interviewed Regional Director of Clinical Operations (RDCO)-D who indicated the facility could not provide a physician response or acknowledgement for pharmacy recommendations for R12 and R18. RDCO-D also indicated R6's name was not on the list the pharmacy provided that indicated reviewed with no changes. RDCO-D stated R6 was in the facility at the time and RDCO-D was unsure why R6 was missed in September. On 12/14/22 at 11:28 AM, Surveyor interviewed DON-B who stated when faxes came from the pharmacy, there were multiple printers the faxes could go to and there seemed to be no rhyme or reason. DON-B confirmed that could be why the faxes were missed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42423 Based on observation and staff interview, the facility did not ensure safe food handling practices were implemented. This had the potential to affect all 45 residents who resided in the facility. A kitchen hood located over cooking surfaces contained visible peeling paint. Findings include: The Wisconsin Food Code reads as follows: 4-601.11 Equipment, Food--Contact Surfaces, Nonfood--Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. 551 AGRICULTURE, TRADE AND CONSUMER PROTECTION ATCP 75 Appendix Published under s. 35. 93, Wis. Stats. by the Legislative Reference Bureau. Updated on the first day of each month. Entire code is always current. The Register date on each page is the date the chapter was last published. Register July 2020 No. 775 (C) NONFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 12/12/22 at 9:40 AM, Surveyor conducted a tour of the facility's kitchen. Surveyor noted the kitchen range hood (a device containing a mechanical fan that hangs above the stove and cooktop and removes airborne grease, fumes, smoke, steam, etc.) was painted with off-white paint and had multiple areas of peeling paint that were hanging from the surface. Surveyor also noted some areas of rust on the edge of the hood. Beneath the hood was a flat cooking surface (burners), a stove and a steamer. The cooking surface contained food debris and appeared to have been recently used. On 12/12/22 at 10:40 AM, Surveyor interviewed and observed the hood and peeling pain with Dietary Manager (DM)-HH who stated, That must have just happened recently. On 12/12/22 at 3:14 PM, Surveyor revisited the kitchen. No changes were noted from the prior observation in regard to the hood. Surveyor also observed a pot that contained food contents on the cooking surface below the hood that contained peeling paint. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/14/22 at 8:04 AM, Surveyor interviewed Maintenance Staff (MS)-Q who stated prior to MS-Q's employment, someone put stainless steel on the hood and then painted the stainless steel. MS-Q stated, Stainless does not take paint very well. MS-Q stated, It (painting) was an easy way to cover the grease. MS-Q stated MS-Q ordered a new stainless steel hood to install over the cooking surfaces; however, MS-Q did not install the new hood yet. MS-Q stated, I know I have to finish it, but I would have to do it at night. MS-Q stated the other options were to sand the paint or use a chemical to remove the peeling paint which MS-Q stated could not be done while the kitchen was in use. MS-Q stated, either way, the hood had to go back to stainless steel.

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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.

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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** 42248 Based on observation, staff interview and record review, the facility did not maintain an Infection Prevention and Control Program designed to provide a safe and sanitary environment and prevent the transmission of communicable disease and infection. This had the potential to affect all 45 residents who resided in the facility. The facility did not appropriately monitor for infections and outbreaks and did not maintain an Infection Prevention and Control Program. DON (Director of Nursing)-B did not maintain infection control standards or adequately perform hand hygiene during wound care for R24. Laundry Aide (LA)-Z did not appropriately wear personal protective equipment (PPE) which resulted in contamination of LA-Z's clothing and residents' clean linens and personal clothing. Maintenance Staff (MS)-Q did not appropriately wear PPE while in R219 and R220's room while R220 was on contact and droplet precaution. In addition, Hospitality Aide (HA)-S did not perform hand hygiene after taking off PPE and exiting R219 and R220's room. Licensed Practical Nurse (LPN)-V did not perform hand hygiene or maintain infection control standards during medication administration for R44. Findings include: The facility's document titled Infection Prevention and Control Program, implemented 10/01/2022, states: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases . 3. Surveillance: b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility . 4. Standard Precautions: b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures . 11. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection . (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 document titled Infection Surveillance, implemented 10/01/2022, states: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections . Definitions: Infection surveillance refers to an ongoing systematic collection, analysis, interpretation, and dissemination of infection-related data . 1. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility . 5. Surveillance activities will be monitored facility-wide, and may be broken down by department or unit, depending on the measures being observed. A combination of process and outcome measures will be utilized. 6. The facility will collect data to properly identify possible communicable diseases or infections before they spread by identifying: a. Data to be collected, including how often and the type of data to be documented, including: i. The infection site, pathogen (if available), signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections: ii. Observations of staff including the identification of ineffective practices, if any; and iii. How the data will be used and shared with appropriate individuals (e.g., staff, medical director, director of nursing, QAA (Quality Assessment and Assurance) committee) when applicable, to ensure that staff minimize spread of the infection or disease . 8. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends. 9. All resident infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. Outbreaks will be investigated . 12. Formulas used in calculating infection rates will remain constant for a minimum of one calendar year . The facility's undated Hand Hygiene policy states: All staff perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . 1. Staff will perform hand hygiene when indicated, using proper techniques consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Alcohol-based hand rub is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty . 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . Hand Hygiene Table: Condition: After handling contaminated objects: Either soap and water or alcohol based hand rub (ABHR) (ABHR is preferred). Before applying and after removing personal protective (PPE), including gloves: Either soap and water or alcohol based hand rub (ABHR is preferred). -Before preparing or handling medications: Either soap and water or alcohol based hand rub (ABHR is preferred). Before performing resident care procedures: Either soap and water or alcohol based hand rub (ABHR is preferred). Before and after providing cares to residents in isolation: Either soap and water or alcohol based hand rub (ABHR is preferred). After handling items potentially contaminated with blood, body fluids, secretions, or excretions: Either soap and water or alcohol based hand rub (ABHR is preferred). When, during resident care, moving from a contaminated body site to a clean body site: Either soap and water or alcohol based hand rub (ABHR is preferred). After assistance with personal body functions (e.g., elimination, hair grooming, smoking): Either soap and water or alcohol based hand rub (ABHR is preferred). When in doubt: Either soap and water or alcohol based hand rub (ABHR is preferred). 1. On 12/13/22, Surveyor performed record review for R40, R49, and R220. Staff stated R40, R49 and R220 were on contact precautions for shingles. R40, R49 and R220's medical records did not include the reason for contact precautions. The Infection Preventionist, who was also DON-B, did not have documentation or surveillance pertaining to R40, R49, and R220's contact precautions. (continued on next page)

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Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/13/22 at 3:21 PM, Surveyor interviewed DON-B regarding the indications for R40, R49 and R220's transmission-based precautions. RDCO (Regional Director of Clinical Operations)-D was present during the interview. DON-B stated R40, R49 and R220 were on transmission-based precautions for shingles. DON-B verified DON-B did not create a line list or have surveillance for the suspected shingles cases. DON-B stated R220 has a cluster and a culture was ordered; however, DON-B was not sure who did what and was not sure why there was no follow up on the culture. No documents related to R220's suspected shingles were discovered. DON-B stated R49 was on reverse isolation (protection from pathogens due to a decreased immune system) and also on acyclovir (an antiviral medication) (since 7/7/22). RDCO-D stated RDCO-D looked into R49's acyclovir and inquired why there was no end date to the order. RDCO-D stated RDCO-D was waiting for a response. DON-B stated R49 had lesions on R49's back that were all dry and verified R49's medical record did not contain documentation related to the lesions or shingles. DON-B stated R220 was on contact precaution. When Surveyor stated R220's door contained a droplet precautions sign in addition to the contact precautions sign, RDCO-D stated the sign should just state contact (precautions). DON-B stated R220's lesions looks like shingles, on lower back. R220's medical record did not contain documentation related to shingles. On 12/13/22 at 12:52 PM, Surveyor interviewed DON-B who stated DON-B kept weekly COVID-19 infection line lists on DON-B's desktop. DON-B started at the facility in August of 2022 and was still learning infection control. DON-B stated DON-B kept the line lists like DON-B was trained by the previous Infection Preventionist and previous Regional Consultant. Surveyor asked DON-B if DON-B documented when staff last worked and when staff were allowed to return to work when diagnosed with COVID-19. Surveyor noted those dates were not documented on the COVID-19 line list. RDCO-D stated RDCO-D verifies when an employee last worked when diagnosed with COVID-19 and that information should be on the line list. The staff COVID-19 line list did not include documentation of testing dates or test results. On 12/13/22 at 2:43 PM, Surveyor interviewed DON-B regarding the process DON-B used to monitor infections. DON-B stated the closest thing since DON-B started was a COVID-19 outbreak with approximately seven to eight people involved. DON-B stated the facility had an RSV (Respiratory Syncytial Virus) outbreak (a contagious virus that is usually mild, but can severely affect the lungs and respiratory airways in older adults), but it was kind of sporadic .no pattern to it different halls. DON-B stated DON-B tries to jot down infection information and just does it in (DON-B's) head and if DON-B identified an outbreak, DON-B would call the County. DON-B stated the residents were in the hospital, tested with a rapid respiratory panel and diagnosed with RSV. Surveyor asked if the RSV cases were considered an outbreak. DON-B stated DON-B did not think so because it's a virus and needs to do it's course. DON-B stated the facility put residents who presented with signs and symptoms of illness on contact isolation. DON-B googled which transmission-based precautions were appropriate for RSV and stated, Contact isolation, I was correct. DON-B stated DON-B did not have a line list or infection surveillance for RSV and verified the facility had an outbreak in either August or September of 2022. DON-B also verified DON-B did not have a line list or infection surveillance for shingles. On 12/13/22 at 3:07 PM, RDCO-D entered to assist DON-B with the interview. RDCO-D stated the facility used IQI (a separate tracking tool for infection control which produced low sheets and charts for quality assurance) which was not yet fully implemented. DON-B stated DON-B did not enter information into the IQI system. RDCO-D stated DON-B was encouraged to use IQI and was still in the process of training. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 12/12/22 at 2:56 PM, Surveyor observed DON-B perform wound care for R24. DON-B donned clean gloves and took off an adhesive bandage that covered R24's left heel wound. With the same soiled gloves, DON-B cleansed R24's wound with a bottle of wound cleanser DON-B brought into the room from the wound cart. DON-B placed the wound cleanser on R24's bed which contained a fitted sheet soiled with debris that appeared to be dried discharge from R24's left toe wound. The wound cleanser also touched the soiled bandage that was on R24's left toe wound and placed on R24's bed by staff prior to DON-B performing wound care. With the same soiled gloves, DON-B applied Medihoney (a medical-grade honey used in wound care) and a non-adherent foam border dressing to R24's left heel. DON-B then removed a Kerlix bandage (gauze bandage roll) that was wrapped loosely around R24's left ankle and used to keep the dressing in place on R24's left foot. DON-B then removed the soiled gloves and stated DON-B didn't touch anything, so I'm just re-gloving. Without performing hand hygiene, DON-B donned clean gloves. DON-B painted R24's left toe with Betadine and stated DON-B did not want to wash R24's toe wound because DON-B did not want to compromise the integrity of the wound. Surveyor asked DON-B about cleaning the dried, crusted drainage that was on and in-between R24's toes surrounding the wound. DON-B picked off some of the dried drainage with gloved hands. DON-B then wrapped R24's left foot with Kerlix. With the same soiled gloves, DON-B felt for tape in DON-B's pockets. DON-B then removed the soiled gloves and washed hands with soap and water. DON-B took the wound cleanser bottle, exited R24's room, used alcohol-based hand rub (ABHR) to clean the bottle and placed the bottle on the wound cart. During the observation, Surveyor noted DON-B did not maintain a barrier between R24's left foot and bed and noted R24's bed was wet with wound cleanser. In addition, R24's legs were in contact with the wet fitted sheet after wound care and DON-B did not elevate R24's feet to ensure R24's heels were floating and not in contact with the mattress. On 12/12/22 at 3:30 PM, Surveyor interviewed DON-B who stated DON-B was nervous about the dressing change. Surveyor asked DON-B about the missed opportunities for hand hygiene, missed opportunities for glove changes between tasks during wound care and placing the wound cleanser on R24's soiled sheets. DON-B stated DON-B was changing gloves all the time. DON-B stated DON-B should not have placed the wound cleanser on R24's bed. DON-B stated DON-B did not want to use a CaviWipe (a sanitizing wipe used to clean equipment) on the wound cleanser bottle which is why DON-B used ABHR to disinfect the bottle. DON-B also verified DON-B should have changed R24's fitted sheet and elevated R24's feet. 3. On 12/12/22 at 10:30 AM, Surveyor observed LA-Z don a washable cloth gown and disposable gloves. LA-Z then opened plastic bags with residents' soiled clothing and linen from one bin and sorted the items into two other bins. LA-Z's gown was tied at the neck, but was not tied tightly enough and exposed approximately one third of the top of LA-Z's shirt. As LA-Z opened the plastic bags and transferred the soiled items to the bins, the soiled items touched LA-Z's exposed shirt. LA-Z's gown was also not tied tightly behind LA-Z's mid-back and exposed the back of LA-Z's shirt and the upper back of LA-Z's left arm which touched the outside of the soiled bins. LA-Z then exited the soiled laundry room with the bins and put the items into two washing machines. After the second washer was loaded, LA-Z removed the soiled gown and placed the gown in the washing machine. LA-Z then removed gloves and performed hand hygiene with soap and water. LA-Z then emptied the dryer. As LA-Z removed clean clothes from the dryer, the clean clothes touched previously contaminated areas of LA-Z's shirt. Surveyor immediately interviewed LA-Z who verified LA-Z should have tied the gown tighter so the soiled items did not contaminate LA-Z's shirt. On 12/12/22 at 10:49 AM, Surveyor interviewed Housekeeping and Laundry Manager (HLM)-AA and Area Manager of Housekeeping and Laundry (AMHL)-BB who stated they would provide immediate in-service to LA-Z and would recommend the use of disposable gowns due to LA-Z's inappropriate use of PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On 12/13/22 at 8:50 AM, Surveyor observed HA-S and Certified Occupational Therapy Assistant (COTA)-Y in R219 and R220's shared room. The room contained transmission-based precautions signs that indicated contact and droplet precautions were in effect and persons who entered the room needed to wear a mask, eye protection, a gown and gloves. Surveyor observed HA-S remove a gown and gloves. Without performing hand hygiene, HA-S walked down the hall to retrieve a tablet and then walked quickly off the unit. Surveyor then observed COTA-Y exit R219 and R220's room. Surveyor immediately interviewed COTA-Y who stated R220 was on transmission-based precautions due to shingles. On 12/13/22 8:51 AM, Surveyor observed MS-Q in R219 and R220's room. Surveyor noted MS-Q was not wearing a gown, gloves and eye protection as required per the contact and droplet signs on the door. MS-Q touched R220's blanket on the side of the bed nearest the door to look at the bed frame. R220 was not in bed at the time. MS-Q did not perform hand hygiene after touching R220's blanket and prior to touching R219's bed which was not working. Surveyor observed MS-Q lay on the floor at one point and potentially contaminate MS-Q's clothing. On 12/13/22 at 8:54 AM, MS-Q washed MS-Q's hands and exited the room. Surveyor interviewed MS-Q who did not realize MS-Q was required to don a gown, gloves and eye protection prior to entering R219 and R220's room. On 12/13/22 at 8:58 AM, Surveyor interviewed HA-S who stated HA-S was in a hurry when HA-S exited R219 and R220's room and removed PPE. HA-S stated HA-S did not touch anything while in the room and because HA-S wore gloves, HA-S did not need to sanitize hands. On 12/13/22 at 3:33 PM, Surveyor interviewed RDCO-D who verified staff missed opportunities for hand hygiene and wearing the required PPE while in R219 and R220's room. 5. On 12/13/22 at 8:01 AM, Surveyor observed LPN-V prepare R44's medication. Without performing hand hygiene, LPN-V donned clean gloves. LPN-V then prepared R44's medication which included an Advair inhaler and a Combivent Respimat inhaler. The Advair inhaler was placed on top of the medication cart without a barrier between the inhaler and the cart. LPN-V then touched medication cards inside the cart and cart surfaces with the same gloves used to touch the inhalers. LPN-V then placed the two inhalers in LPN-V's right shirt pocket. After administering the inhalers to R44, LPN-V put the inhalers back in LPN-V's pocket. With the same soiled gloves, LPN-V opened R44's door and exited the room. LPN-V then removed gloves and, without performing hand hygiene, put the inhalers back in the medication cart. On 12/13/22 at 8:11 AM, Surveyor interviewed LPN-V who stated I have never thought of that when Surveyor asked LPN-V if LPN-V sanitized hands after removing gloves. LPN-V stated there were no hand sanitizer dispensers on the walls of the dementia unit. LPN-V stated there was usually hand sanitizer in the nurses' station that LPN-V put on the medication cart; however, LPN-V forgot to do so prior to the medication pass. LPN-V stated the only hand sanitizer on the unit LPN-V was aware of was in the nurses' station. On 12/13/22 at 8:14 AM, Surveyor and LPN-V verified the locked nursing station and locked medication storage room within the nurses' station did not contain hand sanitizer. LPN-V asked HA-S where to retrieve hand sanitizer. HA-S stated there was one in each garbage room on the unit. Neither LPN-V or HA-S knew where additional hand sanitizer was stored. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/13/22 at 8:42 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-N and CNA-U who stated they did not have access to hand sanitizer on the dementia unit so they washed their hands with soap and water. On 12/13/22 at 3:33 PM, Surveyor interviewed RDCO-D who verified there should be hand sanitizer on the dementia unit and agreed LPN-V missed opportunities for hand hygiene during medication administration. 45943 Resident #63 Bladder and Bowel Incontinence 12/13/22 10:09 AM Admission MDS 11/18/22: C cognitive patterns: BIMS 99 G Functional Status: -BM: extensive assist 1 person -Tx to & from bed, chair, w/c: extensive assist 2 persons -walk b/w locations in rm: 1 person assist -locomotion (how res moves b/w locationsin rm: extensive assist 1 person -Dsg: extensive assist 1 person -Eating: TF -Toilet: extensive assist 1 person -personal hygiene extensive assist 1 person -Bathing: 1 person assist -Balance: not steady, only able to stabilize w staff assist -uses w/c (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	H B & B incont: - frequently incont urine -always incont bowel - no bowel or bladder training program DX: METABOLIC ENCEPHALOPATHY CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED CR(E)ST SYNDROME RESPIRATORY CONDITIONS DUE TO OTHER SPECIFIED EXTERNAL AGENTS HEMORRHAGE, NOT ELSEWHERE CLASSIFIED UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE Cardiovascular and Coagulations AGE-RELATED OSTEOPOROSIS WITHOUT CURRENT PATHOLOGICAL FRACTURE HEART FAILURE, UNSPECIFIED GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS TOXIC EFFECT OF TOBACCO CIGARETTES ARTHRITIS ORDERS: BOWEL POLICY:ON 4th DAY/10 SHIFT W/O BM, ADMINISTER 30 CC OF MOM, ON 11th SHIFT W/O BM, ADMINISTER DULCOLAX SUPP., ON 12th SHIFT W/O BM, ADMINISTER FLEETS, IF NO RESULTS OR INADEQUATE RESULTS CALL MD. CP: Alteration in elimination of bowel and bladder r/t Functional Incontinence due to weakness, physical limitations, and need for staff assistance (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	OBS12/14/22 10:00 AM : RES has bloody nose. assessed by ns who will call doctor. [NAME] & DING provided assist to clean up face. dried blood was present on res rt cheek. performed good hand hygiene. explained procedures prior to doing things.peri care performed. Brief changed, CNAs did not do HH or change gloves after removing soiled brief and putting on new brief. New brief, wipes, & bedding were touched with soiled gloves. Eventually doffed gloves & did HH did do HH after cares completed. HOB elev 45 deg.

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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. 42248 Based on staff interview and record review, the facility did not ensure the Infection Preventionist dedicated a minimum number of part-time hours and was provided the necessary training to adequately manage an Infection Prevention and Control Program. This had the ability to affect all 45 residents who resided in the facility. Director of Nursing (DON)-B was designated as the facility's Infection Preventionist in addition to performing full-time DON duties, working as a floor nurse and completing weekly wound rounds which resulted in DON-B's inability to adequately maintain an Infection Prevention and Control Program. Findings include: The facility's document titled Infection Prevention and Control Program, implemented 10/01/2022, stated: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases . On 12/13/22 at 1:20 PM, the Facility Assessment, dated 10/11/22, stated: DON-1; Infection Control and Prevention is listed as Other and no quantity listed. On 12/13/22 at 12:52 PM, Surveyor interviewed DON-B who stated DON-B kept weekly COVID-19 infection line lists on DON-B's desktop. DON-B stated DON-B kept line lists like DON-B was trained by the previous Infection Preventionist and previous Regional Consultant. DON-B stated DON-B started at the facility in August of 2022 and was still learning infection control. DON-B stated in addition to being the facility's full-time DON and Infection Preventionist, DON-B worked the floor as a nurse and performed weekly wound rounds. DON-B stated there were time challenges and DON-B was unable to dedicate part-time hours to the Infection Prevention and Control Program. DON-B could not provide Surveyor with the exact number of hours DON-B worked because DON-B was salaried and not required to punch in and out. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/13/22 at 3:07 PM, Regional Director of Clinical Operations (RDCO)-D entered to assist DON-B during the interview with Surveyor. RDCO-D stated the facility used IQI (a separate tracking tool for infection control which produced low sheets and charts for quality assurance) which was not yet fully implemented. DON-B stated DON-B had not entered information into the IQI system. RDCO-D stated DON-B was strongly encouraged to use the IQI system, but was still in the process of training. DON-B verified there was no infection surveillance or line list for RSV (Respiratory Syncytial Virus) (a common respiratory virus that causes infections of the lungs and respiratory tract) and the facility had an outbreak in approximately August or September of 2022. DON-B stated moving forward, DON-B will have an RSV line list for infection surveillance. DON-B demonstrated a lack of understanding of how to implement an Infection Prevention and Control Program. In addition, DON-B confirmed DON-B did not receive all of the necessary training to adequately implement an effective Infection Prevention and Control Program.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42248 Based on staff interview and record review, the facility did not ensure medical records contained documentation related to influenza and pneumococcal immunizations for 3 Residents (R) (R36, R49 and R52) of 5 residents reviewed for immunizations. R36's medical record did not contain documentation indicating the facility offered or administered the pneumococcal immunization. R49's medical record contained a signed consent form indicating R49 wished to receive the influenza immunization; however, R49's medical record did not contain documentation the immunization was administered. R52's medical record did not contain documentation indicating the facility offered or administered pneumococcal or influenza immunizations. Findings include: The facility's Pneumococcal Vaccine (Series) policy, implemented 3/1/19, states: Policy Explanation and Compliance Guidelines: .8. The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or resident's representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization. b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal. The facility's Influenza Vaccination policy, implemented 3/1/19, states: Policy Explanation and Compliance Guidelines: .9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal. On 12/14/22 at 5:18 PM, Director of Nursing (DON)-B provided Surveyor with requested documentation related to R36, R49 and R52's pneumococcal and influenza immunizations. Documentation related to proof of vaccine administration or declination for R36, R49 and R52 was not provided following an additional request for the information on 12/14/22 at 6:24 PM. R36 was admitted to the facility on [DATE]. R36's medical record did not contain documentation related to proof of vaccine administration or declination for the pneumococcal immunization. R49 was admitted to the facility on [DATE]. R49's medical record did not contain documentation related to proof of influenza vaccine administration. R49 signed a consent to receive the 2022/2023 seasonal influenza vaccine on 10/30/22. R52 was admitted to the facility on [DATE]. R52's medical record did not contain documentation related to proof of vaccine administration or declination for the pneumococcal or influenza immunizations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42248 Based on staff interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 immunizations for 2 Residents (R) (R8 and R36) of 5 residents reviewed for immunizations. R8 and R36's medical records did not include documentation indicating the facility offered or administered COVID-19 immunizations. Findings include: The facility's COVID-19 Vaccination policy, effective 2/4/22, states: Policy Explanation and Compliance Guidelines: 21. The resident's medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or; c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal. d. Follow-up monitoring of the resident post vaccination. On 12/14/22 at 5:18 PM, Director of Nursing (DON)-B provided Surveyor with requested immunization documentation related to R8 and R36's COVID-19 immunizations. Documentation related to proof of vaccine administration or declination for R8 and R36 was not provided following an additional request for the information on 12/14/22 at 6:24 PM. R8 was admitted to the facility on [DATE]. R8's medical record did not contain documentation related to proof of vaccine administration or declination for the COVID-19 vaccination. R36 was admitted to the facility on [DATE]. R36's medical record did not contain documentation related to proof of vaccine administration or declination for the COVID-19 vaccination.

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

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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 40342 Based on staff interview and record review, the facility did not ensure staff employed at the facility received required annual training for Resident Rights. Failure to provide the required training had the potential to impact multiple residents in the facility. Facility provided documentation indicated only 70 percent of staff received annual Resident Rights training from 12/1/21 through 12/20/22. Findings include: On 12/19/22 at 1:46 PM, Surveyor interviewed Regional Director of Operations (RDO)-M who stated on-going education was completed via a named Internet-based Continuing Education Format. RDO-M further indicated additional trainings were also provided in-person at times. RDO-M stated in-person all-staff education was provided on 9/22/22 which covered the required annual education. On 12/20/22, Surveyor reviewed facility provided education documents related to the in-person all-staff education held at the facility on 9/22/22. The documents did not include education on the topic of Resident Rights. On 12/20/22, Surveyor reviewed facility provided education documents emailed to Surveyor by Regional Director of Clinical Operations (RDCO)-D which covered the date range of 12/2/21 through 12/23/22 and listed percentages of staff compliance with completion of on-line education during that time frame. Regarding the topic of Resident Rights, documentation indicated 70 percent of staff completed the education. On 12/20/22 at 3:16 PM, Surveyor interviewed RDCO-D via phone who indicated it was a condition of employment that all staff complete required education and the facility expected 100% compliance. RDCO-D verified the facility had 57 employees at the time of the survey. RDCO-D verified the report provided to Surveyor from the facility's Internet-based Continuing Education Format indicated 32 of 46 employees assigned Resident Rights education completed the assignment for a 70 percent compliance rate. RDCO-D stated the report did not show new employees hired within the previous three months because the system was refreshed quarterly (every three months). RDCO-D stated new employees would receive Resident Rights education in-person as part of the orientation process and verified the 70 percent compliance rate was not acceptable.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40342 Based on staff interview and record review, the facility did not ensure staff employed at the facility received required annual training for Abuse, Reporting & Dementia Care Management. Failure to provide the required training had the potential to impact multiple residents in the facility. Facility provided documentation indicated only 6 of 57 employees were assigned and completed annual Abuse Prevention in Persons with Dementia training from 12/1/21 through 12/20/22. Findings include: On 12/19/22 at 1:46 PM, Surveyor interviewed Regional Director of Operations (RDO)-M who indicated on-going education was completed via a named Internet-based Continuing Education Format. RDO-M further stated additional trainings were provided in-person at times. RDO-M indicated an in-person all-staff education was provided on 9/22/22 which covered the required annual education. On 12/20/22, Surveyor reviewed facility provided education documents related to the in-person all-staff education held at the facility on 9/22/22. The documents did not include education on the topic of Abuse Prevention in Persons with Dementia. On 12/20/22, Surveyor reviewed facility provided education documents emailed to Surveyor by Regional Director of Clinical Operations (RDCO)-D which covered the date range of 12/2/21 through 12/23/22 and listed percentages of staff compliance with completion of on-line education during that time frame. Regarding the topic of Abuse Prevention in Persons with Dementia, documentation indicated 100% of staff assigned the topic completed the education; however, only 6 staff were assigned the topic. On 12/20/22 at 3:16 PM, Surveyor interviewed RDCO-D via phone who indicated it was a condition of employment that all staff complete required education and the facility expected 100% compliance. RDCO-D verified the facility had 57 employees at the time of the survey. RDCO-D verified the report provided to Surveyor from the facility's Internet-based Continuing Education Format indicated 6 of 6 employees assigned Abuse Prevention in Persons with Dementia education completed the assignment. RDCO-D stated the report did not show new employees hired within the previous three months because the system was refreshed quarterly (every three months). RDCO-D stated new employees would receive Abuse Prevention in Persons with Dementia education in-person as part of the orientation process. RDCO-D verified having only 6 of 57 employees complete the training was not acceptable.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 40342 Based on staff interview and record review, the facility did not ensure staff employed at the facility received required annual training on the written policies and procedures of the facility's Infection Control Program. Failure to provide the required training had the potential to impact multiple residents in the facility. Facility provided documentation indicated only 8 of 57 staff received annual Infection Prevention and Control for All Staff training from 12/1/21 through 12/20/22. Findings include: On 12/19/22 at 1:46 PM, Surveyor interviewed Regional Director of Operations (RDO)-M who stated on-going education was completed via a named Internet-based Continuing Education Format. RDO-M further stated additional trainings were also provided in-person at times. RDO-M indicated an in-person all-staff education was provided on 9/22/22 which covered the required annual education. On 12/20/22, Surveyor reviewed facility provided education documents related to the in-person all-staff education held at the facility on 9/22/22. The documents did not include education on the topic of Infection Prevention and Control for All Staff. On 12/20/22, Surveyor reviewed facility provided education documents emailed to Surveyor by Regional Director of Clinical Operations (RDCO)-D which covered the date range of 12/2/21 through 12/23/22 and listed percentages of staff compliance with completion of the on-line education during that time frame. Regarding the topic of Infection Prevention and Control for All Staff, documentation indicated 53 percent of 15 staff members assigned the topic completed the education. On 12/20/22 at 3:16 PM, Surveyor interviewed RDCO-D via phone who indicated it was a condition of employment that all staff complete required education and the facility expected 100% compliance. RDCO-D verified the facility had 57 employees at the time of the survey. RDCO-D verified the report provided to Surveyor from the facility's Internet-based Continuing Education Format indicated 8 of 15 employees assigned Infection Prevention and Control for All Staff education completed the assignment. RDCO-D indicated the report did not show new employees hired within the previous three months because the system was refreshed quarterly (every three months). RDCO-D stated new employees would receive Infection Prevention and Control for All Staff education in-person as part of the orientation process. RDCO-D verified having only 8 of 57 employees complete the training was not acceptable.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40342 Based on staff interview and record review, the facility did not ensure 4 Certified Nursing Assistants (CNAs) (CNA-I, CNA-J, CNA-K and CNA-L) of 5 sampled CNAs employed at the facility received a performance review every 12 months. Failure to review staff performance had the potential to impact multiple residents in the facility. CNA-I was hired on 12/5/05. The facility was unable to provide documentation that a performance review was completed during the most recent hire date year (12/5/21 through 12/5/22). CNA-J was hired on 3/20/06. The facility was unable to provide documentation that a performance review was completed during the most recent hire date year (3/20/21 through 3/20/22). CNA-K was hired on 10/29/13. The facility was unable to provide documentation that a performance review was completed during the most recent hire date year (10/29/21 through 10/29/22). CNA-L was hired on 8/18/21. The facility was unable to provide documentation that a performance review was completed during the most recent hire date year (8/18/21 through 8/18/22). Findings include: On 12/19/22, Surveyor reviewed a facility provided list of all employees by department and hire date. Surveyor randomly chose five CNAs and requested their most recent Performance Reviews. CNA-I's hire date was listed as 12/5/05. CNA-J's hire date was listed as 3/20/06. CNA-K's hire date was listed as 10/29/13 and CNA-L's hire date was listed as 8/18/21. On 12/19/22, Surveyor reviewed facility provided documents of the most recent Performance Reviews completed for the five requested CNAs. Of the five requested, four had the following concerns: ~ CNA-I's Performance Review was undated and unsigned. ~ CNA-J's Performance Review was undated and unsigned ~ CNA-K's Performance Review was signed and dated 12/4/2015. ~ A Performance Review was not provided for CNA-L On 12/19/22 at 1:55 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified CNA-L did not receive a Performance Review since CNA-L's date of hire on 8/18/21. NHA-A stated CNA-L did not work frequently. NHA-A verified CNA-K's last Performance Review was completed in 2015. NHA-A verified Performance Review documents for CNA-I and CNA-J were undated. NHA-A was unable to determine when the reviews were completed. NHA-A stated the facility would recheck employee files for more recent documents. NHA-A expressed understanding of the requirement that CNA Performance Reviews be completed annually. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/22, Surveyor reviewed an email received from NHA-A that sated, .(CNA-L) last worked on 08/30/2022 . Email attachments did not contain any Performance Reviews dated prior to 12/19/22. On 12/20/22 at 3:16 PM, Surveyor interviewed Regional Director of Clinical Operations (RDCO)-D via phone who stated the facility did not have a policy regarding frequency or content of CNA Performance Reviews. RDCO-D verified CNA-I, CNA-J, CNA-K and CNA-L had not received required annual Performance Reviews.