STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 15522 Based on observation and interview conducted by Surveyor 15522, the facility did not provide an environment that was sanitary, orderly, and well-maintained in one of three shower rooms observed. Findings include: During the initial tour of the shower room on Wing-3 on 12/05/22 at 2:30 p.m. with the Director of Nursing (DON-B), it was noted that the shower room was being used as a storage area and contained a wheelchair and storage bins. The door to the shower room was locked with keycode entry and residents did not have access to this room without staff assistance. The floor was cluttered with a gait belt, used gloves (that were inside out), and multiple empty shampoo and soap containers. A used razor was located on the shower room handrail in the shower, along with half-filled containers of soap products. The cupboard door was broken and lying on the floor. The sink was stained with a rust color. DON-B stated that the room was also being used as a showering space for residents. At the time of the initial tour observation, DON-B stated the staff should not be using the shower room for storage and agreed that it was not sanitary and needed attention.

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15522 Based on observation, interview and record review, the facility did not provide an ongoing program of activities for 1 Resident (R11) of 28 sampled residents designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. R11 did not have an activities plan and was not observed participating in recreational activities during the survey. Findings include: On 12/13/22 the Director of Activities (DA-KK) provided a policy and procedure titled, Activity Evaluation, that was last revised June 2018. The document included the following: In order to promote the physical, mental, and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could effect his/her participation in planned activities. The policy further stated under section 7, Each resident's activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs. According to records reviewed by Surveyor 15522, R11 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, moderate protein - calorie malnutrition, developmental disorder, blindness in both eyes, major depressive disorder, bipolar disorder, and anxiety disorder. The resident had a jejunostomy tube. According to R11's quarterly Minimum Data Set (MDS) dated [DATE], R11 had adequate hearing, sometimes understood others, and was sometimes understood by others; R11's vision was highly impaired. A staff assessment for cognition was conducted and noted R11 had memory problems and the resident's decision making skills were severely impaired. R11 did not experience delirium, however, the MDS was coded to indicate R11 experienced inattention at times. According to the MDS, R11 did not experience behavioral symptoms. R11 required extensive assistance for bed mobility and activities of daily living and total assistance for transfers, bathing, and locomotion on and off the unit. R11 utilized a wheelchair for mobility and did not ambulate. According to the 09/01/22 annual MDS assessment for daily preferences, it was very important for R11 to be involved in favorite activities and listening to music the resident liked; being around animals such as pets was also noted as very important. R11 had an Amazon [NAME] device in his room that he could use to request music to be played. The annual comprehensive review conducted by activities staff was not completed prior to the 09/01/22 MDS assessment and activities staff did not identify approaches based on R11's care needs and preferences. R11's care plan dated 07/30/21- 08/31/22 did not include information related to activities. R11's Bedside care card, which was not dated included the following information: have music or TV playing . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/13/22 DA-KK indicated that R11 attended four activity programs in September 2022, four in October 2022, and two in November 2022; R11 did not participate in any activities in December 2022. According to DA-KK, the facility went into COVID-19 lockdown from 11/18/22 through 12/09/22. R11 was observed daily throughout the survey from 12/05/22 to 12/09/22 and 12/12/22 to 12/13/22; R11 was observed in his room during all observations. At times music was playing in R11's room and at other times it was quiet (for example, on 12/06/22 at 10:30 a.m. and 1:00 p.m., there was no music playing). R11 was observed while sitting in their room or in bed without any stimulation. R11 did not respond appropriately to questions asked by the Surveyor and it was determined R11 was not interviewable. During an interview with DA-KK on 12/13/22 at approximately 2:00 p.m., she agreed there was no care plan related to R11's activity preferences and the comprehensive assessment was not complete.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 15522 Based on observation, interview and record review, the facility did not ensure it provided an environment that was free of accident hazards and safe for 43 residents of 45 residents reviewed for safety concerns. The facility identified at the time of the survey, 40 residents smoked and utilized the smoking patio at the facility. Additional concerns exist regarding R7 and R4. On 12/6/22 Surveyor observed R20 being taken out to the smoking patio by Certified Nursing Assistant (CNA)-P and observed R20 actively had oxygen on. The CNA was heard speaking to R20 about not wearing oxygen and smoking prior to the CNA leaving R20 unsupervised. R20 was then observed interacting with other residents on the patio including R21 who told R20 to take off her oxygen as they walked to R20. R20 was next observed with her oxygen tank and her nasal cannula in her lap as it was actively emitting oxygen. R20 was observed to have a lit cigarette in her mouth at that time while the oxygen was running in her lap. R20's Smoking assessment dated [DATE] indicated the resident liked to smoke, could light cigarettes without difficulty, did not need to have her lighter and cigarettes stored by staff for safety, and had been educated on smoking procedures. The smoking assessment did not indicate the resident used oxygen or delineate safety precautions related to smoking and oxygen use. It was later determined that facility staff stored the resident's smoking paraphernalia, and the smoking assessment was inaccurate. The facility identified that any given time there are currently 40 residents in the facility that actively smoke and could be present on the patio when a resident has oxygen in use. During interview with the Director of Nursing (DON-B) on 12/07/22 at 9:00 a.m., DON-B said, [R20] is the only resident who smokes that wears oxygen. One resident [R24] who smokes needs a smoking apron. Three residents who smoke including [R1] and [R16] go out on the 500-hall patio [Wing-5 patio (non-designated smoking area)]. DON-B indicated the three residents were allowed to smoke on the Wing-5 patio to accommodate social distancing during the coronavirus disease 2019 (COVID-19) pandemic. On 12/07/22 at 9:27 a.m., DON-B provided a list of three residents that included R3 and R20 indicating that the facility keeps their smoking paraphernalia. DON-B said, The nurse keeps their smoking material locked in the cart and the resident must ask for it. The facility identified multiple residents with varying levels of supervision or safety concerns related to smoking and did not have a system in place to ensure safety while smoking. The facility's failure to ensure the safety of residents who smoke and those that are smokers that use oxygen created a situation of immediate jeopardy that started on 12/6/22. Administrator (NHA)-A and Regional Director of Operations (RDO)-E were notified of the immediate jeopardy on 12/7/22 at 10:34 am. The immediate jeopardy was removed 12/7/22 when the facility implemented an action plan. The deficient practice continues at a scope and severity (s/s) of a G (actual harm/isolated) based upon the example regarding R7. R7 was left unsupervised while on the toilet resulting in a fall with three subsequent fractures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R4 was identified as at risk for elopement and was not provided with appropriate interventions to minimize the resident's risk for elopement and was later located walking on a local highway. Observations of the smoking area of the facility identify safety concerns related to debris that could possibly be ignited while resident's smoke. Findings include: 1.) Supervision to Prevent Accidents and Accident Hazards - Smoking The Facility Smoking Policy - Residents, 2001 Med-Pass, Inc (Revised July 2017) was provided by DON-B on 12/07/22 at 8:45 a.m. The policy stated, This facility shall establish and maintain safe resident smoking practices 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. 3. Oxygen use is prohibited in smoking areas. 4. Metal containers, with self-closing cover devices, are available in smoking area .13. Residents are not permitted to give smoking materials to other residents. A facility policy titled, Smoking Guideline, that was dated 10/24/22, specified: The facility may designate certain areas for resident smoking. The facility must ensure precautions are taken for the resident individual safety, as well as the safety of others in the facility. Such precautions may include smoking only in designated areas, supervising residents whose assessment and care plans indicate a need for assisted and supervised smoking, limiting the accessibility of matches and lighters by residents who need supervision when smoking for safety reasons. Smoking by residents when oxygen is in use is prohibited, and any smoking by others near flammable substances is problematic and prohibited. Additional measures may include informing all visitors of smoking policies and hazards. The facility provided a list of residents who smoked. Out of the 40 residents on the list who smoked, R20 was identified as the only resident who was receiving oxygen. During an interview with Director of Nursing (DON)-B on 12/07/22 at 9:00 a.m., DON-B said, [R20] is the only resident who smokes that wears oxygen. One resident [R24] who smokes needs a smoking apron. Three residents who smoke including [R1] and [R16] go out on the 500-hall patio [Wing-5 patio (non-designated smoking area)]. DON-B indicated the three residents were allowed to smoke on the Wing-5 patio to accommodate social distancing during the coronavirus disease 2019 (COVID-19) pandemic. On 12/07/22 at 9:27 a.m., DON-B provided a list of three residents that included R3 and R20 indicating that the facility keeps their smoking paraphernalia. DON-B said, The nurse keeps their smoking material locked in the cart and the resident must ask for it. According to records reviewed by Surveyor, R20 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, and hemiplegia and hemiparesis to the left side. The resident had a left below the knee amputation and was receiving hemodialysis. On the Minimum Data Set (MDS) R20 scored a 12 on the Brief Interview for Mental Status (BIMS) dated 12/01/22 suggesting the resident had moderately impaired cognition. According to a physician's order and observations made during the survey, R20 was receiving oxygen by way of nasal cannula from a portable oxygen tank. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R20's Admission Agreement dated 11/29/22 stated, 12. Smoking, Alcohol, and Drugs - If designated smoking areas are provided, smoking is permitted in designated areas of the Center only and only to the extent permitted by the Residents medical records. If a Resident requires assistance to smoke, you agree to do so only with appropriate assistance. All lighters and matches shall be kept at the nursing station. Residents may not keep lighters and matches in their rooms or on their person. R20's baseline care plan dated 11/29/22 indicated the resident had a self-care deficit related to the left below knee amputation; required one-to-two-person assistance for personal hygiene, toilet use, and transfers using a Hoyer(R) mechanical lift; had a potential for falls; and had cognitive impairment manifested by impaired compromised decision making and inability to understand course of treatment, care, and prognosis/likely outcome. [R20] has a need for a responsible adult to make health care and/or financial decisions on her behalf, has anemia due to dialysis and is on humidified oxygen. R20's baseline care plan dated 11/29/22 did not address smoking. R20 had a physician's order dated 11/30/22 that read, O2 (oxygen) at two to six (2-6) liters per minute via nasal cannula continuously while in room for chronic obstructive pulmonary disease to keep sats (oxygen saturation levels) above 90 percent. R20's Smoking assessment dated [DATE] indicated the resident liked to smoke, could light cigarettes without difficulty, did not need to have her lighter and cigarettes stored by staff for safety, and had been educated on smoking procedures. The smoking assessment did not indicate the resident used oxygen or delineate safety precautions related to smoking and oxygen use. It was later determined that facility staff stored the resident's smoking paraphernalia, and the smoking assessment was inaccurate. The following was observed by the Surveyor on 12/06/22 beginning at 4:00 p.m. Certified Nursing Assistant (CNA-P) transported R20 in her wheelchair to the smoking patio near the dining room. R20 had a portable oxygen cannister and was receiving oxygen through a nasal cannula. CNA-P moved the resident to a non-smoking area of the patio under the easement of the facility with the resident's back against a brick wall, locked the wheelchair brakes, and told R20 to take off her oxygen to smoke. CNA-P then returned to the facility. There were no other staff members on the smoking patio. There were nine other residents on the smoking patio; seven of the residents were smoking. R16 and R21, who were seated at a table about six to eight feet away from R20, yelled across the patio telling R20 to turn off her oxygen to smoke. R21 walked over to R20 and assisted R20 to take the oxygen tank off the back of the wheelchair and placed the oxygen tank on R20's lap; the nasal cannula was also on the resident's lap at this time. R20 had a lit cigarette in her mouth following the interaction with R21. When the Surveyor asked R20's name, the Surveyor could hear the oxygen tank running. The Surveyor immediately went into the building to find the Director of Nursing or a nurse in charge and first located the Regional Registered Nurse (RRN-Q). RRN-Q accompanied the Surveyor to the patio, extinguished R20's cigarette, and brought the resident inside. According to the facility map provided by DON-B on 12/05/22 at 3:30 p.m., R20 was not smoking in the designated smoking area. The designated smoking area is marked by yellow paint on the ground on the concrete patio itself. One side of the line is a designated smoking area, and the other side is non-smoking. R20's wheelchair was positioned in the non-smoking area against the brick building under the overhang. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/06/22 at approximately 4:15 p.m., R16 said, They bring people like her [pointing to R20] out [on the patio] and leave them [without supervision]. R16 expressed concerns that a resident could catch fire and I [R16] would feel responsible. During an interview on 12/06/22 at 4:55 p.m., R21 said she helped R20 place the oxygen tank on her lap as described above. R21 stated that R20 demanded a cigarette and R21 provided a cigarette and lit it for her. R21 said this was the first time she had ever seen R20 and the first time she had ever seen CNA-P, but, according to R21, CNA-P did tell the residents on the patio that it was ok for R20 to smoke without her oxygen tank on. R21 said all the residents know people with oxygen can't smoke. R21's most recent MDS dated [DATE] was coded to indicate the resident scored 15 on the BIMS suggesting R21 was cognitively intact. On 12/06/22 at 5:14 p.m., RRN-Q said, We educated everyone about smoking that is in the building now. Her smoking assessment said she wasn't going to smoke [the resident preferred not to smoke while at the facility]. R20 is her own person and can make her own decisions. We will try to educate her. I don't know why she needs oxygen, but maybe we can dc [discontinue] it. In an observation on 12/07/22 at 9:42 a.m., the Surveyor saw a resident smoking in the same non-designated smoking area under the easement near the designated smoking area by the dining room in his wheelchair. During interview on 12/07/22 at 9:42 a.m., the Administer (NHA-A) said the admissions packet was the only document that residents signed acknowledging the smoking policy. NHA-A stated, The residents are informed, upon admission, that smoking is not permitted in common areas of the center. The designated areas provided for residents are evaluated. On 12/08/22 at 4:10 p.m., a Licensed Practical Nurse Manager (LPNM-G) said, No one is supposed to smoke within 15 feet of the building and the area under the overhang is not a designated smoking area. The facility's failure to ensure Resident's are supervised and safe while smoking created a situation of immediate jeopardy that was removed on 12/7/22 when the facility implemented the following action plan: * Ad Hoc QA meeting was held to educate the entire leadership team on our plan and follow up. * All licensed and unlicensed personnel were educated on the policy regarding smoking, residents that choose to smoke and have oxygen, not giving residents smoking materials, where the designated smoking area is located and the safety equipment that is in the designated smoking area. * All education will be completed with staff in the building currently and all other staff will be educated prior to his/her next scheduled shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* All residents that currently smoke were assessed for the smoking abilities, all care plans were reviewed and updated as necessary for their individual needs. The care delivery guides were reviewed and updated if a resident is an independent smoker or what level of assistance they need to smoke and where there smoking material are located if applicable. The facility smoking policy and procedures were reviewed to ensure that they are based on the current standards of practice. The facility will ensure that all residents currently residing in the facility are educated on the reviewed smoking policy, that they should not be sharing smoking materials with other residents and where the only designated smoking area is located. All new admissions will be educated on the smoking policy on admission to the facility. All resident education will be completed with residents that currently smoke in the facility. * The facility will ensure that smoking assessments are completed timely on new admissions that choose to smoke or any resident that chooses to start smoking. The social service department was educated on completing smoking assessments timely on 12/7/22. The facility will educate all staff to notify the DON/NHA if any resident chooses to start smoking. All education will be completed with staff that are currently in the building and all other staff will be educated prior to his/her next scheduled shift. * All residents that smoke have the potential to be affected by the alleged deficient practice. One resident was identified that currently is choosing to smoke and wears oxygen. The identified resident wasre-evaluated for their ability to smoke, she remains a supervised smoker and her smoking materials will be kept in the nurse's station. The identified residents plan of care was reviewed and updated. Her care delivery guide was updated to reflect her level of supervision needed, where her smoking materials are kept and to remove her oxygen prior to exiting into the smoking area. The resident was educated on the smoking policy, removing her oxygen prior to entering the smoking area and where her smoking materials will be kept if she chooses to smoke. * The social service department was educated on completing smoking assessments timely on 12/7/22. The facility will educate all staff to notify the DON/NHA if any resident chooses to start smoking so that a smoking assessment can be completed, and their care plan and care delivery guide can be updated. All education will be completed with staff that are currently in the building and all other staff will be educated prior to his/her next scheduled shift. * As per above the facility will ensure that all residents currently residing in the facility are educated on the reviewed smoking policy, sharing smoking materials and where the only designated smoking area is located. * All new admissions will be educated on the smoking policy, where the designated smoking area is located and sharing smoking materials on admission to the facility. All resident education will be completed with residents that currently smoke in the facility. * The facility will ensure that smoking assessments are completed timely on new admissions that smoke or any resident that chooses to start smoking. The social service department was educated on completing smoking assessments timely on 12/7/22. The facility will educate all staff to notify the DON/NHA if any resident chooses to start smoking to ensure a smoking assessment is completed and their care plan/care delivery guide is updated. All education will be completed with staff that are currently in the building and all other staff will be educated prior to his/her next scheduled shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* NHA/Designee will audit the designated smoking area for residents with oxygen equipment, randomly 7 times per day Monday through Sunday x 2 weeks, then 5 times per day Monday through Sunday x 2 weeks, then 3 times per week Monday through Sunday x 2 weeks, then randomly through the week x 2 weeks. All audits will be brought to QAPI for review until the IDT determines there is no longer a risk identified. The deficient practice continues at a scope and severity of a G (actual harm/isolated) based upon the example regarding R7. 2.) A policy titled Falls and Fall Risk, Managing Policy Statement, revised March 2018, stated the following: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions 7. In conjunction with the attending physician, staff will identify and implement relevant interventions . to try to minimize serious consequences of falling . According to records reviewed by Surveyor, R7 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident. R7's admission Minimum Data Set (MDS) documented the resident was usually able to understand others and was sometimes understood by others; the resident's vision was adequate, and resident did not wear a hearing aid. The resident scored a 2 on the Brief Interview for Mental Status (BIMS) suggesting severely impaired cognition. The MDS indicated the resident required limited assistance with bed mobility and transfers and walking in the resident's room; R7 required total assistance for bathing and toileting. According to the MDS, R7's balance was not steady, and the resident was only able to stabilize with staff assistance. R7's care plan, dated 09/15/22, was in place prior to the 10/20/22 fall described below and included the following information: The resident is at risk/has potential for falls, accidents R/T [related to] current diagnosis- hx [history] of falls, gait imbalance, generalized weakness, hx of CVA [cerebrovascular accident] with weakness R [right] side. The related care plan problem stated, Injuries will be minimized through the review date. Interventions/approaches were as follows: 9/15/22 - Fall assessment to be completed upon admission after falls, quarterly. Follow therapy - recommendations for transfers and mobility. Review information on past falls and attempt to determine the cause of falls. 10/20/22- Send to ER [emergency room] and do not leave on toilet unattended. This approach was added following the 10/20/22 fall. R7's care card (not dated) included the following: Fall Risk - No, Continent of bowel and bladder and a check and change and utilizes a brief, Transfers with Hoyer. The care card did not include that R7 was at high risk for falling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R7's Bedside/ Kardex report dated 09/15/22 included the following information: Provide and encourage use of adaptive equipment bedpan . A fall risk assessment dated [DATE] indicated R7 was at high risk for falls with a score of 21.0 The physical therapy evaluation dated 09/16/22 also indicated the resident was at high risk for falls and had a fear of falling with unsteadiness to the resident's gait, requiring total support to the right upper extremity. Toilet transfers were not attempted due to medical condition or safety concerns. On 10/20/22 at approximately 6:45 p.m., according to Licensed Practical Nurse Manager (LPNM)-G who was interviewed by the Surveyor on 12/10/22, a Certified Nursing Assistant alerted LPNM-G that R7 was on the floor. LPNM-G entered R7's room and found the resident on her right side on the floor complaining of pain in her right shoulder. LPNM-G notified the medical provider and x-rays were ordered; ultimately the resident was transferred to acute care for further evaluation. According to LPNM-G, R7 sustained three fractures, including a right shoulder fracture, a right hip fracture and a right wrist fracture. During an interview with R7 after the fall she told the staff she was leaning forward and was unable to hold herself and fell . According to LPNM-G, after transferring the resident to acute care she started an investigation; LPNM-G obtained statements from staff working on the wing where R7 resided and determined the resident was assisted to the toilet by Certified Nursing Assistant (CAN)-Z who was provided by a staffing agency. A written statement from CNA-AA (a second agency CNA) further explained that R7 had been on a bedpan for 45 minutes prior to the fall and was taken off the bedpan and taken to the toilet by CNA-Z where the resident was left while CNA-Z went to lunch. R7's roommate (R27) was interviewed on 12/13/22 at 2:00 p.m. R27 stated that CNA-Z came into the room when R7 put on her call light to go to the bathroom. CNA-Z assisted R7 to the toilet and told R7 to call when she was done using the bathroom. R27 heard R7 fall about five minutes after she was assisted to the toilet. In summary, R7 was admitted to the facility on [DATE] following a cerebrovascular accident with right sided weakness. She was assessed at high risk for falling with a score of 21.0. Therapy had not attempted toilet transfers due to medical concerns or safety concerns. The resident was placed on the toilet by CNA-Z and left unattended while she went to lunch. R7 fell off the toilet fracturing her right wrist, right hip, and right shoulder. The Bedside care card/ Kardex indicated to use a bedpan. According to interview with LPNM-G, the grab bar by the toilet and call light in the bathroom are on the right side of the toilet and, due to R7's right sided weakness, the resident could not reach these. R7 was unable to hold herself upright due to the resident's physical limitations and therefore could not avoid falling. The resident was transferred to acute care for treatment and had not returned to the facility as of the dates of the survey. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3.) During observations made by Surveyor on 12/07/22, the facility failed to provide appropriate and safe cigarette butt receptacles and failed to adhere to designated smoking areas. Used coffee containers with cardboard sides, were being used by residents and possibly staff on two facility patios for cigarette ash and butt disposal. On the Wing-5 patio, that was not a designated smoking area, a red garbage can was observed with overflowing paper refuse such as fast-food containers, that prevented closure of the lid. This garbage can also contained multiple cigarette butts. Cigarette butts were observed throughout the Wing-5 patio space near piles of unraked leaves and two cardboard storage boxes that contained wheelchair cushions. A combustible coffee can that was half-filled with cigarette butts was observed on the metal patio table in Wing-5. No approved safety ash receptacles were observed on the Wing-5 patio and facility administration was unaware that people had been smoking in this area. On 12/07/22 from 9:02 a.m. to 9:13 a.m., the Wing-5 patio was observed with Licensed Practical Nurse Manager (LPNM)-G and Director of Nursing (DON)-B. LPNM-G told the Surveyor that during a recent facility quarantine for a respiratory virus, the smokers were smoking on the Wing-5 patio to limit resident movement in the building. LPNM-G stated that she was unaware when the last time anyone smoked on this patio and that the door codes had been changed recently to limit resident access this area. Upon entering the Wing-5 patio area on 12/07/22 with LPNM-G and DON-B, a round metal patio table and metal chairs were observed. Multiple cigarette butts, too numerous to count, and crushed beer cans were observed on the cement under the patio table. In the center of the metal table, a combustible, cardboard sided, used coffee container was observed half filled with cigarette butts. A red garbage can was observed to be overfilled with paper waste including fast food packages and liquor bottles that prevented the safety lid from closing. No approved ash receptacle was observed in this area. Approximately four feet away from the metal table, were two sealed cardboard boxes that contained wheelchair cushions. Next to these cardboard boxes were small piles of unraked leaves. When the clear, over-filled garbage bag was lifted out of the red waste can, numerous cigarette butts and used alcohol bottles could be seen amongst the garbage. On 12/07/22 at 9:32 a.m., Maintenance Supervisor (MS-J), the Regional Director of Operations (RDO-E), and the Assistant Administrator (AA-D) were observed on the patio removing smoking materials. RDO-E indicated not being aware people were using this area for smoking and this was not a designated smoking area. DON-B indicated not knowing how long it had been since anyone smoked in this area and did not know if staff were using this area to smoke. None of the staff knew who was drinking alcohol on the Wing-5 patio. On 12/07/22 at 9:42 a.m., the designated smoking area near the facility dining room was observed to have eight used coffee containers placed on the ground and on the tables. Five of these containers were combustible with cardboard siding and three were solid metal and non-combustible. All of the containers had cigarette butts in them. Two tall tower approved ash receptacles were also observed on this patio. 4.) According to records reviewed by Surveyor, R4 was admitted to the facility on [DATE] and discharged to home on 08/23/22. The resident's diagnoses included cerebral infarction, respiratory failure, hypoxic ischemia, and rhabdomyolysis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the admission Minimum Data Set (MDS) dated [DATE], R4 had adequate hearing, was understood, and was able to understand others. The MDS was coded to indicate R4 scored 11 on the Brief Interview for Mental Status (BIMS) which suggested moderately impaired cognition. According to the MDS, R4 required limited assistance for bed mobility, transfers, dressing, and bathing, and supervision for locomotion off the unit. An Elopement Risk Review dated 07/18/22 indicated R4 was not at risk for elopement. In contrast, the 08/01/22 Elopement Risk Review identified the resident as at risk for elopement; Director of Nursing (DON)-B and facility staff were unable to provide an explanation as to why R4 became at risk for elopement. Risk factors identified in the assessment included the resident being ambulatory, having predisposing conditions and a cognitive impairment, and taking antidepressants. Review of R4's care plan indicated there was no plan to prevent R4 from eloping from the facility despite the resident being identified as at risk for elopement. A smoking assessment, which was completed on 07/18/22 identified R4 as someone who did not currently smoke, although the resident had previously smoked. An investigation completed by the facility on 08/10/22 indicated that on 08/07/22 at approximately 4:00 p.m., R4 was observed leaving the facility through the gate in the smoking patio by an unidentified resident. The unidentified resident did not report this to anyone at the time of the observation, according to DON-B, however the unidentified resident was interviewed at a later time. Around 4:20 p.m., R4 was brought back to the facility by a community man that saw her walking up the highway [on the highway] and stopped to help her. R4 stated to the male, who found the resident, that she was going home. According to facility staff, R4's home was over an hour away from where the facility was located. During interview with DON-B on 12/06/22 at 1:00 p.m., DON-B stated that the resident refused to wear a Wanderguard (R) device and confirmed that there were no additional interventions to prevent the resident from eloping. The resident continued to smoke and spent time on the smoking patio, which was surrounded by a chain link fence that could be opened at the entrance.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07157 Based on observation, interview, record and policy review, the facility did not ensure medications were properly administered through a gastrostomy tube to prevent complications and maintain the integrity of the tube; a resident's (R19's) gastrostomy tube was not flushed prior to or in between each medication administered for one of three residents observed. Findings included: Director of Nursing (DON)-B provided a facility policy on 12/09/22 titled, Administering Medications through an Enteral Tube, that was dated November 2018. The policy indicated the enteral tube was to be flushed with at least 15 milliliters (ml) of warm purified water prior to medication administration and staff were to, administer each medication separately and flush between medications .flush tubing with at least 15 milliliters (ml) of warm purified water (or prescribed amount). A review of the Face Sheet completed by Surveyor indicated the facility admitted R19 on 02/23/21 with diagnoses that included dysphagia and gastrostomy status [presence of a feeding tube]. The MDS dated [DATE] was coded to indicate R19 had a BIMS score of 8 suggesting moderately impaired cognition and used a feeding tube while a resident at the facility. R19's care plan that was initiated on 03/01/21 stated, medications administered orally, but can be administered per G-tube [gastrostomy tube] if unable to take them orally. The care plan identified problems with the gastrostomy tube clogging on 06/11/22 and 07/25/22. Interventions directed staff to sent [send] to ER [emergency room] for G-tube unclogging or replacement. R19 had the following physician orders: o 04/28/22: Cyclobenzaprine HCL [hydrochloride] tablet, 5 milligrams (mg), by mouth three times a day for muscle spasm. o 04/28/22: Quetiapine fumarate tablet 100 mg, 1 tablet by mouth three times a day for depression. o 04/28/22: Gabapentin tablet 600 mg, give 1 tablet by mouth three times a day for nerve pain. o 04/28/22: Meds may be administered via G-tube if unable to take them orally. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/06/22 at 1:00 p.m., a Registered Nurse (RN-L) was observed administering medication for R19. RN-L told the Surveyor that R19 received 280 milliliters (ml) of water every four hours for hydration and that R19 had a long history of tube clogging. RN-L crushed cyclobenzaprine, quetiapine fumarate, and gabapentin and placed each medication into a separate plastic cup with approximately 60 ml of water to dissolve the medications. RN-L checked for gastrostomy tube placement by inserting an enteral syringe into the gastrostomy tube port, injecting air into the gastrostomy tube, and auscultating with a stethoscope. RN-L then poured each medication separately into the enteral syringe allowing each medication to flow into the gastrostomy tube. No water flush was provided in between each of the three medications administered. After the last medication was administered, RN-L poured 280 ml of water into the enteral syringe allowing water to flow into the gastrostomy tube by way of gravity. Following the observation of medication administration, the Surveyor discussed flushing the gastrostomy tube with water prior to and in between administration of medications through the tube. RN-L agreed that flushes with water should have been provided during the administration of medication for R19. During an interview on 12/13/22 at 1:10 p.m., DON-B indicated that flushing prior to administration of medications and between medications would be her expectation and that she would be conducting a policy review. In summary, RN-L did not flush a gastrostomy tube prior to and in between medication administration in accordance with facility policy and to reduce the risk of gastrostomy tube clogging and maintain the integrity of the tube.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15522 Based on observation, interview and record review, the facility did not provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 resident (R11) of a sample of 28 residents. Findings include: According to records reviewed by Surveyor, R11 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, moderate protein - calorie malnutrition, developmental disorder, blindness in both eyes, major depressive disorder, bipolar disorder, and anxiety disorder. R11 had a jejunostomy tube. According to R11's quarterly Minimum Data Set (MDS) dated [DATE], R11 had adequate hearing, sometimes understood others, and was sometimes understood by others; R11's vision was highly impaired. A staff assessment for cognition was conducted and noted R11 had memory problems and R11's decision making skills were severely impaired. R11 did not experience delirium, however, the MDS was coded to indicate R11 experienced inattention at times. According to the MDS, the staff assessment for mood (PHQ-9-OV) was completed with a score of zero (no depression present). According to the MDS, R11 did not experience behavioral symptoms. R11 required extensive assistance for bed mobility, eating, dressing, toilet use, and personal hygiene and total assistance for transfers, bathing, and locomotion on and off the unit. R11 utilized a wheelchair for mobility and did not ambulate; R11 was incontinent of bowel and bladder. R11's bedside care card, which was not dated included the following information: Use two person assist with a Hoyer lift .abdominal binder on, soft touch call light .WC [wheelchair] .two people when working with J-tube [Jejunostomy Tube]. Announce who you are when entering room and have music or TV playing .legally blind, tube feeding . R11's care plan, which was dated 07/30/21 to 10/02/22 included the following information: o Behavior Problem - physically abusive/hitting staff during care. Disruptive/yelling out during cares. Depression and Bipolar 9/01/2021- snapped the double tubes of his tube feeding set-up. Note that staff did not conduct a root cause analysis to determine why R11 was experiencing physical and verbal behaviors of potential distress during care and did not track the behavioral symptoms to determine antecedents. o Resident has Impaired Mobility-Total assist for all ADL [activities of daily living] completion . The bedside care card and care plan did not address R11's schedule regarding when R11 stayed in bed and got out of bed and did not address R11's history related to pulling out R11's jejunostomy tube. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour on 12/05/22 at 2:30 p.m., R11 was observed in bed. Music was playing in R11's room and R11 was singing along with the tunes. On 12/06/22 at 10:00 a.m., R11 was again observed in bed; R11 was unable to be interviewed due to R11's cognitive status. At the time of the observation, R11 who had a call light within reach, was overheard saying, I want to get up. After Surveyor inquiry, staff assisted R11 out of bed. During survey, R11 was observed during care and transfers. During the observations, R11 did not demonstrate any behavioral symptoms. During an interview with a Licensed Practical Nurse (LPN-M) on 12/06/2022 at 1:45 p.m., LPN-M stated R11 had not been out of bed for approximately two months due to behaviors. According to LPN-M, R11 pulled out R11's J-Tube many times, gouges staff's arms, and hurts them [staff] leaving scars. Interviews on 12/09/22 at 10:47 and 11:18 a.m. with Certified Nursing Assistants (CNA)-S and CNA-T, who were both full time CNAs on the wing where R11 resided, confirmed R11 had not been out of bed for approximately two months. According to staff, R11 remained in bed as an attempt to minimize R11's behaviors including physical behavioral symptoms directed toward staff during care. DON-B was interviewed on 12/06/22 at 4:00 p.m. and stated she was not aware that R11 was not out of bed during the past two months. In summary, R11 was experiencing behavioral symptoms including physical behavioral symptoms directed toward staff during care and the staff determined that it was in R11's best interest to remain in bed due to those behaviors for approximately two months. Staff did not conduct a root cause analysis to determine why R11 was experiencing physical and verbal behaviors of potential distress during care and did not track the behavioral symptoms to determine antecedents. The isolation to bed was not documented on R11's care plan or care card. There was no intervention/plan that would indicate that R11 was to be in bed or out of bed during certain times and no approaches for staff to use during the delivery of care to minimize R11's behavioral symptoms. DON-B was not aware that R11 was confined to the bed. After the Surveyor questioned the plan for R11, R11 was observed out of bed in a wheelchair in R11's room. R11 appeared to be enjoying music from the Amazon [NAME] and singing along.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 07157 Based on observation, interview and policy review, the facility did not store food in accordance with professional standards for food service safety. Food items provided by the facility and food brought in by residents and family members were stored in a dining room refrigerator; food items were not consistently labeled in a manner to differentiate the source and use by date of the food and a log was not maintained indicating the temperature was monitored. This has the potential to affect all residents who eat food or store items in the dining room refridgerator which is accessible to most of the facility residents. Findings include: A facility policy provided by Director of Nursing (DON)-B on 12/12/11 at 10:11 a.m. titled, Food Brought by Family/Visitors, and dated October 2017, specified: Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. The policy also indicated, The nursing staff will discard perishable foods on or before the 'use by' date The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). On 12/09/22 at 12:12 p.m., two refrigerators were observed in the shared activity and dining room. One refrigerator was observed to have a padlock on the door restricting access and a temperature monitoring paper log taped to the outside. Director of Activities (DA)-KK indicated that the padlocked refrigerator belonged to the activity department and did not include personal resident food items. DA-KK said that the second refrigerator located at the end of the kitchen counter contained food items that belonged to individual residents and was monitored by the nursing department. This was the only refrigerator in the facility that was used for storage of resident food items. On 12/09/22 at 12:15 p.m., the second refrigerator was observed to have a sign posted on the outside that stated, refrigerator will be checked daily, label food with date opened, food will be trashed after label date or if not labeled. There was no temperature monitoring paper log on this refrigerator. The Surveyor opened the refrigerator and observed no refrigerator thermometer. Many food items stored in the refrigerator had no names or dates on them as described below. The Surveyor also observed a tray of food items that appeared to come from the kitchen that had computer-printed labels with names on them for some of the food items; however, fifteen sandwiches in individual sandwich bags were not labeled with names or dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/09/22 at 12:55 p.m., AA-D assisted the Surveyor in identifying the contents of the second refrigerator. AA-D took out food items such as ham salad in a deli container that was partially empty; the container was not labeled with a resident name or date. Multiple sealed pre-packaged meals were stacked in the refrigerator with no names or dates on them. In the refrigerator door, multiple deli meats including Polish deli ham and turkey slices were stored; some of the storage bags were not fully closed. The bags were labeled with a resident room number but not names or use by dates. A partially consumed Braunschweiger meat roll was observed in an unzipped Ziploc(R) type bag with no label indicating resident name or date. A pumpkin pie with no label indicating resident name or date was also observed stored in this refrigerator. An opened sweet potato pie box contained a partially consumed pie; the box was not labeled with a name, room number or date. Two unlabeled large Styrofoam(R) cups with lids were opened by AA-D who indicated the cups contained milk; AA-D disposed of the milk by pouring it down the sink drain. Two Sun Meadow total health system boxes were observed on the inside shelf of the refrigerator door; the boxes were not labeled with names and dates. On 12/09/22 at 1:12 p.m., DON- B stated she did not know the owner of all of the pre-packaged food items and that housekeeping was responsible for overseeing that refrigerator. On 12/09/22 at 1:55 p.m., AA-D told the Surveyor that he cleaned out the refrigerator and found the thermometer buried behind all the food items. During observations made during the remainder of the survey, no further concerns were identified.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 35199 Based on interview and record review, the facility did not provide behavioral health training for staff who cared for residents who were diagnosed with a mental, psychosocial, or substance use disorder (SUD), or had a history of trauma and/or posttraumatic stress disorder consistent with the facility assessment. During interviews with facility staff 4 residents (R2, R10, R14, and R17) of a sample of 28 were identified as being affected by the lack of staff training. Findings include: The most current Facility Assessment Tool provided on 12/06/22 at 11:35 a.m. by Administrator (NHA)-A stated that common diagnoses treated by staff included impaired cognition, anxiety disorder, depression, behavior that needs interventions, peripheral vascular disease, hemiparesis, Alzheimer's disease, non-Alzheimer's disease, and chronic obstructive pulmonary disease. Special Treatments and Conditions listed on the Facility Assessment Tool included: Mental Health: Behavioral health needs, active or current substance use disorders. Services and care we offer based on our resident's needs- Mental Health and behavior: Manage the medical conditions and medical related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD [posttraumatic stress disorder], other psychiatric diagnosis, intellectual or developmental disabilities. During staff interviews it was noted that direct care staff were not trained on behavioral health needs and management or substance use disorders (SUDs). During an interview on 12/13/22 at 8:38 a.m., Certified Nursing Assistant (CNA)-II, said she received no training on SUDs or behavioral health. On 12/13/22 at 9:29 a.m., a Registered Nurse Unit Manager (RNUM-CC) said R17, who has a substance use disorder, can go out of the facility whenever he wants and staff cannot stop him. RNUM-CC said signs indicating R17 used alcohol included mood changes and lethargy but there is no way to communicate to the [nursing assistant] staff [signs or symptoms indicating R17 was using alcohol was not included in the care plan or care card]. RNUM-CC said R17's falling might be a sign of substance use. RNUM-CC said R17 has a history of going out of the facility and obtaining drugs and alcohol. RNUM-CC reportedly took care of R17 and administered Narcan when the resident overdosed with alcohol, marijuana, and fentanyl that he got from someone outside the facility. RNUM-CC said that after the incident they provided training about alcoholism, but it was general training, not symptoms or signs to look for by the Certified Nursing Assistants. The CNAs are not specifically trained on SUDs. [R17] was referred to psychiatry/psychology but refused to see them. We cannot do anything because [R17] is their own responsible party. Now that [R17] is not on 15-minute checks, the CNAs don't keep track of when he is in the building or out, or if he is misusing drugs or alcohol. On 12/13/22 at 8:45 a.m., CNA-JJ described a SUD as taking drugs or alcohol. CNA-JJ stated that she did not receive training on SUDs or behavioral health needs. (continued on next page)

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/13/22 at 10:32 a.m., Licensed Practical Nurse (LPN)-GG said she received training on SUDs at her previous job, but not at this facility. On 12/13/22 at 10:34 a.m., RN-HH said they provided care for a resident who was obviously drunk, and that the resident returned to the facility with a six pack of beer to put in the refrigerator for later. It was unclear when this incident occurred; the resident was no longer residing in the facility at the time of survey. On 12/13/22 at 10:42 a.m. during an interview with the Social Services Director (SSD-FF), SSD-FF said, [R17] has episodes of taking narcotics and drinking alcohol. I believe he bought something on the street and was doing an ingestible substance. The only thing I can do is to encourage [R17] to be careful of [about] what he buys at the gas station, like gummies and alcohol, as he independently walks around everywhere. When the Surveyor asked about staff training on behavioral health needs, alcoholism or substance use disorders, SSD-FF said, I ask the Ombudsman for outside resources. The CNAs are so new with a high turnover rate, so we need to remind the nursing caregivers to provide care. SSD-FF stated, The CNAs don't have a lot of training through the Wisconsin training, or they are agency nurses. Programs with substance use and alcohol are a much-needed thing that I want to implement in the future. The only program we offer about SUD is a smoking cessation group [that was offered] before the [coronavirus disease 2019] outbreak. We want our facility to be safe. I would love to have some information on behavioral health and substance use disorders for [R2, R10, R14, and R17]. During an interview on 12/13/22 at 12:28 p.m. with Social Services (SS)-R, SS-R said, [R17] has been involved and has been accused of drinking and doing drugs. [R17's] case workers from the insurance company said the family has brought him drugs and alcohol. SS-R said, The day [R17] had the suspected overdose [on 11/19/22], [R17's] son was here, and I [SS-R] notified the case workers. The case workers said that was common for [R17] to have drugs and alcohol. The nursing staff would have gone to [SSD-FF] and told [SSD-FF] about drinking and drugs. Alcohol and drugs are substances that would be included in SUDs. I think it would be good to have education on SUDs and behavioral health needs. On 12/13/22 at 12:43 p.m., CNA-DD who was responsible for providing care for R17 (who had a SUD as indicated above), said she never received training on substance abuse or behavioral health. CNA-DD was not aware of R17 being out of the building and did not know R17's whereabouts. R17 was not in the facility on 12/13/22; according to sign out documentation, the resident was on a walk. R17 returned to the facility at 12:45 p.m.