STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menomonee Falls Health Services	N84 W17049 Menomonee Ave Menomonee Falls, WI 53051

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not provide a notice of rights and services prior to or upon admission for 1 (R11) of 2 newly admitted residents. R11 was admitted to the facility on [DATE]. No facility admission agreement packet, that included a notice of rights and services, was provided to R11 at any time prior to or while a resident at the facility. Findings: The facility policy and procedure entitled Admission Requirement Policy dated 1/1/2018 states: The facility's admission policies: -Provide uniform guidelines for the admission of residents to the facility. -Ensure that only residents who can be adequately cared for by the facility are admitted . -Reduce the fears and anxieties of resident and family during the admission process. -Are reviewed with the resident/representative (as are the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.). -Ensure that appropriate medical and financial records are provided to the facility prior to or upon the resident's admission. R11 was admitted to the facility on [DATE] with diagnoses of sepsis due to Escherichia coli, dysphagia, chronic obstructive pulmonary disease, diabetes, bipolar disorder, anxiety, glaucoma, heart failure, chronic kidney disease, and fibromyalgia. R11's admission Minimum Data Set (MDS) assessment dated [DATE] coded R11 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R11 did not have an activated Power of Attorney. R11 was discharged from the facility on 9/21/2021 to another facility. Review of R11's medical record by Surveyor did not reveal an admission agreement had been signed. (continued on next page)

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

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/21/2021 at 10:54 AM, Surveyor asked Social Worker (SW)-X what the process is for new admissions when it comes to completing the admission packet paperwork. SW-X stated nurses do the clinical assessment of the resident and take care of the orders. Surveyor asked SW-X who reviews the admission packet with the resident and has the resident or resident representative sign the paperwork. SW-X stated SW-X dos not complete any part of the admission paperwork with a newly admitted resident. SW-X stated the Business Office Manager or the Nursing Home Administrator goes over the information with the resident. In an interview on 9/21/2021 at 11:10 AM, Business Office Manager (BOM)-W stated the admission packet is divided between nursing and BOM-W. BOM-W stated BOM-W goes over the financial part of the admission packet, but was unsure of who completes the rest of the admission packet including reviewing the rights and services provided. BOM-W stated that has been a question BOM-W has brought up since 2/2021 when BOM-W started working at the facility and had never gotten an answer. Surveyor asked if the admission packet information with signatures are scanned into the medical record or if a hard copy is kept in the resident's hard file. BOM-W stated BOM-W had never seen them scanned in and was not even sure they were being completed. BOM-W stated there were many residents with missing admission packets from their medical records. BOM-W stated copies of some of the financial agreements are in a file BOM-W keeps in the Business Office. Surveyor requested a copy of the signed financial agreements for R11. On 9/21/2021 at 11:35 AM, Surveyor asked Nursing Home Administrator (NHA)-A and Corporate Registered Nurse (RN)-H what the process was for a new admission in regards to completing the admission packet and paperwork. NHA-A stated SW-X meets with the new resident to review the packet with them and get signatures and BOM-W gets the financial paperwork from the admission packet from the new resident. Surveyor shared SW-X had just been interviewed and SW-X had stated SW-X does not complete any part of the admission process. Surveyor shared with NHA-A and Corporate RN-H the inability to find R11's admission agreement in the medical record. Surveyor requested a copy of R11's admission agreement. On 9/21/2021 at 1:58 PM, BOM-W stated R11 did not have any financial admission paperwork on file. On 9/21/2021 at 3:15 PM, Corporate RN-H stated no admission paperwork was found in either the hard chart or scanned into R11's medical record. No further information was provided at that time.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the Facility did not immediately consult with a physician from general surgery when ordered and did not inform the resident's representative of the condition change and need for surgical consult for 1 (R5) of 6 Residents reviewed for notification. On 9/20/20 facility staff identified a mass on R5's left thigh. The physician gave orders for a consult with a physician from general surgery. The facility did not consult with a general surgeon and get an appointment. The facility did not inform the Health Care Power of Attorney, who is actively involved in her brother's care, about the left thigh mass and the order for a consult for general surgery. On 3/15/21 the facility again identified the left thigh mass when doing a skin sweep. The physician again gave orders for a general surgery consult. The facility did not consult with a general surgeon and obtain an appointment and did not inform the resident's Health Care Power of Attorney. One year later, when a consult was finally obtained, results confirmed the mass was a high grade sarcoma. The Facility's failure to consult with a physician from general surgery regarding the left thigh mass and to arrange for R5 to see a general surgeon and its failure to notify R5's Health Care Power of Attorney about R5's left thigh mass and an order for a general surgery consult on 9/29/20 and 3/15/21 created a finding of Immediate Jeopardy (IJ) which began on 9/29/20. Administrator-A and Corporate RN (Registered Nurse)-H were notified of the Immediate Jeopardy on 10/11/21 at 11:40 a.m. The immediate jeopardy was removed on 10/11/21. The deficient practice continues at a scope and severity of a D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: R5's diagnoses includes Alzheimer's Disease, diabetes mellitus, and dementia. R5 has an activated Health Care Power of Attorney (HCPOA). The order administration note dated 9/29/20 documents, Consult to general surgery for left thigh mass evaluation one time only for left thigh mass for 1 day. Will obtain. Surveyor noted there was no follow up consultation with the physician from general surgery regarding R5's left thigh mass. Surveyor noted there is no documentation R5's HCPOA was informed of the left high mass and general surgery consult. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care conference note dated 10/1/20 documents, Care conference held today with POA attending via phone. Resident remains in the facility for LTC (long term care), he is a DNR (do not resuscitate), no changes made to code status. Plan of care reviewed with no changes. Resident's vitals and BS (blood sugar) reviewed, at times resident refuses medication/treatment however with re-approach 10-15 minutes later he accepts cares/treatment. Should resident refuse after reapproach, POA would like to be notified, care plan continues to reflect this request. POA brought in special orthopedic boot that she ordered for resident on the recommendation of specialist MD (medical doctor), he has been agreeable to wearing it as per POA's request. POA will also purchase closed toe shoes for resident as the weather is getting colder. Therapy discharge summary reviewed, resident is back to PLOF (previous level of function). Resident's cognitive status discussed, no changes he remains stable and alert. Nutrition assessment reviewed with POA. POA denies concerns, she may set up outdoor visit, she understands to call facility in advance to arrange. IDT (interdisciplinary team) to continue to follow. Surveyor noted there is no documentation R5's POA was informed of the left high mass and general surgery consult. Surveyor noted there was no follow up consultation with the physician from general surgery regarding R5's left thigh mass. The nurses note dated 3/15/21 documents Skin sweep and assessment completed. OA (open area) to L (left) ball of foot medial side tx (treatment) CDI (clean dry intact) followed by wound clinic goes q (every) week. L hip/thigh large solid mass skin intact. The nurses note dated 3/15/21 documents Writer updated [name of doctor] and NP (Nurse Practitioner) [name] regarding mass to resident L upper thigh. Awaiting response. The nurses note dated 3/15/21 documents MD called back regarding L upper thigh mass. NOR (new order received) for general surgery, order transcribed. Surveyor was unable to locate any information the Facility consulted with a physician from general surgery and there is no documentation R5's HCPOA was informed of the left thigh mass or need for a general surgery consult. The progress note dated 9/2/21 documents Spoke with sister who states she is working on changing cardiologist and will let the staff know when she arranges the appointment. Writer also reviewed recent NP appointment and expressed findings related to the Lt (left) leg lipoma which has been there over a year as sister indicates she was not aware of it. Appointment is pending to f/u (follow up) on area as the size has changed per NP since onset. No pain or discomfort, no warmth or pain no changes in skin color. Resident currently in room awaiting lunch. The nurses note dated 9/10/21 documents Appointment for surgical consult made for [R5] on 9/14/21 re left thigh lipoma. [Name of POA] aware and pleased. Transportation set up. On 9/14/21 the report of consultation under findings documents 10 x 13 cm (centimeter) Mass (L) (left) thigh 30# (pound) wt (weight) loss. Suspicious. Needs MRI of (L) thigh & then possible referral to sarcoma team @ (at) [name of hospital]. On 9/20/21 at 1:34 p.m. Surveyor informed Corporate RN (Registered Nurse)-H Surveyor was unable to locate when R5's HCPOA was informed of the left thigh mass identified on 9/29/20 and consult for general surgery. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/21/21 at 10:10 a.m. Surveyor spoke with R5's HCPOA on the telephone. During this conversation R5's HCPOA informed Surveyor she was not informed of the mass on R5's left thigh. R5's HCPOA stated, This could have been looked at .No way this would have been ignored with me. I've been taking care of [R5] since 2006 .Would of never let it go like that. R5's HCPOA informed Surveyor first time she became aware of the mass on her brother's thigh was on 9/10/21. R5's HCPOA informed Surveyor she received two phone calls from [name of hospital] to set up surgical consult. On 9/21/21 11:55 a.m. Corporate RN-H informed Surveyor she was unable to locate any information. On 10/6/21 the Facility emailed to the Division of Quality Assurance, R5's interventional radiology biopsy dated 10/1/21 for cytologic interpretation under preliminary diagnosis documents left thigh mass, core biopsy: High grade sarcoma. R5's condition went undiagnosed for over a year, creating an opportunity for cancerous cells to spread if the mass was cancerous. According to Is the Lump Sarcoma? Lipoma? Learn the Difference, lipomas are fatty non-cancerous tumors (which tend to be squishy, non-tender and <2 inches) while sarcomas are cancerous tumors and tend to be firm, tender and >5 inches. The earlier a sarcoma is found, the less likely it has spread, and the better the outcome. https://www.premierhealth.com/your-health/articles/health-topics/is-this-lump-a-sarcoma-lipoma-learn-the-difference. Similarly, United States Bone and Joint Initiative: The Burden of Musculoskeletal Diseases in the United States notes, For high-grade soft tissue sarcomas, the most important prognostic factor is the stage at which the tumor is identified. Staging criteria for soft tissue sarcomas are primarily determined by whether the tumor has metastasized or spread elsewhere in the body . Using the staging criteria of soft tissue sarcomas of the American Joint Committee on Cancer (AJCC) produces similar results for sarcomas found in the limbs (arms or legs): 90% 5-year survival rate for Stage 1 sarcomas; 81% for Stage 2; and 56% for Stage 3. Sarcomas identified as Stage 4 have a very low 5-year survival rate . http://www.boneandjointburden.org. Failure to consult with a physician from general surgery as ordered by the attending physician prevented early diagnosis and treatment of the underlying condition. The facility's failure to notify R5's HCPOA, who is actively involved in R5's care, prevented her from ensuring that a consult with a physician from general surgery was obtained when requested. This led to a finding of immediate jeopardy. Cross reference F684. The immediate jeopardy was removed on 10/11/21 when the facility implemented the following action plan: * Notification to MD and Resident's HCPOA of any abnormal findings if noted. * The Facility completed a follow up call to the Resident's HCPOA to review current care planning and review related to any additional surgical follow up appointments that may be scheduled. * Facility initiated training with Licensed Nursing Staff on documenting and reporting Changes of Condition at the time of time of observation to the Physician and the Resident's responsible party participating in care planning for the identified Resident. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Reviewed the policy and procedure for changes of condition F580. * Re-educated Licensed Nursing Staff on identifying and reporting of changes of condition when newly identified changes in health status are identified. * Re-educated Licensed Nursing Staff on completing a notification to the MD, RP (responsible party) and or Guardian at the time of identification. * The Facility will review Point Click Care (PCC) daily during morning meeting to identify changes of condition and ensure notifications/consultations were completed. Follow up will be completed if indicated based on the outcome of the audit. * The Facility will complete random audits 3x weekly on scheduling of appointments to ensure notifications were completed to the Responsible Party and to ensure notifications of MD orders were completed. * The Facility will complete random audits 3x weekly to ensure skin events with a change in clinical presentation are reported at the time of identification to the MD and Responsible Party. * The Facility will ensure Residents with growths have a focused routine assessment that identifies changes in dimensions, color, shape, presentation and overall decline and or improvement in characteristics and reported to the MD and RP and Guardian at the time of identification.

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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. 21855 Based on record review and interviews, the facility did not ensure a grievance was thoroughly investigated to determine appropriate resolution. This was observed in 1 (R13) of 5 resident reviews. R13 had expressed a concern on 8/10/21 regarding not being transferred to bed until the following morning. There was no addition interviews to determine cause and resolution. Findings include: The facility's Grievance Policy and Procedure, dated 2/24/2018 was reviewed by Surveyor. The procedures include the written grievance resolution decisions include the date when the original concern was received, a summary statement of the concern, steps taken to investigate, a summary of findings or conclusions regarding the concern, whether the concern was confirmed or not, any corrective action taken and the date the written decision was issued. R13 verbalized a grievance on 8/10/21. The Grievance Report from the facility indicates on 8/10/21 R13 reported that they did not get help into bed last night and has been up in their wheelchair since last night. R13 indicated at 10:00 PM they asked the Aid to lay down. The Aid wanted to use a Hoyer lift and R13 indicated they use a sit-to-stand. The Aid did not want to use the sit-to-stand and did not assist R13 into bed. The documented facility follow-up section dated 8/10/21 completed by Administrator-A indicates: Administrator will set alarm to call staff nightly at 10:00 PM to ensure staff lay R13 down. The documented resolution section dated 8/10/21 completed by Administrator-A indicates: staff are to lay down R13 when asked and ED (Executive Director) calls to follow-up. The Grievance Report does not include a thorough investigation. There are no staff interviews to gather information to what happened. R13's concern with the appropriate transfer equipment was not addressed in the investigation, nor staff involved. On 9/21/21 at 9:14 AM Surveyor spoke with Administrator-A and CRN-H (Corporate Registered Nurse). Administrator-A did not have any other documentation pertaining to this grievance. Administrator-A indicated they talked to staff and R13 didn't want to use the Hoyer and then was agreeable in the morning. Administrator-A did not have additional information regarding the staff involved, cares provided/ offered during that time period or if this met criteria to be reported to the State Agency. On 9/21/21 at 10:35 AM Surveyor spoke with R13. R13 uses a regular wheelchair and is their own person. R13 indicated they use a sit-to-stand for transfers and has been a little bit better. R13 did not recall details from a month ago. R13 did not have any skin concerns after sitting up all night.

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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** 38253 Based on record review and interviews, the facility did not ensure residents and their representatives received the written transfer notice with the date of transfer, the reason for the discharge, the location of the transfer, the appeal rights, and the contact information of the State Long-Term Care Ombudsman for 1 (R9) of 3 residents reviewed for admissions and discharges. R9 was transferred to the hospital on 4/18/2021. A transfer notice was not provided to R9 or R9's representative. Findings: R9 was admitted to the facility on [DATE] with diagnoses of intervertebral disc disorders with myelopathy, spondylosis of the lumbosacral region, chronic obstructive pulmonary disease, Barrett's esophagus, unspecified disorder of adult personality and behavior, depression, anxiety, intellectual disabilities, and gastroesophageal reflux disease. R9 did not have an activated Power of Attorney (POA). On 4/18/2021, R9 was transferred to the hospital due to aggressive behaviors toward staff and others for evaluation and treatment. R9 did not return to the facility. Review of R9's medical record did not show a transfer notice was provided to R9 or R9's representative. An E-Interact Transfer form was initiated on 4/18/2021 and the form was blank. In an interview on 9/20/2021 at 3:00 PM, Nursing Home Administrator (NHA)-A stated on 4/18/2021 R9 was sent to the hospital for a psychological evaluation because of the behaviors R9 was exhibiting. NHA-A stated the hospital called the facility after R9 had been in the emergency room for only five minutes and was going to send R9 back to the facility. NHA-A stated NHA-A contacted R9's case manager and had a conversation agreeing the best care for R9 would be a psychological evaluation and the hospital was the best place to have R9 treated. NHA-A stated the case manager and the contact at the hospital both agreed R9 needed to stay at the hospital for psychological services. NHA-A stated the safety of the staff and residents at the facility needed to be considered and having R9 return to the facility was not in their best interest. In an interview on 9/21/2021 at 11:05 AM, Surveyor asked Social Worker (SW)-X who sends a transfer notice with a resident when they are sent out to the hospital. SW-X did not know what is sent with a resident and did not know who would send the appropriate paperwork. In an interview on 9/21/2021 at 11:13 AM, Surveyor asked Business Office Manager (BOM)-W who sends a transfer notice with a resident when they are sent out to the hospital. BOM-W did not know what is sent with a resident and did not know who would send the appropriate paperwork. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/21/2021 at 11:35 AM, Surveyor asked NHA-A and Corporate Registered Nurse (RN)-H where is the appeal rights documented for a resident when they transfer to the hospital. NHA-A stated the appeal rights is part of the E Interact Transfer form that is generated by the nurse when the resident goes to the hospital. Surveyor shared with NHA-A and Corporate RN-H the observation of the E Interact Transfer form started on 4/18/2021 was blank. Surveyor asked for a copy of the forms that were sent with R9 on 4/18/2021 to show the transfer notice with appeal rights was provided to R9. On 9/21/2021 at 3:25 PM, NHA-A stated there was no evidence of a transfer notice information found for R9. No further information was provided at that time.

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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** 38253 Based on record review and interviews, the facility did not ensure residents and their representatives received a bed hold notice upon transfer to a hospital for 1 (R9) of 3 residents reviewed for admissions and discharges. R9 was transferred to the hospital on 4/18/2021. A bed hold notice was not provided to R9 or R9's representative. Findings: The facility policy and procedure entitled Bed-Hold Policy dated 6/12/2018 states: 1. The facility has a bed-hold policy and readmission policy that outlines the terms and conditions for holding a bed if the resident is transferred out of the facility for any reason. 2. The facility will notify the resident at the time of admission and again prior to a hospital transfer or therapeutic leave of its bed-hold and return policies. 3. Before any transfer, advance notice of the policy is given, usually at the time of admission and also included in the admission packet. RE-issuance of the first notice is not required unless the facility's policy changes. 4. The bed-hold notice specifies: a. The duration of the bed-hold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility. b. The nursing facility's policies regarding bed-hold periods permitting a resident to return. c. In cases of emergency transfer, notice at the time of transfer means that the resident, family or representative is provided with written notification within twenty-four (24) hours of the transfer. d. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. R9 was admitted to the facility on [DATE] with diagnoses of intervertebral disc disorders with myelopathy, spondylosis of the lumbosacral region, chronic obstructive pulmonary disease, Barrett's esophagus, unspecified disorder of adult personality and behavior, depression, anxiety, intellectual disabilities, and gastroesophageal reflux disease. R9 did not have an activated Power of Attorney (POA). On 4/18/2021, R9 was transferred to the hospital due to aggressive behaviors toward staff and others for evaluation and treatment. R9 did not return to the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's medical record did not show a bed hold notice was provided to R9 or R9's representative. An E-Interact Transfer form was initiated on 4/18/2021; the form was blank. In an interview on 9/20/2021 at 3:00 PM, Nursing Home Administrator (NHA)-A stated on 4/18/2021 R9 was sent to the hospital for a psychological evaluation because of the behaviors R9 was exhibiting. NHA-A stated the hospital called the facility after R9 had been in the emergency room for only five minutes and was going to send R9 back to the facility. NHA-A stated NHA-A contacted R9's case manager and had a conversation agreeing the best care for R9 would be a psychological evaluation and the hospital was the best place to have R9 treated. NHA-A stated the case manager and the contact at the hospital both agreed R9 needed to stay at the hospital for psychological services. NHA-A stated the safety of the staff and residents at the facility needed to be considered and having R9 return to the facility was not in their best interest. In an interview on 9/21/2021 at 11:05 AM, Surveyor asked Social Worker (SW)-X who sends a bed hold notice with a resident when they are sent out to the hospital. SW-X did not know what is sent with a resident and did not know who would send the appropriate paperwork. SW-X stated SW-X does not do any follow up with the resident of family on the bed hold status. In an interview on 9/21/2021 at 11:13 AM, Surveyor asked Business Office Manager (BOM)-W who sends a bed hold notice with a resident when they are sent out to the hospital and who follows up with the bed hold. BOM-W did not know what is sent with a resident and did not know who would send the appropriate paperwork. BOM-W stated BOM-W does not do any follow up with the resident or family on the bed hold status. In an interview on 9/21/2021 at 11:35 AM, Surveyor asked NHA-A and Corporate Registered Nurse (RN)-H how is a bed hold notice provided to a resident when they transfer to the hospital. NHA-A stated the bed hold notice is sent by the nurse when the resident goes to the hospital. Surveyor asked if a copy of the bed hold notice was kept in the resident's chart. NHA-A did not know. Surveyor asked for a copy of the forms that were sent with R9 on 4/18/2021. On 9/21/2021 at 3:25 PM, NHA-A stated there was no evidence of a bed hold notice was provided/found for R9. No further information was provided at that time.

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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** 20483 Based on interview and record review the facility did not ensure 1 (R5) of 6 Residents reviewed received care and treatment in accordance with their physician's orders. The Nurse Practitioner (NP) note dated 9/29/20 documents under assessment and plan, Left Thigh Mass - patient notes duration is 8 months - non-tender, non-mobile. firm -will refer to general surgery. Under physical exam for extremities documents, No edema noted. Not cyanotic. left thigh mass. There are no measurements of the left thigh mass and no revisions in R5's skin integrity care plan. The order administration note dated 9/29/20 documents, Consult to general surgery for left thigh mass evaluation one time only for left thigh mass for 1 day. Will obtain. There is no information regarding an appointment being made or R5 having a general surgery consult. There are no subsequent measurements of the thigh mass by facility staff. On 3/15/21 a skin sweep was conducted and LPN-CC identified the left thigh mass. R5's physician was notified and an order for a general surgery consult was obtained. There is no information regarding an appointment being made or R5 having a general surgery consult. There are no subsequent measurements by facility staff. On 8/31/21 the NP note documents under assessment and plan, Left Thigh Mass -has been present over 1 year - may be limpoma (fatty lump) or something more - non-tender, non-mobile firm - referred to general surgery back in [DATE] however no follow up arranged - reorder general surgery consult today as staff note increase in size. Under physical exam for extremities documents No edema noted. Not cyanotic. firm left thigh mass. Surveyor noted there were no measurements of the left thigh mass until 9/13/21 when the non pressure weekly tracker documents for site, .left thigh (rear) and under description Intact attached Lipoma. Circumference 7 cm (centimeters). Protrudes off thigh 3 cm in height. Surveyor noted this is the only measurement taken by Facility staff that Surveyor was able to locate. An appointment was made for general surgery consult on 9/14/21. The report of consultation dated 9/14/21 under findings documents, 10 x 13 cm (centimeter) Mass (L) (left) thigh 30# (pound) wt (weight) loss. Suspicious. Needs MRI of (L) thigh & then possible referral to sarcoma team @ (at) [name of hospital]. The interventional radiology biopsy dated 10/1/21 for cytologic interpretation under preliminary diagnosis documents left thigh mass, core biopsy: High grade sarcoma (cancer). (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 failure to routinely monitor and assess R5's left thigh mass until 9/13/21, to document at least monthly on its size, and to follow physician's orders and to make timely surgical consult appointments as ordered by the physician on 9/29/20 and 3/15/21 prevented early diagnosis and early treatment to prevent any underlying condition from worsening. This created a finding of Immediate Jeopardy (IJ) which began on 9/29/20. Administrator-A and Corporate RN (Registered Nurse)-H were informed on 10/11/21 at 11:40 a.m. The immediate jeopardy was removed on 10/11/21. The deficient practice continues at a scope and severity of a D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: R5's diagnoses include Alzheimer's Disease, diabetes mellitus, and dementia. R5 has an activated power of attorney. The MD (Medical Doctor) note dated 7/12/20 does not have any documentation regarding a left thigh mass. The NP (Nurse Practitioner) notes dated 7/13/20, 7/20/20, 7/23/20, 8/7/20, and 8/11/20 do not have any documentation regarding a left thigh mass. The MD note dated 9/1/20 does not have any documentation regarding a left thigh mass. The NP note dated 9/29/20 documents under assessment and plan Left Thigh Mass - patient notes duration is 8 months - non-tender, non-mobile. firm -will refer to general surgery. Under physical exam for extremities documents No edema noted. Not cyanotic. left thigh mass. Surveyor noted there are no measurements of the left thigh mass. The order administration note dated 9/29/20 documents Consult to general surgery for left thigh mass evaluation one time only for left thigh mass for 1 day. Will obtain. Surveyor was unable to locate any information regarding an appointment being made or R5 having a general surgery consult. On 9/21/21 at 9:57 a.m. Surveyor informed LPN (Licensed Practical Nurse)-Y she had written an order administration note for R5 dated 9/29/20 for a general surgery consult. Surveyor asked if she could remember making this appointment. LPN-Y informed Surveyor she doesn't recall anything about this. The NP note dated 10/14/20 documents under assessment and plan: Left Thigh Mass - patient notes duration is 8 months - non-tender, non-mobile, firm -referral placed to general surgery Sept (September) 2020. Under physical exam for extremities documents No edema noted. Not cyanotic. left thigh mass. Surveyor noted there are no measurements of the left thigh mass. The NP note dated 10/23/20 documents under assessment and plan: Left Thigh Mass - patient notes duration is 8 months - non-tender, non-mobile. firm -referral placed to general surgery [DATE]. Under physical exam for extremities documents No edema noted. Not cyanotic. left thigh mass. Surveyor noted there are no measurements of the left thigh mass. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NP note dated 10/27/20 documents under assessment and plan: Left Thigh Mass - patient notes duration is 8 months - non-tender, non-mobile. firm -referral placed to general surgery [DATE]. Under physical exam for extremities documents No edema noted. Not cyanotic. left thigh mass. Surveyor noted there are no measurements of the left thigh mass. The MD note dated 1/13/21 documents under assessment and plan Left Thigh Mass - patient notes duration is 8 months - non-tender, non-mobile. firm -referral placed to general surgery [DATE]. Under physical exam for extremities documents No edema noted. Not cyanotic. Surveyor noted there are no measurements of the left thigh mass and there have been no ongoing measurements by facility staff. The NP note dated 3/3/21 does not have any documentation regarding a left thigh mass. The MD note dated 3/14/21 does not have any documentation regarding a left thigh mass. The nurses note dated 3/15/21 documents Skin sweep and assessment completed. OA (open area) to L (left) ball of foot medial side tx (treatment) CDI (clean dry intact) followed by wound clinic goes q (every) week. L hip/thigh large solid mass skin intact. The nurses note dated 3/15/21 documents Writer updated [name of doctor] and NP (Nurse Practitioner) [name] regarding mass to resident L upper thigh. Awaiting response. The nurses note dated 3/15/21 documents MD called back regarding L upper thigh mass. NOR (new order received) for general surgery, order transcribed. Surveyor was unable to locate any information regarding an appointment being made or R5 having a general surgery consult. The NP note dated 4/13/21 under physical exam for extremities documents No edema noted. Not cyanotic. Left thigh soft tissue mass. The MD note dated 5/24/21 does not have any documentation regarding a left thigh mass. The NP notes dated 6/2/21 and 8/11/21 do not have any documentation regarding a left thigh mass. The NP note dated 8/31/21 documents under assessment and plan Left Thigh Mass -has been present over 1 year - may be limpoma (fatty lump) or something more - non-tender, non-mobile firm - referred to general surgery back in [DATE] however no follow up arranged - reorder general surgery consult today as staff note increase in size. Under physical exam for extremities documents No edema noted. Not cyanotic. firm left thigh mass. Surveyor noted there are no measurements of the left thigh mass and there have been no measurements by facility staff since the mass was first discovered on 9/29/20. The progress note dated 9/2/21 documents, Spoke with sister who states she is working on changing cardiologist and will let the staff know when she arranges the appointment. Writer also reviewed recent NP appointment and expressed findings related to the Lt (left) leg lipoma which has been there over a year as sister indicates she was not aware of it. Appointment is pending to f/u (follow up) on area as the size has changed per NP since onset. No pain or discomfort, no warmth or pain no changes in skin color. Resident currently in room awaiting lunch. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated 9/10/21 documents, Appointment for surgical consult made for [R5] on 9/14/21 re left thigh lipoma. [Name of POA] aware and pleased. Transportation set up. The non pressure weekly tracker with an effective date of 9/13/21 documents for site 36) left thigh (rear) and under description Intact attached Lipoma. Circumference 7 cm (centimeters). Protrudes off thigh 3 cm in height. Surveyor noted this is the only measurement taken by Facility staff that Surveyor was able to locate. On 9/14/21 the report of consultation under findings documents 10 x 13 cm (centimeter) Mass (L) (left) thigh 30# (pound) wt (weight) loss. Suspicious. Needs MRI of (L) thigh & then possible referral to sarcoma team @ (at) [name of hospital]. On 9/20/21 at 12:16 p.m. Surveyor asked LPN (Licensed Practical Nurse)-CC who is responsible for making consult appointments. LPN-CC informed Surveyor the nurses are. LPN-CC explained after they get an order, the doctors office is called and then they make transportation. LPN-CC informed Surveyor sometimes it can take a couple days to make the appointment. Surveyor asked if a progress note would be written regarding the appointment. LPN-CC replied, Yes, should make a note. On 9/20/21 at 1:19 p.m. Surveyor asked LPN-CC if R5 was one of her Residents. LPN-CC informed Surveyor she is not on that side. Surveyor informed LPN-CC Surveyor had noted three nurses notes on 3/15/21 regarding a skin sweep for R5. LPN-CC informed Surveyor Administrator-A asked her to do a skin sweep of all the Residents in the building at this time and she gave all the sheets to Administrator-A. Surveyor informed LPN-CC one of the notes indicated a new order was received for general surgery and the order was transcribed. Surveyor asked LPN-CC if she made the appointment for this consult. LPN-CC informed Surveyor she would not have made the appointment as she was not the nurse. LPN-CC informed Surveyor she knows she updated the Director of Nursing at that time and spoke with LPN-Y the nurse on that side. On 9/21/21 at 9:54 a.m. Surveyor informed LPN-Y, LPN-CC had conducted a skin sweep on 3/15/21, noted R5 had a left thigh mass, and that LPN-CC had informed her that R5's physician had ordered a general surgery consult. Surveyor asked LPN-Y if she made the general surgery appointment for R5 which was ordered on 3/15/21. LPN-Y informed Surveyor she doesn't recall if an appointment was made. Surveyor asked who would be responsible to ensure an appointment was made. LPN-Y informed Surveyor she doesn't recall who would be responsible. On 9/21/21 at approximately 2:10 p.m. Corporate RN-H informed Surveyor she wasn't able to find the general surgery consults for 9/29/20 and 3/15/21. Administrator-A informed Surveyor R5's POA would sometimes cancel R5's appointments. Surveyor informed Administrator-A and Corporate RN-H there is no evidence Facility staff made these appointments and there is no documentation in R5's medical record R5's POA canceled appointments. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/5/21 at 1:25 p.m. Surveyor spoke with Physician-DD on the telephone regarding R5's left thigh mass. Surveyor asked Physician-DD if he saw R5's left thigh mass. Physician-DD replied yes and explained on 9/1/20 did not see a mass and on 9/29/20 the NP did see it, patient notes (it was) there for 8 months and refer to general surgery. Physician-DD informed Surveyor for a couple month they noted the mass and also in January and then lost follow up. Physician-DD informed Surveyor more recently the mass grew in size. On 8/31/21 the NP saw R5 and she reordered a general surgery consult as staff said it has increased in size. Physician-DD informed Surveyor he was looking at his & the NP's documentation and does not have any of the Facility's documentation. Surveyor asked Physician-DD if he actually saw the mass on R5' left thigh. Physician-DD informed Surveyor he must have but is not visualizing and not picturing the mass. Physician-DD indicated his partner saw R5 on 9/20/21 and R5 was going to see the surgeon the next day. Surveyor asked Physician-DD what his expectations are for staff monitoring R5's left thigh mass. Physician-DD informed Surveyor he doesn't know how to answer this, he does know the Facility does regular skin checks and doesn't know who first noticed the mass, was it the patient asking about it or did staff. Surveyor asked Physician-DD if he would expect staff to measure R5's left thigh mass. Physician-DD replied I would. Surveyor asked if staff should be measuring the mass weekly. Physician-DD informed Surveyor he didn't think it would have to be measured weekly as it's not an active wound but should be measured monthly. Surveyor asked Physician-DD if he was aware R5 did not see the general surgeon which was ordered on 9/29/20. Physician-DD informed Surveyor their notes mention the general surgeon the first month or two and after that point doesn't know if the consult got lost. Surveyor asked Physician-DD if he was aware there was another general surgery consult ordered on 3/15/21. Physician-DD informed Surveyor he was personally not aware. Surveyor then informed Physician-DD of the nurses notes dated 3/15/21 regarding a skin sweep, a call being placed to himself and the NP awaiting a call back and the MD calling back and ordering a general surgery consult. Physician-DD informed Surveyor he has no recollection of that but it's a plausible story. Surveyor asked Physician-DD if there is any impact on R5 with the delay in the general surgery consult. Physician-DD informed Surveyor he can't answer that. He knows a biopsy was recently done and they are waiting for the results. On 10/6/21 the Facility emailed to the Division of Quality Assurance R5's interventional radiology biopsy report. The interventional radiology biopsy report, dated 10/1/21, for cytologic interpretation under preliminary diagnosis documents, left thigh mass, core biopsy: High grade sarcoma. R5's condition went undiagnosed for over a year, creating an opportunity for cancerous cells to spread if the mass was cancerous. According to Is the Lump Sarcoma? Lipoma? Learn the Difference, lipomas are fatty non-cancerous tumors (which tend to be squishy, non-tender and <2 inches) while sarcomas are cancerous tumors and tend to be firm, tender and >5 inches. The earlier a sarcoma is found, the less likely it has spread, and the better the outcome. https://www.premierhealth.com/your-health/articles/health-topics/is-this-lump-a-sarcoma-lipoma-learn-the-difference. Similarly, United States Bone and Joint Initiative: The Burden of Musculoskeletal Diseases in the United States notes, For high-grade soft tissue sarcomas, the most important prognostic factor is the stage at which the tumor is identified. Staging criteria for soft tissue sarcomas are primarily determined by whether the tumor has metastasized or spread elsewhere in the body . Using the staging criteria of soft tissue sarcomas of the American Joint Committee on Cancer (AJCC) produces similar results for sarcomas found in the limbs (arms or legs): 90% 5-year survival rate for Stage 1 sarcomas; 81% for Stage 2; and 56% for Stage 3. Sarcomas identified as Stage 4 have a very low 5-year survival rate . http://www.boneandjointburden.org. (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 failure to ensure R5 received appropriate care and treatment of his left thigh mass, for failing to document at least monthly on its size, and for failing to follow physician's orders and to make timely surgical consult appointments as ordered by the physician on 9/29/20 and 3/15/21 until 9/14/21 created a finding of Immediate Jeopardy (IJ) which began on 9/29/20. The immediate jeopardy was removed on 10/11/21 when the facility implemented the following action plan: * The Facility reviewed the care plan of R5 to identify and complete follow up, if indicated, on any outstanding orders pertaining to consultations for specialty provider services. * The Facility performed and updated complete head to toe skin assessment of R5 to identify any abnormal findings. * The Facility reviewed the care planning of R5 to ensure monitoring orders related to the left thigh mass are in place. The Facility will monitor the dimensions, skin type of actual growth, skin type of surrounding tissue, new onset pain or worsening pain and opening or reopening of identified area. * The Facility reviewed the details of the care planning related to R5 with the Medical Director who is also resident's attending physician. * The Facility initiated a review of each Resident currently admitted to identify any possible similar events related to abnormal findings related to the skin review. * The Facility initiated a review of each Resident with an identified growth on the skin for new orders related to care planning and on going observation of the identified area. * The Facility initiated a review of each Resident currently admitted to identify and complete follow up on any identified growths on the skin for additional care planning and observation to the identified area. * The Facility completed a review with each current attending physician in relation to outstanding consultation orders and initiate follow up if indicated. * The Facility reviewed the policy and procedures for Physician Services F684. * Re-educated all Licensed Nursing Staff on identifying changes in health status. * Re-educated all Licensed Nursing Staff on completion of a comprehensive assessment on all skin events with a noted change in size, shape, and clinical presentation at the time of discovery. * Re-educated all Licensed Nursing Staff on the importance of following up on identified changes to the skin upon notification by the Certified Nursing Assistant. * Re-educated all Licensed Nursing Staff on completing a detailed or comprehensive assessment on identified growths that have changed in size or clinical presentation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Re-educated all Licensed Nursing Staff on following up on all abnormal findings during the weekly skin review process. * The Facility reviewed the appointment scheduling process to ensure consistency in scheduling and follow up. * The Facility will review orders to identify and ensure follow upon recommendations for consultations during daily morning meeting. * The Facility will review Point Click Care (PCC) daily during morning meetings to identify changes of condition. Follow up will be completed if indicated based on the outcome of the audit. * The Facility will complete random audits 3x weekly with Licensed Nurses to gauge understanding related to completion of changes of condition. Remedial education will be provided at the time of completion of audits if indicated. * The Facility will review orders to identify and ensure follow up on recommendations for consultations daily during morning meeting. The Facility will ensure Residents with growths have a focused routine assessment that identifies changes in dimensions, color, shape, presentation and overall decline and or improvement in characteristics.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview, and record review the Facility did not ensure 2 (R10 & R8) of 3 Residents received adequate supervision and assistive devices to prevent accidents. * R10's mat was not observed on the left side of the bed according to R10's plan of care. The Facility did not investigate R10's fall on 4/14/21 including why R10 was wearing two briefs & bed linen was saturated and why the bed not at the lowest position according to the plan of care. R10's falls care plan was not revised after the 4/14/21 fall. * On 8/16/2021, R8 had an unwitnessed fall. The fall was not thoroughly investigated and the care plan was not updated with an intervention specific to the cause of the fall. Findings include: 1. R10's diagnoses includes malignant neoplasm of colon, chronic kidney disease, hypertension, and dementia. The at risk for falls care plan initiated & revised on 3/3/20 has the following interventions: * Anticipate and meet the Resident's needs. Encourage the Resident to always call for assistance. Initiated 3/3/20. * Assist into Broda chair as tolerated. Ensure door is kept open and resident in view of staff. Initiated 3/3/20 & revised 8/19/20. * Ensure that the Resident is wearing appropriate footwear (shoes/gripper socks). Initiated 3/3/20 & revised 6/10/20. * Place bed at lowest position. Initiated 3/3/20. * Place call light or communication device within reach. Answer call light promptly - always. Initiated 3/3/20. * Place floor mat to left side of resident when in bed. Initiated & revised 6/10/20. * Review information on past falls and attempt to determine cause of falls for prevention and to minimize injuries. Initiated 3/3/20. The nurses note dated 4/14/21 documents Resident found on the floor by OT (Occupational Therapist)-AA after hearing a thump. Resident was found soaked through 2 briefs and bed completely saturated. VS (vital signs) were stable. Resident complaint of pain in her back, Tylenol was given and effective. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident report dated 4/14/21 under incident description for nursing description documents Resident was found on the side of her bed on the bedside pad after OT-AA heard a thump. Resident was soaked through 2 briefs and bed completely soaked as well, bed was not in the lowest position, side pads were down on the floor. Under Resident description documents Resident unable to give description. Under immediate action taken documents Resident was picked up and put back on the bed after the linen was changed. VS were taken and were stable. Bed was placed in the lowest position with floor pads still in place. The post fall assessment dated [DATE] documents for date and time of fall 04/14/2021 0700 (7:00 a.m.). Unknown is answered for the questions what time was the Resident last seen, who was the staff member that last saw the Resident and what position was the Resident when last seen? Under list immediate interventions documents Bed was lowered to the lowest position. Surveyor noted R10's fall care plan was not revised after this fall. The quarterly MDS (Minimum Data Set) with an assessment reference date of 8/29/21 documents a BIMS (Brief Interview Mental Status) score of 6 which indicates severe impairment. R10 requires limited assistance with one person physical assist for bed mobility, transfer & toilet use occurred once or twice with two plus person physical assist and does not ambulate. R10 is always incontinent of urine and bowel and is coded as not having any falls since prior assessment period. On 9/20/21 at 12:11 p.m. Surveyor observed R10 in bed on her back with two pillows under her head. Surveyor observed there is not a floor mat on the left side of R10's bed. On 9/20/21 at 1:38 p.m. Surveyor observed R10 continues to be in bed on her back. Surveyor observed there is still not a floor mat on the left side of R10's bed. On 9/20/21 at 3:54 p.m. Surveyor observed R10 continues to be in bed on her back. Surveyor observed there is still not a floor mat on the left side of R10's bed. On 9/21/21 at 7:21 a.m. Surveyor observed R10 in bed on her right side. Surveyor observed there is not a floor mat on the left side of R10's bed. On 9/21/21 at 10:02 a.m. Surveyor observed R10 in bed on her back. Surveyor observed there is still not a floor mat on the left side of R10's bed. On 9/21/21 at 11:24 a.m. Surveyor observed R10 in bed on her back. Surveyor observed there is still not a floor mat on the left side of R10's bed. On 9/21/21 at 12:15 p.m. Surveyor accompanied Corporate RN (Registered Nurse)-H to R10's room. R10 was in bed on her back without a floor mat on the left side. Surveyor informed Corporate RN-H according to R10's plan of care, there should be a floor mat on the left side of R10's bed. Surveyor informed Corporate RN-H Surveyor did not observe the floor mat yesterday or today. On 9/21/21 at 12:40 p.m. Surveyor asked LPN (Licensed Practical Nurse)-F if R10 should have a floor mat on the left side. LPN-F informed Surveyor R10 actually has a floor mat on both sides of her bed. LPN-F informed Surveyor the floor mat was behind the head board and indicated she didn't know why. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/21/21 at 1:04 p.m. Surveyor asked Corporate RN-H who should Surveyor speak with regarding R10's fall on 4/14/21. Corporate RN-H informed Surveyor she wasn't at the Facility at this time and Surveyor should speak to Administrator-A. Surveyor also informed Corporate RN-H Surveyor was unable to locate a fall assessment for R10. On 9/21/21 at 1:29 p.m. Surveyor informed Administrator-A, Corporate RN-H had recommend Surveyor speak to him regarding R10's fall on 4/14/21. Surveyor asked Administrator-A if they investigated this fall including why R10 was wearing two incontinent products with the bed completely soaked and not at the lowest position per plan of care. Administrator-A informed Surveyor he'll have to look to see if they did an investigation. On 9/21/21 at 2:47 p.m. Corporate RN-H informed Surveyor the last fall assessment completed for R10 is dated 9/2/20. On 9/21/21 at 3:24 p.m. Administrator-A informed Surveyor they do not have any information regarding R10's fall on 4/14/21. 38253 2. R8 was admitted to the facility on [DATE] with a left humerus fracture from a fall on 7/25/2021, dementia, and osteoporosis. R8 had a T8 vertebral body compression fracture 4/2021 and a left hand fifth metacarpal fracture 6/2021. R8's admission Minimum Data Set (MDS) assessment dated [DATE] coded R8 as having moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 8 and needing extensive assistance with bed mobility, transfers, dressing, and toilet use. R8 had an activated Power of Attorney (POA). A fall risk assessment was completed on admission as part of the admission process. A Fall Care Plan was initiated on 7/29/2021 using the fall assessment. The following interventions were put in place: -Apply non-skid socks -Bed in low position -FALL RISK On 7/29/2021 in the early morning, R8 fell in the room trying to ambulate to the bathroom independently to brush teeth. No injuries were sustained in the fall. The physician and POA were notified. The Fall Care Plan was updated to include: provide assist to transfer and ambulate as needed and reinforce need to call for assistance. On 8/7/2021 at 11:00 PM, R8 slid off the edge of the bed. R8 was attempting to put a nightgown on over a nightgown R8 already had on. No injuries were sustained. The physician and POA were notified. The Fall Care Plan was updated to include: have commonly used articles within easy reach. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/10/2021 at approximately 9:00 PM, R8 was found on the floor in the room. R8 stated R8 stepped on the foot and fell to the floor. No injuries were sustained in the fall. The physician and POA were notified. The Fall Care Plan was updated to include: place R8 at nursing station for closer monitoring. On 8/16/2021 at 8:30 PM, R8 had an unwitnessed fall in the room. No documentation was found describing the cause of the fall. No injuries were sustained in the fall. The physician and POA were notified. The Fall Care Plan was not revised. R8 discharged from the facility to a memory care facility on 8/27/2021. In an interview on 9/21/2021 at 10:54 AM, Social Worker (SW)-X stated the nurse on the floor at the time of the fall does a post-fall assessment and then resident falls are reviewed during the morning meetings with the interdisciplinary team. Surveyor asked SE-X who was part of the interdisciplinary team. SW-X stated all of the department heads are at morning meeting such as nursing, social services, and therapy. Surveyor asked SW-X who updates the resident care plan following a fall. SW-X stated the interdisciplinary team updates the care plan at the meeting. SW-X did not differentiate which team member updates the care plan. On 9/21/2021 at 11:35 AM, Surveyor shared with Nursing Home Administrator-A and Corporate Registered Nurse-H the concern R8 had a fall on 8/16/2021 and the fall was not investigated thoroughly and the care plan was not updated with an intervention specific to the cause of the fall. No further information was provided at that time.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review the Facility did not ensure 1 (R10) of 3 Residents reviewed maintained acceptable parameters of nutritional status. On 6/15/21 there was an order for monthly weights. There were no weights obtained in July 2021 or August 2021. On 8/25/21 RD-Z completed a nutritional assessment for R10 using the latest weight dated 6/17/21 of 119.2 pounds. RD-Z requested a weight and on 9/13/21 R10 weighed 99.6 pounds and on 9/14/21. R10 weighed 99.9 pounds. This represented a severe weight loss of 16.19% during 3 months from 6/17/21 (119. 2lbs.) to 9/14/21 (99.9 lbs.) This represents a severe weight loss of 19.82% from 1/1/21 (124.6 lbs) to 9/14/21 (99.9 lbs). The facility was not monitoring R10's weights until the noted weight loss on 9/13/21. Findings include: R10's diagnoses includes malignant neoplasm of colon, chronic kidney disease, hypertension, and dementia. R10 is currently on hospice which was initiated on February 2020. The at risk for altered nutritional status care plan initiated 2/26/20 & revised 9/15/21 has the following interventions: * Determine Resident's likes, dislikes and prior eating habits. Initiated 2/26/20. * Diet as ordered. Initiated 8/29/20 & revised 7/7/21. * Document amount of meals consumed. Initiated 2/26/20. * Follow RD (Registered Dietitian) recommendation and MD (Medical Doctor) orders for diet type and texture. Diet as ordered, supplement as ordered. Initiated & revised 2/26/20. * Follow tray card preferences and meal types. Double check at all tray passes. Initiated 2/26/20. * Provide a pleasant dining environment. Accommodate Resident preferences in dining locale. Initiated 2/26/20. * Provide Resident set up and adaptive equipment as specified. Initiated 2/26/20. R10's weights are as follows: 01/01/21 124.6 pounds 02/12/21 124.4 pounds 030/3/21 121.8 pounds (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No April 2021 weight record 05/27/21 119. pounds The physician's order dated 5/7/21 documents Regular diet dysphagia mechanical soft texture, regular/thin consistency. The quarterly MDS (Minimum Data Set) with an assessment reference date of 5/29/21 has a BIMS (brief interview mental status) score of 3 which indicates severe impairment. R10 is coded as independent with set up help only for eating. The nutritional assessment dated [DATE] for most recent weight documents 119.0. Date (of weight was) 05/27/21. IBW (ideal body weight) range is 105, UBW (usual body weight) 120s and average meal intake percentage per day 50-75% at most meals plus snacks. Total calories is 1413-1695 cals (calories) (25-30 cal/kg (calorie/kilogram). For the question was there a change in weight weight loss is answered. Under evaluation of nutritional status documents Dx (diagnoses) includes colon CA (cancer), dementia, HTN (hypertension), CKD (chronic kidney disease). Resident tolerating regular diet well with no known c/s issues, no current GI (gastrointestinal) upset. PO (by mouth) intakes good, 75-100% plus snacks. Honor food preferences. Encourage po/fluids as tolerated. Weight history is: 119# (pounds) on 5/27, 121.8# 3/3, 124.4# on 2/12, 124.6# on 1/1, 120.2# on 11/18 Non sig (significant) weight loss. BMI (body mass index) 22.5 (wnls). Wt (weight) to be monitored as tolerated and/or per hospice recommendations. Meds (medication reviewed), see chart for full list. Include laxative. Will monitor/follow up PRN (as needed). The physician's order with an order date of 6/15/21 & start date of 7/1/21 documents Monthly weight every evening shift starting on the 1st and ending on the 1st of every month for weight monitoring. R10's weight on 6/17/21 was 119.2. There is no weight during July 2021 & August 2021. Surveyor reviewed July 2021 meal intake and noted the following: 7/1/21 breakfast, lunch and supper are blank. 7/2/21 breakfast 0-25%, lunch 26-50%, & supper is blank. 7/3/21 breakfast, lunch & supper are blank. 7/4/21 breakfast & lunch 0-25% & supper 76-100%. 7/5/21 breakfast & lunch are blank and supper 0-25%. 7/6/21 breakfast & lunch 0-25% and supper is NA (non applicable). 7/7/21 breakfast & lunch 26-50% and supper 51-75%. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/8/21 breakfast 26-50%, lunch 76-100%, & supper 26-50%. 7/9/21 breakfast 51-75%, lunch blank, & supper 0-25%. 7/10/21 breakfast 51-75%, lunch 26-50%, & supper 51-75%. 7/11/21 breakfast & lunch 51-75% and supper is blank. 7/12/21 breakfast 51-75%, lunch & supper 76-100%. 7/13/21 breakfast & lunch 0-25% and supper 51-75%. 7/14/21 breakfast resident refused, lunch 51-75%, & supper 26-50%. 7/15/21 breakfast 51-75%, lunch 26-50%, & supper 0-25%. 7/16/21 breakfast & lunch 51-75% and supper 26-50%. 7/17/21 breakfast & lunch 51-75% and supper 76-100%. 7/18/21 breakfast 76-100%, lunch 0-25%, and supper 76-100%. 7/19/21 breakfast & lunch 0-25% and supper 76-100%. 7/20/21 breakfast 76-100%, lunch 26-50%, & supper 51-75%. 7/21/21 breakfast & lunch 0-25% and supper 76-100%. 7/22/21 breakfast & lunch 51-75% and supper 76-100%. 7/23/21 breakfast 76-100%, lunch 26-50%, & supper 51-75%. 7/24/21 breakfast & lunch are blank and supper 51-75%. 7/25/21 breakfast, lunch, & supper are blank. 7/26/21 breakfast & lunch are blank and supper 51-75%. 7/27/21 breakfast & lunch are blank and supper 76-100%. 7/28/21 breakfast & lunch are blank and supper 76-100%. 7/29/21 breakfast, lunch, & supper are blank. 7/30/21 breakfast & lunch 51-75% and supper is blank. 7/31/21 breakfast, lunch, & supper are blank. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician progress note dated 8/5/21 under history of present illness includes Patient is very thin and cachectic currently also on hospice care. Under assessment documents Monitor weight. The physician's order with an order & start date of 8/6/21 documents Regular diet Dysphagia Pureed texture, Regular/Thin consistency, dysphagia. Surveyor reviewed August 2021 meal intake and noted the following: 8/1/21 breakfast & lunch are blank and supper 26-50%. 8/2/21 breakfast, lunch, & supper are blank. 8/3/21 breakfast & lunch are blank and supper is 51-75%. 8/4/21 breakfast & lunch 0-25% and supper 76-100%. 8/5/21 breakfast 26-50%, lunch 0-25%, and supper are blank. 8/6/21 breakfast & lunch 0-25% and supper 51-75%. 8/7/21 breakfast 76-100%, lunch & supper 51-75%. 8/8/21 breakfast, lunch, & supper are blank. 8/9/21 breakfast 26-50%, lunch 0-25%, & supper 51-75%. 8/10/21 breakfast & lunch are blank and supper 51-75%. 8/11/21 breakfast & lunch 51-75% and 0-25%. 8/12/21 breakfast 76-100%, lunch & supper 51-75%. 8/13/21 breakfast 51-75%, lunch 0-25%, and supper is blank. 8/14/21 breakfast resident refused, lunch & supper 26-50%. 8/15/21 breakfast, lunch, & supper are blank. 8/16/21 breakfast 51-75%, lunch 26-50%, & supper 51-75%. 8/17/21 breakfast, lunch, & supper are blank. 8/18/21 breakfast & lunch 51-75% and supper is blank. 8/19/21 breakfast 26-50%, lunch 51-75%, & supper 26-50%. 8/20/21 breakfast & lunch 51-75% and supper is blank. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/21/21 breakfast & lunch 51-75% and supper is blank. 8/22/21 breakfast, lunch and supper are blank. 8/23/21 breakfast, lunch and supper are blank. 8/24/21 breakfast, lunch and supper are blank. 8/25/21 breakfast, lunch and supper are blank. 8/26/21 breakfast, lunch and supper are blank. 8/27/21 breakfast, lunch and supper are blank. 8/28/21 breakfast 76-100%, lunch 51-75%, & supper is blank. 8/29/21 breakfast & lunch 0-25% and supper is blank. 8/30/21 breakfast 76-100%, lunch 51-75%, and supper is blank. 8/31/21 breakfast & lunch is 26-50% and supper is blank. The nutritional assessment note dated 8/25/21 documents Diet order: regular, dysphagia puree, thin liquids. Average meal intake: 50-75% at most. Received nutritional supplements and/or fortified foods. 2 cal supplement 4 oz (ounce) BID (twice daily). Eating ability: Supervision. Current weight: 119.2 lb (pounds) - 6/17/21 13:17 (1:17 p.m.) Scale: Wheelchair sale. BMI: 22.5 Weight stable. Skin condition: No skin issues noted. No edema present. Summary: Current diet order remains appropriate for management of resident. Intake is 50-75% at most meals of a dysphagia puree diet. Has order for 2 cal supplement 4 oz BID (480 kcal and 20 g (grams) PRO (protein), per MAR (medication administration record) taking 100% at most offerings. Res (resident) is on hospice, goal is comfort cares. Met with Res. Reports no issues with n/v/d/c (nausea/vomiting/diarrhea/constipation) or c/s. Eating breakfast well at time of meeting. Wt (weight) hx (history) is: 119.2 on 6/17, 119# on 5/27, 124.4 on 2/12, 124.6# on 1/1. No sig (significant) weight changes. Updated weight requested. BMI is 22.5 (WNLs (within normal limits)). Goal is for weight to remain stable. Will monitor/follow up PRN. Continue current nutritional plan of care. Care plan reviewed and updated. The quarterly MDS with an assessment reference date of 8/29/21 has a BIMS score of 3 which indicates severe impairment. R10 is coded as requiring supervision with set up help only for eating. The plan of care note dated 8/31/21 includes Resident is now on a dysphagia puree textured diet with thin liquids due to difficulty swallowing. Her PO intake remains 50-75% of meals with snacks between meals. Surveyor reviewed September 2021 meal intake and noted the following: 9/1/21 breakfast 0-25%, lunch 26-50%, and supper is blank. 9/2/21 breakfast, lunch, & supper 51-75%. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/3/21 breakfast & lunch 51-75% and supper is blank. 9/4/21 breakfast & lunch are blank and supper 76-100%. 9/5/21 breakfast & lunch are blank and supper 76-100%. 9/6/21 breakfast & lunch are blank and and supper 0-25%. 9/7/21 breakfast, lunch, & supper are blank. 9/8/21 breakfast, lunch & supper are blank. 9/9/21 breakfast & lunch are blank and supper 0-25%. 9/10/21 breakfast & lunch 26-50% and supper is blank. 9/11/21 breakfast, lunch & supper are blank. 9/12/21 breakfast, lunch & supper are blank. 9/13/21 breakfast, lunch & supper are blank. R10's weight on 9/13/21 was 99.6 pounds and on 9/14/21 99.9 pounds. The nutritional note dated 9/15/21 documents WEIGHT WARNING: Value 99.9 Vital Date: 2021-09-14 20:43:00.0 (8:43 p.m.) -7.5% change [16.2%, 19.3] Wt (weight) hx (history) is: 99.9# on 9/14, 99.6# on 9/13, 119.2# on 6/17, 119# on 5/27, 121.8# on 3/3. Triggers for a 16.2% weight loss over 3 months. Weight loss likely r/t (related to) varied intake at times, decline in condition, on hospice. Intake is 43% avg (average) plus snacks of a dysphagia puree diet. Meal intake provides approximately 1055 kcal and 41 g PRO. Has order for 2 cal supplement 4 oz BID, per MAR taking 100% at most offerings. Estimated needs are 1135-1362 kcal (25-30 kcal/kg) and 45 g PRO (1 g/kg). BMI is 18.9 (WNLs). Discussed with IDT (interdisciplinary team) via WAR. Team in agreement to increase 2 cal supplement as it is accepted well. Recommending 2 cal supplement 4 oz TID (three times daily) (720 kcal and 30 g PRO). Meeting estimated needs. Goal is weight to remain stable or show gradual weight gain as is medically feasible. Goal comfort cares, on hospice. Will monitor/follow-up PRN. The physician order with an order & start date of 9/15/21 documents Med Plus 2.0 120 ml (milliliter) three times a day for supplemental nutrition. On 9/20/21 at 12:00 p.m. Surveyor observed Administrator-A enter R10's room with her lunch tray and ask R10 if she wants to eat. R10 replied no. Administrator-A informed R10 they can get her a snack. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/21/21 at 9:18 a.m. Surveyor spoke with RD (Registered Dietitian)-Z on the telephone and asked how she receives Resident's weights. RD-Z informed Surveyor weights are done via the nursing staff and either the nurse or the CNA (Certified Nursing Assistant) weighs the Resident. RD-Z informed Surveyor she communicates if there is a specific weight or an updated weight she needs by email. Surveyor inquired about R10's weight loss. RD-Z informed Surveyor she was on leave for three months and another dietitian completed the nutritional assessment in June. RD-Z informed Surveyor she completed the August 25th assessment. At that time the last weight she had was in June and that's why she requested an updated weight. Surveyor inquired when she requested this weight. RD-Z replied on that day I would of requested it. RD-Z explained she probably would have requested a weight prior to her assessment as she reviews the weights. Surveyor asked RD-Z if she asked for a weight on 8/25 and didn't receive the weight until 9/13 which was almost three weeks later. RD-Z replied yes, that's what it looks like from the notes. Surveyor inquired how she becomes aware of Resident's weight loss. RD-Z informed Surveyor the computer will generate when there is a weight change. RD-Z explained there are some weekly weights but most Resident's weights are monthly. RD-Z explained usually by the middle of the month she prints out a report to see if any Residents still need their monthly weights and will forward this information. Surveyor inquired who she forwards this to. RD-Z informed Surveyor to management which consists of the Administrator, Director of Nursing, Social Worker, and if there is an MDS (minimum data set), ADON (Assistant Director of Nursing), & unit manager. RD-Z informed Surveyor after she was aware of R10's significant weight loss, R10 was discussed with the interdisciplinary team during the WAR meeting and she requested R10's supplement be increased. On 9/21/21 at 9:52 a.m. Surveyor asked LPN (Licensed Practical Nurse)-Y to explain to Surveyor how Resident's weights are obtained. LPN-Y explained weights are suppose to be completed by the 7th of the month. The nurse will assign weights to the CNA's (Certified Nursing Assistants) and they are also on the assignment sheets. Surveyor asked LPN-Y who follows up to ensure a Resident's weight has been taken. LPN-Y replied the nurses do. On 9/21/21 at 10:03 a.m. Surveyor asked LPN-F to explain to Surveyor how Resident's weights are obtained. LPN-F informed Surveyor they get Resident's weights between the 1st and 7th of the month. Surveyor inquired who assigns the weights. LPN-F replied the nurses. Surveyor inquired who ensure the weights were taken. LPN-F replied actually the DON (Director of Nursing). LPN-F explained the day shift weighs residents on the even side of the unit, the PM (evening) shift weighs the odd side and the night shift weighs the wheelchairs. On 9/21/21 at 12:01 p.m. Surveyor informed Administrator-A and Corporate RN (Registered Nurse)-H R10's weights were not obtained monthly according to physician's orders and when a weight was obtained in September R10 was identified as having a significant weight loss. Corporate RN-H informed Surveyor they did a critical event, obtained another scale and provided education. Surveyor asked Corporate RN-H for this information. Surveyor noted education provided on 8/26/21 was only to Administrator-A and Interim DON-BB. Administrator-A and Interim DON-BB were inserviced on weight management with the objectives of obtaining weights upon admission times three weekly x three monthly unless otherwise stated. Consistent planning in process and follow up. Surveyor noted none of the licensed floor nurses or CNA's received inservice. No other information was provided to Surveyor prior to exit. On 9/23/21 the Field Operation Supervisor at the Division of Quality Assurance, Southeastern Regional office received via email the following additional information: (continued on next page)

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	525415	A. Building B. Wing	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menomonee Falls Health Services	N84 W17049 Menomonee Ave Menomonee Falls, WI 53051

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's face sheet. Corporate RN-H's summary which indicated R10 was on Hospice for Colon CA. R10 did not have orders to complete weight measurements upon admission and thus the weight measurements were sporadic. An order appears for weight measurements in June 2021 to be begin in July which is believed to be added in error. Hospice identified weights for recert purposes as goal planning for the end of life is not to gain weight but to achieve the best overall quality of life. The Resident unavoidably started to decline in May and thus her diet has continued to be downgraded as she is not tolerating solid foods well at this time due to swallowing consideration. In correlation her weight has declined and as this was unavoidable due to her end-of life process as it relates to Colon CA. Order summary sheet. Care plans for at risk for alteration in hydration, terminal process, at risk for altered nutritional status, falls, incontinent of bowel and bladder, advanced directives, and cognition. Hospice addendum Plan of Care review/Recert not dated 9/15/20 which documents under gastrointestinal monitor bowels, eats app. (approximately) 50% of regular diet, thin liquids. Regular BM's (bowel movements). Hospice addendum Plan of Care review/Recert not dated 11/17/20 which documents under gastrointestinal Monitor bowels. Eating 50%. Regular BM's. Hospice Interdisciplinary team plan of care revision/physician orders dated 2/10/20 & updated 8/5/20. Hospice Addendum plan of care review/recert note dated 1/21/21. Hospice Addendum plan of care review/recert note dated 5/6/21 which documents mechanical soft diet with thin liquids. If swallowing difficulty continues progress to pureed with thicken liquids. Weight assessment and Intervention policy and procedure revised 10/14/20. Under policy #4 is highlighted which documents In some cases, weight monitoring may not be indicated and may be discontinued with a physician order (e.g. terminal illness, under comfort care). The Interdisciplinary Team will review the risk/benefits/resident goals and discuss with the resident, resident representative and PCP (primary care physician) prior to making changes to the resident's plan of care. Surveyor noted there was not an order to discontinue R10's weights. Resident receiving hospice services policy and procedure with an effective date of 6/1/17. Critical event dated 8/26/21, which Surveyor had reviewed during the survey.

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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** 38253 Based on record review and interview, the facility did not ensure medications were acquired from the pharmacy for administration as ordered for 2 (R11 and R8) of 3 residents reviewed for new admission medications. R11 was admitted to the facility on [DATE] and did not receive Latanoprost Solution eye drops for glaucoma for 4 of the first 5 days of admission, Prosight Tablet (multivitamin) for 3 days on admission and 8 additional days during stay, Pantoprazole for gastric ulcer for 3 days during stay, Questran packet for hyperlipidemia for 3 days, Breo Ellipta Aerosol Powder for chronic obstructive pulmonary disease was not given on admission and then the order was discontinued with no follow up, and Cyanocobalamin (Vitamin B12) Solution intramuscular injection scheduled and not given on 9/5/2021 (to be given monthly) and no follow up to reschedule medication. R8 was admitted to the facility on [DATE] and did not receive Fluoxetine for depression for 2 days on admission and Alendronate Sodium for osteoporosis scheduled once weekly 2 times during stay. Findings: 1. R11 was admitted to the facility on [DATE] with diagnoses of sepsis due to Escherichia coli, dysphagia, chronic obstructive pulmonary disease (COPD), diabetes, bipolar disorder, anxiety, glaucoma, heart failure, chronic kidney disease, and fibromyalgia. R11's admission Minimum Data Set (MDS) assessment dated [DATE] coded R11 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R11 did not have an activated Power of Attorney. LATANOPROST SOLUTION Latanoprost solution is an eye drop that is given for glaucoma. The admission order was to instill one drop in each eye at bedtime. On 9/4/2021 on the Medication Administration Record (MAR), a 9 was entered into the box indicating Other/See Progress Notes. The progress notes did not indicate why the medication was not administered. On 9/5/2021 on the MAR, the nurse put their initials in the box indicating the medication was administered. On 9/6/2021 and 9/7/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was unavailable. On 9/8/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was awaiting from pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation was found stating the physician had been notified of the medication not being administered. No documentation was found stating the pharmacy had been contacted to obtain the medication. PROSIGHT TABLET Prosight tablet is a multivitamin with minerals to supplement the diet. The admission order was to take two tablets once daily for vision. On 9/5/2021, 9/6/2021, and 9/7/2021 on the MAR, a 9 was entered into the box. The progress notes stated the medication was unavailable. R11 received the medication from 9/8/2021-9/13/2021. From 9/14/2021-9/21/2021 on the MAR, a 9 was entered into the box. The progress notes stated the medication was unavailable. No documentation was found stating the physician had been notified of the medication not being administered. No documentation was found stating the pharmacy had been contacted to obtain the medication. PANTOPRAZOLE Pantoprazole is a medication used to treat esophageal ulcers and gastroesophageal reflux disorder. The admission order was to take 40 mg daily. On 9/11/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was Not available. On 9/16/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was unavailable will call pharmacy. On 9/18/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was Not available. The facility had contingency medications available for use. The facility's medication contingency roster listed 30 tablets of Pantoprazole 20 mg was available. The nurse did not administer pantoprazole from the contingency stock. No documentation was found stating the physician had been notified of the medication not being administered. No documentation was found stating the pharmacy had been contacted to obtain the medication. QUESTRAN PACKET Questran is a medication used to help lower cholesterol. The admission order was to take one 4-gram packet twice daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/2021 on the MAR for both the first and second dose, a 9 was entered into the box. The progress notes stated the medication was unavailable. On 9/6/2021 on the MAR for the first dose, a 9 was entered into the box. The progress note stated the medication was unavailable. On 9/7/2021 on the MAR for the first dose, a 9 was entered into the box. The progress note stated the medication was unavailable. Questran was signed out as administered for the second dose on 9/4/2021, 9/6/2021, 9/7/2021, and 9/8/2021. No documentation was found stating the physician had been notified of the medication not being administered. No documentation was found stating the pharmacy had been contacted to obtain the medication. BREO ELLIPTA AEROSOL POWDER Breo Ellipta is a combination medication used to treat COPD and asthma. The admission order was to take one puff daily. On 9/5/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was unavailable. The order was discontinued on 9/5/2021. No documentation was found stating why the medication was discontinued. CYANOCOBALAMIN SOLUTION Cyanocobalamin is another name for Vitamin B12. Vitamin B12 helps maintain the health of your metabolism, blood cells, and nerves. The admission order was to inject 1,000 mcg intramuscularly once a month on the fifth of the month. On 9/5/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was unavailable. No documentation was found stating the physician had been notified of the medication not being administered. No documentation was found stating the pharmacy had been contacted to obtain the medication. The medication was not rescheduled to be administered when the medication was available. R11 was discharged from the facility on 9/21/2021 to another facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/21/2021 at 1:40 PM, Surveyor reviewed with Director of Nursing (DON)-BB medication that was not administered to R11 on admission and during facility stay. DON-BB reviewed R11's MAR and progress notes and was not aware medications were not given. DON-BB stated there was no documentation that the physician was notified of medications not administered and DON-BB stated that is an expectation. DON-BB stated this will be investigated and DON-BB would let Surveyor know any findings. Surveyor requested reconciliation forms from the pharmacy to show when the medications were delivered. DON-BB did not provide any further information. 2. R8 was admitted to the facility on [DATE] with a left humerus fracture, dementia, and osteoporosis. R8's admission Minimum Data Set (MDS) assessment dated [DATE] coded R8 as having moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 8. R8 had an activated Power of Attorney. FLUOXETINE Fluoxetine is a medication used to treat depression. The admission order was take 20 mg daily. On 7/29/2021 on the Medication Administration Record (MAR), a 9 was entered into the box indicating Other/See Progress Notes. The progress notes stated awaiting to be dispensed from pharmacy. On 7/30/2021 on the MAR, a 2 was entered into the box indicating Drug Refused. No documentation was found stating the physician had been notified of the medication not being administered. No documentation was found stating the pharmacy had been contacted to obtain the medication. ALENDRONATE SODIUM Alendronate sodium is a medication used to treat or prevent osteoporosis. The admission order was take 70 mg once a week on Sundays for 90 days. On 8/8/2021 on the MAR, a 9 was entered into the box. The progress note stated the medication was on order. On 8/22/2021 on the MAR, a 9 was entered into the box. The progress note stated medication is unable. No documentation was found stating the physician had been notified of the medication not being administered. No documentation was found stating the pharmacy had been contacted to obtain the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/21/2021 at 1:25 PM, Surveyor asked Director of Nursing (DON)-BB what the process was for a new admission to get their ordered medications. DON-BB stated when residents come in, the hard scripts are sent over to pharmacy and once the pharmacy has the script, the nurse can get the medication from contingency. DON-BB stated the pharmacy will give the nurse a one-time access code to get the medication. Surveyor shared with DON-BB R8 did not get fluoxetine for two days on admission. DON-BB stated DON-BB was not at the facility when this event occurred and had no idea what the nurses did at that time. DON-BB stated the nurse should have gone to contingency to get the medication. Surveyor asked DON-BB if that medication was in contingency. DON-BB stated Fluoxetine is a common medication and it should be in there. DON-BB reviewed R8's MAR and progress note and stated there was no note to the physician that the medication was not available. DON-BB stated notification to the physician is an expectation when a medication is not administered. Surveyor requested reconciliation forms from the pharmacy to show when the medications were delivered. DON-BB did not provide any further information.