STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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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 0580 Level of Harm - Minimal harm or potential for actual harm 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** 44552 Based interview and record review the facility failed to notify the physician with a change in weight for 2 (R10 and R14) of 3 residents reviewed for weight changes. R10's provider was not notified of R10's weight loss and the lack of follow through on the Registered Dietician's recommendations. R14's provider was not notified of R14's weight gain as ordered or when R14's weight was not completed as ordered Example 1 R10 was admitted to the facility on [DATE] with diagnoses including: hyperosmolality and hypernatremia, chronic embolism, and thrombosis of unspecified deep veins of unspecified distal lower extremity, chronic pain, major depressive disorder, benign prostatic hyperplasia without lower urinary tract symptoms, kidney disease, muscle wasting, anxiety disorder, and degenerative disease of nervous system. R10's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/29/23, indicates R10 has a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. R10 has an Activated Health Care Power of Attorney. Surveyor reviewed R10's Weight Summary. Weight Summary states, in part. 12/23/22 123.8 lbs. 1/25/23 119.3 lbs. It is important to note no weights were taken in the months of February and March 2023. 4/14/23 95 lbs. 4/17/23 102.1 lbs. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R10's Nursing Progress Notes. Progress Note from 4/19/23 states, Note Text: Resident refused re-weigh, states they already got weight yesterday. Resident weight is down, NP to be updated once re-weight is obtained. It is important to note there are no other attempts to weigh R10 documented in R10's Progress Notes. R10's most recent Dietary Progress Note dated 4/17/23 indicates, in part; Note Text: Nutritional Signif wt. (weight) loss: Res with a significant wt. loss reported x 3 months & 6 months. CBW (Current Body Weight): 95# (4/14/23), Ht. 63 in. BMI (Body Mass Index) 16.8 underweight for geriatric age. Recent weight obtained after almost 3 months w/o (without) one. Signif wt. loss reported x 3 months. (24.3# 20.3%) & 6 months (25. 3# 21%) Recommendations: recommend prune juice 4 oz daily honey thickened, magic cup BID, recommend reweigh & weekly weights x4 weeks to maintain accuracy, recommend ST (Speech Therapy) evaluation. Goals: no significant weight loss triggers, po (oral) intake 75% food & fluids, maintain skin integrity, diet texture tolerance. RD (Registered Dietician) to f/u (follow-up) PRN (as needed). On 5/4/23 at 9:15AM, NP D (Nurse Practitioner) indicated NP D first met R10 on 4/17/23. Previously, R10 was being seen by the Medical Director. NP D indicated R10's friend/POA requested R10 to switch providers. NP D indicated on 4/17/23 she noted R10 to have significant weight loss. NP D indicated R10 reported he hates the supplement Mighty Shake and will often decline it. NP D indicated there were malnutrition concerns and that R10 requires 1:1 assistance. NP D indicated she fed R10 dinner on 4/17/23 and that R10 ate around 50% of his meal and that he requested ice cream at that time. NP D indicated from what she is understanding R10's ability to self-feed has declined over the last several months. NP D indicated she has received no further updates on R10's weight after 4/17/23 or how the recommendations that were made by the Registered Dietician were not followed up on. On 5/4/23 at 2:30PM, IDON B (Interim Director of Nursing) indicated she would expect the Registered Dietician's recommendations to be followed through on. IDON B indicated she would expect the provider to be notified of weight changes. 29360 Example 2 R14 was admitted to the facility on [DATE]. R14's diagnoses include CKD (chronic kidney disease), CAD (coronary artery disease), diabetes, and pulmonary edema. R14 has a telephone order, dated 4/3/23, that includes the following: Monitor daily weights; notify provider for 3 lb. (pound) weight gain in one day or 5 lbs. in 1 week. R14's weight documentation: 4/4/23 - no documented weight 4/5/23 - no documented weight 4/6/23 - 235.8 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/7/23 - 236.4 4/8/23 - 236 4/9/23 - no documented weight 4/10/23 - 235 4/11/23 - 235.5 4/12/23 - 235.5 4/13/23 - 235 4/14/23 - 194.8 (R14's previous weights were found to be inaccurate per Dietician documentation) 4/15/23 - 193.2 4/16/23 - 192.7 4/17/23 - 195 4/18/23 - 191 4/19/23 - 192.3 4/20/23 - 191 4/21/23 - 190.6 4/22/23 - 192 4/23/23 - 192 4/24/23 - 195.4 (this is a 3.4-pound weight gain) 4/25/23 - 196.6 4/26/23 - 194 4/27/23 - no documented weight 4/28/23 - 195 4/29/23 - 193.4 4/30/23 - 195.2 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/1/23 - 202.4 (this is a 7.2-pound weight gain) 5/2/23 - no documented weight 5/3/23 - 202.3 5/4/23 - 197.4 No documentation could be found in R14's medical record to show R14's provider was updated on R13's weight gain of over 3 pounds in a day on 4/24/23 or 5/1/23 or that R1's daily weights were not completed on 4/4/23, 4/5/23, 4/9/23, 4/27/23, and 5/2/23. On 5/4/23 at 12:00 PM Surveyor interviewed NP D (Nurse Practitioner) via telephone. NP D stated she was not updated of R14's weight gain of over 3 pounds in a day on 4/24/23 or 5/1/23 or that R1's daily weights were not completed on 4/4/23, 4/5/23, 4/9/23, 4/27/23, and 5/2/23. On 5/4/23 at 3:30 PM Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B if she would expect staff to contact R14's provider when R14 gained 3 pounds in a day. IDON B stated she would expect staff to contact R14's provider when R14 gained 3 pounds in a day. Surveyor asked IDON B if she would expect staff to contact R14's provider if R14's daily weight was not gotten as ordered. IDON B stated she would expect staff to contact R14's provider when R14's weight was not gotten as ordered.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14305 Based on record review and staff interview, the facility did not investigate an allegation of neglect to the state agency for 1 (Resident 8) of 3 sampled residents. An allegation of neglect was faxed to the facility regarding the care of R8. The facility did not submit the allegation to the state agency. Findings include: The facility's undated Policy and Procedure titled, Abuse Neglect and Exploitation, indicated the following: ~ reporting of all alleged violations to the Administrator, state agency and adult protective services and all other required agencies within specific time frames: not later than 24 hours if the events that cause the allegation do not involve abuse and not result in serious bodily injury. ~ The Administrator will follow up with government agencies during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. According to a fax that was submitted to the facility on [DATE] by ICare Independent Care Health Plan, there was a concern regarding wound care supplies not being available, wound care being signed out as completed but was not done and medications being administered late. On 5/3/23 at 2:45 PM, the Surveyor interviewed Director of Nursing B (DON) regarding if the allegation was submitted to the state agency. DON B stated she had not submitted the concerns to the state agency because the facility has time to investigate and does not need to be submitted unless the concern was found to be accurate.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14305 Based on record review and staff interview, the facility did not thoroughly investigate 2 of 3 (Residents 8 & 11) allegations of neglect or misappropriation of resident property. An allegation of neglect was faxed to the facility regarding the care of R8. The facility did not investigate the allegation. R11 reported concerns with narcotic count sheet and reported there were two days and three different times that he did not ask for his Oxycodone, yet it was signed out. R11 indicated that on 4/10/23 8AM, 4/10/23 11:30 PM, and 4/13/23 11:30 PM Oxycodone was signed out but he did not request it. The facility did not thoroughly investigate possible misappropriation regarding R11's Oxycodone. The facility did not interview all staff who work with R11 to determine if there were any trends or concerns identified. Findings include: The undated Policy and Procedure titled, Abuse, Neglect and Exploitation, indicated the following: ~ An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. ~ Identify staff responsible for the investigation ~ Exercising caution in handling evidence that could be used in a criminal investigation ~ Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations ~ Focusing the investigation on determining if abuse, neglect or exploitation and/or mistreatment as occurred, the extent, and cause; and ~ Providing complete and through documentation of the investigation Example 1 According to a fax that was submitted to the facility on [DATE] by ICare Independent Care Health Plan, there was a concern regarding wound care supplies not being available, wound care being signed out as completed but was not done and medications being administered late. On 5/4/23 at 8:30 AM, the Surveyor interviewed Social Worker U (SW) who stated she was the facility's grievance officer. SW U indicated she started employment with the facility about a month ago and was learning the process yet. SW U indicated Nursing Home Administrator A (NHA) was currently doing the investigations to grievances. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/23 at 11:00 AM, the Surveyor interviewed NHA A in regards to the investigation for the concerns that were submitted on behalf of R8. NHA A stated the previous Director of Nursing was completing the investigations at the time the concern was submitted. NHA A indicated she would have to try and locate the investigation. The investigation to the concerns that was submitted was never received. 44552 Example 2 R11 reported concerns with narcotic count sheet and reported there were two days with three different times that he did not ask for his Oxycodone, yet it was signed out. R11 indicated that 4/10/23 8AM, 4/10/23 11:30PM, and 4/13/23 11:30PM Oxycodone was signed out, but he did not request it. The facility did not thoroughly investigate possible misappropriation regarding R11's Oxycodone. The facility did not interview all staff who work with R11 to determine if there were any trends or concerns identified. R11 was admitted to the facility on [DATE] with diagnoses including hypertension, diabetes, hyperlipidemia, kidney failure, chronic pain syndrome, pressure ulcer of sacral region, muscle weakness, other abnormalities of gait and mobility, and lack of coordination. R11's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/14/23, indicates R11 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R11 is cognitively intact. R11 is his own person. On 5/3/23 at 8:45 AM, Surveyor met with R11. R11 indicated he reported concerns about Oxycodone to NHA A (Nursing Home Administrator) on 4/17/23. R11 indicated the DON (Director of Nursing) at the time interviewed him. R11 indicated the DON was snarky with him, like he was playing victim in the situation. R11 indicated he doesn't know why someone would take Oxycodone, he just knows that he did not ask or take it himself. R11 indicated he typically asks for Oxycodone once a day and it's always around the same time of the day. R11 indicated for one of the times that he doesn't recall, staff could have put the Oxycodone in his pill container and not have told him. R11 indicated the other times - 4/10/23 at 8AM and 4/13/23 at 11:30PM - he is certain he did not ask for the medication because he would have been in bed. R11 indicated NHA A started an investigation and had met with R11. NHA A indicated there would be two staff present when giving Oxycodone. R11 indicated he has only seen two staff present for his Oxycodone once. R11 indicated he did tell the facility that it takes a long time to get two staff available to administer medication. R11 indicated he asks for Oxycodone when he's been up in his wheelchair all day, on wound care treatment days, and it's typically always in the evening hours. Surveyor reviewed R11's narcotic count sheets from 3/28/23-5/4/23. There are three days that there is no time written in. 4/9/23-4/13/23 are the only days that have more than one Oxycodone administered. 4/10/23 and 4/13/23 are the only days that the Oxycodone was administered at 11:30 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/23 at 11:00 AM, RN E (Registered Nurse) indicated R11 typically will request Oxycodone around the same time. RN E indicated R11 will request the PRN (as needed) on the days he goes to the wound care clinic it's a lot with the transportation too. RN E indicated the order says two staff present to administer the Oxycodone. RN E indicated it is her understanding that there needs to be two staff present when the medication is administered. RN E indicated she doubts it's double signed out for. On 5/4/23 at 8:45 AM, LPN N (Licensed Practical Nurse) indicated R11 will let staff know if he needs his Oxycodone and it typically is in the early evening hours because he's been up in his wheelchair. LPN N indicated there is an order saying two staff need to be present when administering Oxycodone to R11. On 5/4/23 at 10:40AM, LPN O indicated R11 takes his Oxycodone in the evening hours. R11 has an order that two staff need to be present when Oxycodone is administered. LPN O indicated she has not worked with R11 since this order was put in place for two staff to administer Oxycodone. On 5/4/23 at 4:25PM, NHA A (Nursing Home Administrator) indicated an investigation was immediately started and self-report completed when R11 voiced concerns about Oxycodone. NHA A indicated a sweep of the house was done and all residents interviewed. No additional concerns had been identified. [NAME] Police and Ombudsman notified. NHA A completed education with facility staff. NHA A indicated R11's care plan updated, discussion started on lock box and possible self-administrating, 2nd staff put in place for administrating Oxycodone, and pain assessment completed for R11. Surveyor asked if NHA A interviewed all staff that work with R11 to help identify trends. NHA A indicated she did not interview all staff because there were trends she identified with R11's reporting and that this is the third self-report completed regarding R11. Surveyor indicated interviewing all staff for this self-report possibly could have helped identify trends on times R11 requests Oxycodone and possible additional information. Surveyor asked NHA A if the second staff signs out for the Oxycodone as well. NHA A indicated there is only one staff that signs out for the Oxycodone.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 14305 Based on record review and staff interview, the facility did not ensure that 1 (Residents 9) received treatment and care in accordance with professional standards of practice. R9 was admitted to the facility for wound care and did not receive the treatments that were ordered by the provider for 5 days. Also, the wound care treatment was not provided consistently when the facility did initiate the wound treatment. The wound assessment was also not completed weekly in accordance with professional standards. Findings include: Example 1 According to the electronic medical record, R9 was admitted to the facility on [DATE]. The hospital discharge summary dated 3/22/23, R9 was admitted with diagnoses of Enterocutaneous fistula, recurrent ventral hernia with incarceration, and wound of the abdomen. The discharge orders directed facility staff to cleanse the abdominal wound with normal saline, apply skin prep to peri-wound, fill wound with chlorpactin moistened roll gauze, cover with an ABD dressing, secure with medipore tape. Change BID (twice daily). The Surveyor reviewed R9's Treatment Administration Record (TAR). The wound treatment was not written on the TAR, so was not completed. On 3/27/23, R9 was seen by the Nurse Practitioner on 3/27/23. Orders for wound care was again received. The new treatment orders direct staff to cleanse wound to abdomen with normal saline. Pat dry. Lightly pack normal saline soaked gauze in right upper tunneling area. Lightly pack rolled gauze soaked in normal saline to remaining wound. Apply Calmoseptine to per wound (red areas). Apply ABD and secure with medipore tape. Change every 6 hours for wound healing. The TAR indicated this treatment was not started until 3/28/23 at 8:00 AM, although it was scheduled by the facility at 2:00 AM, 8:00 AM, 2:00 PM and 8:00 PM. The TAR indicated the treatment was not completed on 3/30/23 at 8:00 PM, 3/31/23 at 2:00 AM and 8:00 AM, and again on 4/3/23 at 2:00 AM and 8:00 AM. The facility completed a comprehensive wound assessment on 3/23/23, but a follow up wound assessment was not located after 3/23/23. On 5/3/23 at 12:15 PM, the Surveyor interviewed Interim Director of Nursing B (IDON). IDON B stated it appears the nurse did not transcribe the initial wound care orders, so the treatment was not completed until new orders were received on 3/27/23. IDON B verified the wound care treatment appears to not have been consistently completed after new orders were given on 3/27/23. IDON B stated the nurses that worked during the times of when it appears the wound care was not completed are no longer employed at the facility and unavailable to interview. IDON B indicated a follow up wound assessment was not located after the initial assessment which was completed on 3/23/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/23 at 2:20 PM, the Surveyor interviewed Nurse Practitioner D (NP). NP D stated she changed orders for wound care on 3/27/23 and verified the wound care treatment was not completed prior to that date. NP D indicated R9's wound was excreting copious amounts of drainage and believed wound care was not consistently being done after the new orders were received.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on observation, interview, and record review, the facility did not implement professional standards of practice to prevent pressure injuries (PI) from worsening for 1 of 3 resident reviewed for PIs, out of a sample of 16 residents (R4). The facility did not ensure interventions were in place to prevent the PI from developing or worsening. R4 had a pressure injury on the heel that had closed and then redeveloped on 1/27/23. R4's pressure injury to the heel worsened and became an Unstageable PI on 4/25/23. The facility failed to complete weekly skin assessments and did not follow care plan interventions. This is evidenced by: The facility's policy, Pressure Injury Prevention Guidelines, implemented 2/2023, states in part . Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Policy Explanation and Compliance Guidelines: 1. Individualized interventions will address specific factors identified in the resident's risk assessment (e.g., nutritional deficit, staging, wound characteristics). 3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. 5. Prevention devices will be utilized in accordance with manufacturer recommendations (e. g., heel flotation devices, cushions, mattresses). 7. Interventions will be documented in the care plan and communicated to all relevant staff. 8. Compliance with interventions will be documented in the medical record. 9. The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. 3. Apply heel suspension devices according to the manufacturer's instructions. b. For stage 3, 4, unstageable, or deep tissue injury: Place foot and leg into a heel suspension boot that elevates the heel from the surface of the bed, completely offloading the pressure injury. Check the skin each shift and prn for signs of redness or skin breakdown related to the boot. The facility's policy, Skin Evaluation, implemented 02/2023, states, in part . Policy: It is out policy to perform a full body skin evaluation as part of our systematic approach to pressure injury prevention and management. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin evaluation will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The evaluation may also be performed after a change of condition or after any newly identified pressure injury. 6. Documentation of skin evaluation b. Document observations (e.g., skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Documents if resident refused assessment and why. f. Document other information as indicated or appropriate. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's policy, Wound Treatment Management, implemented 02/2023, states, in part . Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidenced-based treatments in accordance with current standards of practice and physician orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes. 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. The facility's policy, Pressure Injury Preventions and Management, implemented 2/2023, states, in part . The facility shall establish and utilize a systematic approach for pressure injury preventions and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Evaluation of Pressure Injury Risk. a. Licensed nurses will conduct a pressure injury risk evaluation, using the Braden, on all residents upon admission/re-admission, weekly x (times) four weeks, then quarterly or whenever the resident's condition changes significantly. d. Assessments of pressure injuries; will be performed by a licensed nurse and documented. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS (Minimum Data Set). 4. Interventions for Prevention and to Promote Healing f. Interventions will be documented in the care plan and communicated to all relevant staff. g. Compliance with interventions will be documented in the weekly summary charting. 5. Monitoring a. The RN (registered nurse) Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. b. The attending physician will be notified of ii. The progression towards healing, or lack of healing, of any pressure injuries weekly. According to the National Pressure Injury Advisory Panel an Unstageable Pressure Injury is defined as, Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. According to the National Pressure Injury Advisory Panel a Deep Tissue Pressure Injury is defined as, Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood filled [NAME]. R4 was admitted to the facility on [DATE] with diagnoses including . Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, nontraumatic intracranial hemorrhage, reduced mobility, muscle weakness, and acute kidney failure. R4's last 3 Braden Scores are as follows . Braden completed on 7/11/22, shows a score of 16, indicating R4 is at moderate risk for PI development. Braden completed on 7/18/22, shows a score of 16, indicating R4 is at moderate risk for PI development. (continued on next page)

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Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Braden completed on 4/03/23, shows a score of 11, indicating R4 is at high risk for PI development. Note: Per Hospice Notes R4's pressure injury reopened on 1/27/23 and a new Braden assessment was not completed until 4/3/23. R4's Comprehensive Care Plan, initiated 9/9/22, revised 4/26/23, states in part . Focus: Resident has Impaired Skin Integrity: Right heel pressure injury non-stageable and right foot 2nd toe callous. Interventions: Keep Mepilex on coccyx to prevent potential wound, initiated 3/8/23; measure area weekly, initiated 9/9/22; monitor for s/sx (signs and symptoms) of infection, initiated 9/9/22; monitor for s/sx (signs and symptoms) of worsening skin tissue, initiated 9/9/22; monitor pain and offer PRN (as needed) analgesic as ordered, initiated 9/9/22; treatment as ordered, initiated 9/9/22; update MD (medical doctor) with changes in wound status and PRN, initiated 9/9/22. R4's Comprehensive are Plan, initiated 11/04/21, revised, states in part . Focus: Skin Integrity: At Risk / and/or Potential for complications with impaired skin integrity and/or pressure r/t (related to) DM (diabetes mellitus) and decreased mobility, initiated 11/13/21, revised 5/2/23. Interventions: Air mattress settings are based on weight. Setting is at 185# (pounds). Check function of air mattress every shift, initiated 6/9/22, revised 6/20/22; heel boots on at all times, resident will kick off heel boots or refuse them at times, initiated 2/22/22; meds (medications)/labs/tx's (treatments) as ordered, initiated 11/13/21. R4's Comprehensive are Plan, initiated 11/4/21, revised 11/13/21 states in part . Focus: At Risk and/or Potential for Complications with Deficit's with ADL's (Activities of Daily Living) r/t current medical Recent Non-ST Elevation MI (myocardial infarction), severe bicuspid valve stenosis. Interventions: Bed Mobility - assist 1, pillow to left side when in bed. Bilateral side bars on bed to improve independence with bed mobility, initiated 11/04/21, revised 6/22; Transfer - 2 assist with Hoyer, initiated 11/4/21, revised 1/19/22. R4's most recent Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview of Mental Status (BIMS) of 8, indicating R4 has moderate cognitive deficits. In R4's most recent MDS, section G0110 indicates extensive assist of one staff is needed with bed mobility, transfers, hygiene, and dressing. R4 is dependent of one staff member for toileting. R4 is always continent of bowel and bladder. M0150 - At Risk for Pressure Injury. Yes. M0210 - Unhealed Pressure Injury. Yes. M0300 - Stage 2. M1200 - Skin and Ulcer Treatments: Pressure reducing device for bed; Pressure reducing device for chair; Nutrition or hydration intervention to manage skin problems; pressure ulcer care; applications of dressing to feet (with or without topical medications). R4's Physician's Orders stated in part . Blue boots it [sic] bilateral heels at all times every shift for wound. Start Date: 2/8/23. R4's Certified Nursing Assistant (CNA) Care sheet states in part . Heel boots at all times; mattress extender at the end of the bed. (Note: The facility did not have pressure relieving boots in place prior to 2/22/22 and R4 was at risk for PI's.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(Note: Per interview with NP D (Nurse Practitioner) and Hospice notes R4's pressure injury (PI) on right heel reopened on 1/27/23. The facility was unable to provide Surveyor with any of the NP's notes or documentation for the last 3 months as requested.) (Note: The 3/6/23 Wound Evaluation is the first documentation of R4's wound being evaluated since it opened on 1/27/23.) (It is important to note that PI was initially discovered on 1/27/23 but the facility did not complete an assessment of the area until 3/6/23. Interventions to prevent and/or heal pressure injuries were observed not in place during this Survey.) R4's Weekly Skin Impairment and Wound Evaluation -V 1, dated 3/6/23 at 20:14 (8:14 PM), states in part . A. Assessment Date: 3/6/23. 2. Wound Description: Site: Right Heel. Type: Pressure. Length: 2.5. Width: 1. 6. Depth: 0. Stage: (blank). Are abnormalities noted to wound edges/peri-wound? 2. No. 5. Exudate Amount: 2. Scant. 5a. Check all tat [sic] apply: 1. Serous. 6. Is wound/exudate odorous? 2. No. C. Wound Progress: 1. Onset Date of Treatment: 3/6/23. 1a. Check all treatments that apply: 3. Turning and repositioning; 4. Positioning/splinting device. E. Wound Pain: 1. Is pain associated with the wound? 2. No. F. Other: 1. Other comments/recommendations: tan fibrin attached to wound edges, scant drainage. Pressure boots on. Signed by: NHA A. Signed Date: 5/4/23. R4's Weekly Skin Impairment and Wound Evaluation -V 1, dated 4/4/23 at 09:32 (9:32 AM), states in part . A. Assessment Date: 4/4/23. Type of wound: Pressure. 2. Wound Description: Site: Right Heel. Type: Pressure. Length: 2. Width: 1.5. Depth: 0.1. Stage: III 4j. Predisposing Factors: 8. Other. 4k. If other, please describe boney prominence. 5. Exudate Amount: 2. Small. 5. Wound Progress: 2. Stable/No Change. Onset Date of Treatment: 1/14/22. 1a. Check all treatments that apply: 1. Bed pressure reduction/redistribution mattress. 2. Chair pressure reduction/redistribution cushion. 3. Turning and repositioning; 5. Wound treatment/application of dressing. Current level of pain: Hurts a Little More. 3. Pain Management Plan: c/o (complains of) pain when sock and heel padding is removed. R4's Weekly Skin Impairment and Wound Evaluation -V 1, dated 4/11/23 at 18:46 (6:46 PM), states in part . Assessment Date: 4/11/23. Type of wound: Pressure. 2. Wound Description: Site: Right Heel. Length: 1.5. Width: 2. Depth: 0.1. Stage: III. Predisposing Factors: 3. Erythema. 5. Exudate Amount: 2. Scant. 5. Wound Progress: 2. Improved. 1a. Check all treatments that apply: 1. Bed pressure reduction/redistribution mattress. 2. Chair pressure reduction/redistribution cushion. 3. Turning and repositioning; 5. Wound treatment/application of dressing. E. Wound Pain: 1. Is pain associated with the wound? 2. No. 3. Pain Management Plan: offer PRN analgesia as indicated. F. Other: 1. Other comments/recommendations: (blank). Pressure boots on. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's Weekly Skin Impairment and Wound Evaluation -V 1, dated 4/25/23 at 15:37 (3:37 PM), states in part . A. Assessment Date: 4/25/23. B. Wound Description: Pressure. 2. Wound Description: Site: Right Heel. Type: Pressure. Length: 1.0 cm (centimeters). Width: 1.5 cm. Depth: UND (undetermined). Stage: Unstageable. 4. Are abnormalities noted to wound edges/peri-wound? 2. No. 5. Exudate Amount: 2. Small. 6. Has the physician been notified of no change or deterioration over the past 2 weeks? 1. Yes. 5. Wound Progress: 3. Deteriorated/declined. Onset Date of Treatment: 3/17/23. 1a. Check all treatments that apply: 1. Bed pressure reduction/redistribution mattress. 2. Chair pressure reduction/redistribution cushion. 3. Turning and repositioning; 5. Wound treatment/application of dressing. 8. Other. 1b. If other, please describe heel boot. E. Wound Pain: 1. Is pain associated with the wound? 1. Yes. 2. Current level of pain. Hurts a little more. 3. Pain Management Plan: Pre medicated prior to dressing change. F. Other: 1. Other comments/recommendations: Area to heel is a NS (non-stageable) pressure injury with slough covering. Facility has identified as stage II (2) on last assessment, so this is a decline. Area to toe remains stable callous. Receives 4oz (ounces) house supplement with med pass and mighty shake to help facilitate wound healing. (Note: Weekly Skin Assessments were not completed between 3/6/23 and 4/4/23, between 4/11/23 and 4/25/23, and between 4/25/23 and 5/3/23.) (Note: The PI to the right heel was not staged on first documented skin assessment on 3/6/23. Wound was first staged on 4/4/23 at a stage 3.) (Note: There is no documentation to indicate the NP or MD were notified of R4's wound decline on 4/25/23.) R4's Physician's Orders include . - Weekly Skin Check: Complete weekly skin assessment under assessment tab, report any abnormal findings to PCP (primary care provider) every day shift every Thu (Thursday) for skin monitoring. Start Date: 9/29/22. - Pain Evaluation 0=no pain 1-3=mild pain 4-6=moderate pain 7-10=severe pain every shift, document pain level 1-10. State Date: 5/02/23. - R4 to be premedicated 1 hour PRIOR to (RIGHT heel) wound care with Morphine 7.5mg (milligrams) AND Lorazepam 0.5mg (Note: both medications are available under PRN (As needed) medications) every shift for pain management. Start Date: 4/2/23. - Nsg (Nursing) Order: Wound care to heel is daily, please enter a note about having done it. Every day and evening shift for wound care. Start Date: 3/16/23. - Blue boots it [sic] bilateral feet at all times every shift for wound. Start Date: 2/8/22. - Evaluate pain Every Shift using Numerical or Visual Analog pain scale every shift for Pain Management. Start Date: 11/03/21. - 1. Cleanse w (with) soap and water or wound cleanser, pat dry; 2. Apply medihoney to slough; 3. Skin prep peri- wound; 4. Cover w bordered gauze or mepilex; 5. Change daily and prn everyday shift for wound care also PRN if soiled. Start Date: 3/16/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Air Mattress setting is based on weight. Setting is at 185. Check function of air mattress every shift. Every shift. Start Date: 6/9/22. - House supplement three times a day 4 ounces to be given with med pass. Start Date: 9/12/22. - Mighty Shake two times a day for supplement. Start Date: 10/6/22. Physician Orders for Wound Care are as follows: Wound Care Order: On 2/17/23 at 8:17 AM, Wound care to R heel: 1. Cleanse with soap and water or wound cleanser; pat dry. 2. Apply medihoney to slough on wound. 3. Apply skin prep to peri wound. 4. Cover with bordered gauze or mepilex. 5. Change daily and PRN. To be completed by facility nurse; Hospice nurse will complete once weekly on Thursdays. R4's Treatment Administration Record (TAR) for the months of February, March, April and May, state in part . 1. Cleanse w soap and water or wound cleanser, pat dry. 2. Apply Medihoney to slough. 3. Skin prep peri-wound. 4. Cover w bordered gauze or mepilex. 5. Change daily and prn. One time a day for wound care tx to right heel daily on pm shift and prn. Start Date: 3/16/23. Wound care Treatments reviewed for February, March, April, and May indicate wound care was not signed out as completed on the following dates with the following reasons if indicated . 2/05/23 2/15/23 2/20/23 3/17/23 - Refused 3/18/23 3/21/23 - Refused 3/22/23 - Refused 3/25/23 3/26/23 3/27/23 - Refused 3/31/23 - Refused 4/03/23 - Refused (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4/09/23 4/10/23 4/11/23 - Refused 4/19/23 - See Nurses Note: Completed on day shift by this nurse. 4/23/23 - See Nurses Note: Nurses Note dated, 4/23/23 at 17:11 (5:11 PM), states in part . Dressing change to be done by PM nurse this day. Nurses Note dated, 4/23/23 at 18:54 (6:54 PM), states in part . Dressing change completed by AM nurse. Charting to be completed by AM nurse. (Note: Notes from 4/23/23 indicate PM shift to complete dressing change and another indicates dressing change was completed on AM shift. There is no documentation to indicate the dressing change was completed on either shift.) 4/25/23 - See Nurses Note Nurses Note dated, 4/25/23 at 15:23 (3:23 PM), states in part . AM nurse completed wound care. Note not completed by this writer. (Note: Note from 4/25/23 nurse indicates she did not complete the wound treatment. There is no documentation by the any nurse indicating that the treatment was completed by on 4/25/23.) 4/29/23 - See Nurses Note Nurses Note dated, 4/29/23 at 17:17 (5:17 PM), states in part . completed by am nurse. Nurses Note dated, 4/29/23 at 21:01 (9:01 PM), states in part . completed on am. Nurses Note dated, 4/29/23 at 22:15 (10:15 PM), states in part . completed on AM shift. (Note: Nurses notes from 4/29/23 indicate that the AM nurse completed the treatment, there is no documentation or indication the treatment was completed by the AM nurse.) Nurses Note dated 3/29/23 15:12 (3:12 PM) states, Writer updated the POA that the Resident had been refusing his wound care related to pain and his refusal to get OOB (out of bed) at all. NP (Nurse Practitioner) also updated, and a request was made to pre-medicate for wound care. Resident has been angrier with people tending to me [sic], appears more despondent. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nurses Note dated, 4/2/23 at 15:34 (3:34 PM) states in part . Received order from NP [name] to start morphine 15mg: Take 0.5-tab (7.5mg) PO (by mouth) one-time daily PRN (to be given daily, 1 hour PRIOR TO right heel WOUND CARE). Also, R4 is to be premedicated 1 hour PRIOR to (RIGHT heel) wound care with Morphine 7.5mg AND Lorazepam 0.5mg (Note: both medications are available under PRN medications). Avoid pressure with medical devices. Orders to be placed in [electronic charting system name] and faxed to pharmacy. Nurses Note dated 4/17/23 at 14:48 (2:48 PM), states, The resident refused all treatments today. Writer did call the residents POA at 1445 (2:45 PM) and informed him. Writer did explain that writer being new and not knowing the resident's routine may have affected residents' refusal. Writer expressed using a different strategy tomorrow. The resident is currently laying in his bed awake showing no signs of pain or distress. Note placed in 24-hour report. Nurses Note dated 4/17/23 at 15:01 (3:01 PM), states, NP notified, and writer was instructed to ask oncoming shift to attempt dressing changes with resident. Oncoming nurses notified. Hospice Note dated 4/6/23 at 10:57 AM, states in part . Wound 1/27/23 Pressure Injury Heel Right. Wound Assessment: Bleeding; Moist; Painful; Slough; [NAME] (100% slough, scant). Drainage Description: Purulent; Serosanguineous; Tan. Wound Length 2 cm. Wound Width: 1.6 cm. Hospice Note dated 4/13/23 at 11:34 AM, states in part . Wound 1/27/23 Pressure Injury Heel Right. Wound Assessment: Moist; Painful; Pink; Slough. Drainage Amount: Small. Drainage Description: Serous; Tan. Wound Length 1.5 cm. Wound Width: 1.5 cm. Hospice Note dated 4/20/23 at 11:30 AM, states in part . Wound 1/27/23 Pressure Injury Heel Right. Wound Assessment: Moist; Painful; Pink; Tan. Drainage Amount: Small. Drainage Description: Tan. Wound Length 1.5 cm. Wound Width: 1.3 cm. Hospice Note dated 4/27/23 at 11:49 AM, states in part . Wound 1/27/23 Pressure Injury Heel Right. Wound Assessment: Fragile/Friable; Granulation tissue; Moist; Pink; Slough. Drainage Amount: Small. Drainage Description: Serous; Tan. Wound Length 1.3 cm. Wound Width: 0.8 cm. On 5/3/23 at 8:42 AM, Surveyor observed RN E (Registered Nurse) complete wound care for R4. Upon entering R4's room, he was noted to being lying in bed supine with heels directly on the bed, no boots on as ordered. RN E washed hands and then gloves applied. RN E removed old dressing from wound, area cleansed with 4x4's, and patted dry with 4x4's. Skin prep applied to peri-wound. RN E placed Medihoney on gloved finger and applied it to the wound bed. RN E removed gloves, sanitized hands, and applied new gloves prior to putting on new Mepilex dressing to wound. Following R4's treatment, RN E did not put R4's heel protector boots on him. (Note: R4 did not have heel protector boots on when Surveyor entered room to observe wound care with RN E. RN E did not put heel protector boots on R4 following the treatment or prior to leaving R4's room.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/3/23 at 9:03 AM following wound care, Surveyor interviewed RN E. Surveyor asked RN E if she had time for a few questions. Surveyor asked RN E if R4 was premedicated prior to R4's treatment, RN E stated, R4 did complain of pain during the treatment when the old dressing was removed, and the area was cleansed. Surveyor asked RN E if she should have removed gloves, washed hands, and applied new gloves when going from dirty to clean. RN E stated, I guess I was a step too late. On 5/3/23 at 11:40 AM, R4 was noted to be in the dining room in his wheelchair. Heel protectors were not on at that time. On 5/3/23 at 12:06 PM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B when doing wound care when would it be expected staff remove gloves and perform hand hygiene. IDON B stated, Hands should be washed when going from dirty to clean. On 5/4/23 at 9:20 AM, Surveyor entered R4's room to see Hospice RN F just finishing wound care. Surveyor asked Hospice RN F how R4 tolerated his wound care. Hospice RN F stated, He was not happy with wound care today. I had talked with the nurse on duty and asked that the resident be pre medicated but it did not appear as if he was. On 5/4/23 at 9:28 AM, Surveyor spoke with NP D (Nurse Practitioner). Surveyor asked NP about R4's wound on the right heel. NP D stated, From the notes I have, this area was an area that had previously healed and then reopened on 1/27/23. On 5/4/23 at 1:57 PM, Surveyor interviewed CNA G (Certified Nursing Assistant). Surveyor asked CNA G if R4 should have heel protector boots on. CNA G stated, R4 is supposed to have the big heel protector boots on but hospice hasn't been putting them on him. The Hospice CNA told me about the sleeves with padding on the heel were better protection. Surveyor asked CNA G if R4's care plan states he should have the big heel protector boots on. CNA G stated, Yes. On 5/4/23 at 1:59 PM, Surveyor interviewed CNA H. Surveyor asked CNA H if R4 should be wearing heel protector boots. CNA H stated, He is supposed to have those on. I haven't seen anyone put them on him, but it is something that he probably needs. On 5/4/23 at 2:00 PM, Surveyor observed R4 in bed watching television without heel protector boots on. On 5/4/23 at 2:07 PM, Surveyor interviewed IDON B. Surveyor asked IDON B if R4 should be wearing heel protector boots as indicated on his care plan. IDON B stated, He doesn't have them on? I will take care of that right now. On 5/04/23 at 2:15 PM, Surveyor interviewed LPN T (Licensed Practical Nurse). Surveyor asked LPN T if R4 should be wearing heel protector boots. LPN T stated, Aren't they on? I will get them on him right now. R4 was at risk for PI's. R4 did not have wound care assessments completed weekly per standard of practice, treatments were not completed as ordered, observation of poor hand hygiene during wound care, and three separate observations were made of R4's heels not being offloaded. R4's heel worsened from a stage III to an unstageable PI. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility completed an Ad Hoc QAPI Meeting on 4/25/23 for PI's which included wound rounds, notifications, skin assessments, and Braden's. During this survey, current non-compliance was identified.

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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** 44552 Based on observation, interview, and record review, the facility did not ensure resident's received adequate supervision, assistance, and interventions to prevent accidents for 1 (R13) of 2 residents reviewed. R13's meal ticket indicated R13 is to be supervised at all times when eating. Surveyor observed R13 eating in bedroom with no supervision. R13 is at risk for choking/pneumonia due to swallowing difficulties. R13 was readmitted to the facility on [DATE] with diagnoses including: acute respiratory failure with hypoxia, dysphasia following nontraumatic subarachnoid hemorrhage, and pneumonitis due to inhalation of food and vomit. R13's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/9/23, indicates R13 has a Brief Interview for Mental Status (BIMS) score of 8 indicating R13's cognition is moderately impaired. R13's Comprehensive Care Plan with a revision date of 4/7/23 states, in part; NUTRITION/HYDRATION: At risk for complications with nutrition/hydration r/t (related to) swallowing difficulty AEB (As Evidenced By) need for altered texture and consistency. Swallowing difficulty r/t dysphagia dx (diagnosis) AEB mech soft, nectar thickened liquids. Regular, mech soft (minced, moist) nectar thickened liquids .Interventions ST (Speech Therapy) to eval and treat as ordered/PRN (As Needed) 11/7/22, Adaptive equipment: lipped plate, use maroon spoons with meals. Provale cup for thin liquids. If using regular cup, nectar thick liquids . R13's Certified Nursing Assistant (CNA) Care Card indicates, ADL (Activities of Daily Living): EATING: Assist of 1 set and cues to be in hall dining room for meals. Use maroon spoons with meals. On 5/3/23 at 11:45AM, Surveyor observed R13 in bedroom sitting in wheelchair eating lunch. No staff were present in R13's room. At 11:55AM, CNA picked up roommate's tray and told R13 she would be back to check on him. At 12:10PM, Surveyor observed on resident's tray a maroon spoon, fork, and knife. R13 had a lipped plate and a Styrofoam cup with a straw. 100% of meal was eaten. R13's meal ticket states, in part; Regular/mechanical soft. No silverware only maroon spoon. Colored spoon, inner lip plate. Provale cup @ meals for thin liquids. Special Notes: Allergies: yellow dye, sorbitol. No bread products. Total assist, Supervision at all times when eating. Meat to be chopped by CNA. Dislikes: Salt, Butter. On 5/3/23 at 12:15PM, Surveyor interviewed CNA S, CNA S indicated R13 shouldn't have a fork or knife on his meal tray. CNA S indicated she does not know what a Provale cup is and has never seen one. CNA S indicated R13 usually eats in dining room, and he shouldn't eat alone. (continued on next page)

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Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/23 at 12:20PM, Regional Dietician K indicated R13 has the maroon spoon because he takes large bites of food. Regional Dietician K indicated R13 shouldn't have silverware on his tray, and he should have a Provale cup. R13 was left in his room unattended and should have had staff present when received his meal tray due to risk for choking or pneumonia related to swallowing difficulties. R13 was left unattended and unsupervised which placed R13 at risk.

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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** 44552 Based on observation, interview, and record review, the facility did not ensure adequate nutrition monitoring and weight management for 1 resident (R10) of 2 residents reviewed for nutrition/weight management. R10 did not receive adequate nutrition and supports to maintain a stable weight. Evidenced by: The facility policy, Nutritional Management with no date, states, in part; Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall his or her stay.Compliance Guidelines: A systematic approach is used to optimize each resident's nutritional status: Identifying and assessing each resident's nutritional status and risk factors. Evaluating/analyzing the assessment information. Developing and consistently implementing pertinent approaches. Monitoring the effectiveness of interventions and revising them as necessary . Identification/assessment: .The dietary manager or designee shall obtain the resident's food and beverage preferences upon admission, significant change in condition, and periodically throughout .Interventions will be individualized to address the specific needs of the resident. Examples include but are not limited to: Diet liberalization unless the resident's medical condition warrants a therapeutic diet. Altered- consistency food/liquids after underlying causes of symptoms are addressed (i.e., new dentures, dental consult, dysphagia therapy). Weight-related interventions. Environmental interventions. Disease-specific interventions. Physical assistance or provision of assistive devices. Interventions to address food-drug interactions or medication side effects. Real food will be offered first before adding supplements. Tube feeding or parenteral fluids will be provided in the context of the resident's overall clinical condition and resident goals/preferences. Monitoring/revision: Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis. Examples of monitoring include Interviewing the resident and/or resident representative to determine if their personal goals and preferences are being met. Directly observing the resident. Interviewing the direct care staff to gain information about the resident, the interventions currently in place, what their responsibilities are for reporting on these interventions, and possible suggestions for changes if necessary. Reviewing the resident-specific factors identified as part of the comprehensive assessment to determine if they are still relevant or if new concerns have emerged such as new diagnoses or medications. Evaluating the care plan to determine if current interventions are being implemented and are effective. The resident will be monitored for complications associated with interventions. The care plan will be updated as needed .Informed consent: The facility shall discuss the risks and benefits associated with the resident/representative decision and offer alternatives, as appropriate. The comprehensive care plan should describe any interventions offered but declined by the resident or resident's representative. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Weight Assessment and Intervention, Revised September 2022, states, in part; The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Policy Interpretation and Implementation .3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician and MD in writing. Verbal notification must be confirmed in writing .4. The Dietician will respond with written notification .6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria .a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months- 10% weight loss is significant; greater than 10% is severe . R10 was admitted to the facility on [DATE] with diagnoses including: hyperosmolality and hypernatremia, chronic embolism, and thrombosis of unspecified deep veins of unspecified distal lower extremity, chronic pain, major depressive disorder, benign prostatic hyperplasia without lower urinary tract symptoms, kidney disease, muscle wasting, anxiety disorder, and degenerative disease of nervous system. R10's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/29/23, indicates R10 has a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. R10 has an Activated Health Care Power of Attorney. R10's MDS dated , 1/29/23 under Section K-Swallowing/Nutritional Status indicates, in part; R10 holding food in mouth/cheeks or residual food in mouth after meals and coughing or choking during meals or when swallowing medications. R10's current weight 119#. R10 requires extensive assist with physical staff assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. R10 requires supervision with one-person physical assist for eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's Comprehensive Care Plan dated 5/29/21 indicates, in part; Focus: NUTRITION/HYDRATION: I am at risk for complications with nutrition/hydration d/t (due to) need for mechanically altered diet and fluids. Goal: I will consume and tolerate at least 75% of meals to help maintain nutritional status with no s/s (signs and symptoms) of dehydration and malnutrition Revision on: 2/28/23. No sig wt. (Significant weight) changes x 30-180 days Gradual weight will not experience negative effects related to dehydration/fluid deficit. I will accept a diet or consistency deemed appropriate per SLP/MD (Speech Language Pathologist/Medical Doctor) with no s/s of aspiration, choking, chewing, or swallowing difficulties. Interventions: Discuss nutritional approaches with IDT (Interdisciplinary team) as needed. Review with nurse prn (as needed) for changes in medical status that may impact nutritional stress. Encourage diet compliance 6/22/22. Obtain weight per facility protocol using same weight method for weight trend accuracy. Report significant weight changes to MD/NP and RD/DM (Registered Dietician/Dietary Manager). Provide oral supplements per MD order-resident declines supplements offered. Resident does not like chocolate. Resident chooses not to eat in dining rooms dt reports being embarrassed by eating in front of other people 11/1/22. Resident is now a complete 1:1 FEED 3/29/23. Resident wishes not to get up in w/c for meals 11/1/22. Diet type: Regular. Diet Texture: Puree. Fluid consistency: Honey thick. Lg portions recommended 9/13/22. Adaptive equipment: lipped plate 5/29/21. See Dietary profile for fluids provided with meals nursing to offer and encourage fluids with medication pass. Meds and labs as ordered per MD. Observe for S&S of dehydration 5/29/21. Offer 1:1 supervision sitting upright for all PO intake, slow pace alternate food and fluid, frequent throat clearing 11/21/22. Offer fluid with each encounter due to need of 1:1 supervision for all PO intakes; 3/19/22 hydration protocol 120 cc honey thick liquids qid (Four Times a Day) between meals and HS 5/29/21. R10's Certified Nursing Assistant (CNA) Care Card dated, 5/3/23, indicates, in part; MONITOR: Monitor/document/report PRN any s/sx of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. ADL: EATING: honey thick liquids, pureed texture, encourage to ask for help as needed. Eating follow up intervention: for meals, staff to offer appropriate positioning in bed, offer assistance with eating and review the swallow strategies if resident allows. Meals to be served on a LIP PLATE. Eating: Provide oral supplements per MD order- resident declines supplements offered. Resident does not like chocolate. Dining/Eating/Nutrition: Diet type: Regular. Diet Texture: Puree. Fluid consistency: Honey thick. Lg portions recommended 9/13/22. Adaptive equipment: lipped plate. Offer 1:1 supervision sitting upright for all PO intake, slow pace alternate food and fluid, frequent throat clearing. Offer fluid with each encounter due to need of 1:1 supervision for all PO intakes; 3/19/22 hydration protocol 120 cc honey thick liquids qid between meals and HS. Adaptive equipment as suggested/requested by therapy. Check mouth after meal for pocketed food and debris. Report to nurse. Provide oral care to remove debris. Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. Resident to eat only with supervision. Monitoring: Obtain weight per facility protocol using same weight method for weight trend accuracy. Report significant weight changes to MD/NP and RD/DM. Surveyor reviewed R10's Nutritional assessment dated [DATE]. Nutritional Assessment states, in part; most recent weight 123.4. Status: WRWR (within recommended weight range) 3 months gain. 6 months stable . Resident continues on a regular, pureed diet w/honey thick liquids. Receives large portions and mighty shake daily to help meet his ENN (Estimated Nutritional Needs). Consumes 50-100% of most meals. Wts reviewed. Wts: 12/23/22 123.8 lbs., BMI (Body Mass Index) 21.9 wt. hx (History) 11/15/22 117 lbs. 9/7/22 114.2 lbs. 7/14/22 120 lbs. Goal is for weight maintenance. No new concerns or recommendations at this time. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R10's Nutritional assessment dated [DATE]. Nutritional Assessment states, in part; Diet order: regular, puree, honey thickened liquids, w/large portions might shake 4 oz once a day. Intake: fair. most recent weight 102.1 Status: underweight. 3 months: -17.2# (-14.4%) 6 months: -18.2# (-15.1%) Significant weight changes Yes. Planned weight changes no Assessment: .intakes have been variable over the last 30 days .monitor dehydration risk. 1:1 feeder recent order (3/29/23) .Res doesn't like current diet texture leading to decreased oral intakes. Slightly better appetite lately. Wts reviewed. Wts: 4/17 102.1# BMI 18.1 underweight, signif (Significant) wt. loss 3 (14%) & 6 mos (15%), undesired. Possible wt. loss given dysphagia, decreased po intake/appetite, dislikes facility food r/t texture, depression dx. Goal is wt. maintenance/wt. gain .Plan/Recommendations: Recommend prune juice 40z honey thickened once a day recommend adding magic cup 4oz BID Recommend ST evaluation for possible diet upgrade recommend weekly wt. until week (5/8/23). Surveyor reviewed R10's Weight Summary. Weight Summary states, in part. 12/23/22 123.8 lbs. 1/25/23 119.3 lbs. It is important to note no weights were taken in the months of February and March 2023. 4/14/23 95 lbs. 4/17/23 102.1 lbs. Surveyor reviewed R10's Nursing Progress Notes. Progress Note from 3/29/23 states, Note Text: Resident has expressed to his POA (Power of Attorney) that he realizes that he can no longer feed himself and he is now a 1:1 FEED. Nursing order entered, Care Plan updated, CNA Care Guide updated. R10's most recent Dietary Progress Note dated 4/17/23 indicates, in part; Note Text: Nutritional Significant wt. loss: Res with a significant wt. loss reported x 3 mos & 6 mos. CBW (Current Body Weight): 95# (4/14/23), Ht (Height) 63 in. BMI 16.8 underweight for geriatric age. Recent wt. obtained after almost 3 mos w/o one. Significant wt. loss reported x 3 mos (24.3# 20.3%) & 6 mos (25.3# 21%) Significant wt. loss contributions include: depression/anxiety, dysphagia dxs, (Diagnosis) advanced age, hx TIA/cerebral infarction. Writer spoke with RN this morning, no concerns indicated over the weekend regarding dietary concerns. No tolerance concerns indicated too. Writer spoke with res, reports not liking the food because of the texture. No food preference updates. Writer suggested having Magic cup supplement agreeable. Res is on a regular, puree texture, honey thickened liquids with large portions at meals. Nutritional supplement: mighty shake 40z once a day, continue as tolerable & thickness appropriate. Writer plans to add additional supplement (magic cup). Meal intakes have been variable over the last 30 days documented being ~71% (0-25% x3, 26-50% x6, 51-75% x14, 76-100% x13, refuses x2). Fluid intakes over the last week documented has been b/w 180-720ml/d, no s/s of dehydration reported. Push thickened fluids ordered (7/6/21). Monitor dehydration risk, 1:1 feeder recent order (3/29/23). No BM documented since 4/10, recommended adding prune juice given no BM. No n/v. Skin is intact (4/6/23). Meds reviewed: noted multivit, mom, trazodone, finasteride, folic acid, B1, topiramate, florajen3, senna-plus, MiraLAX, sertraline, tamsulosin. Recs: recommend prune juice 4 oz daily honey thickened, magic cup BID, recommend reweigh & weekly wts x4 to maintain accuracy, recommend ST evaluation. Goals: no significant wt. loss triggers, po intake 75% food & fluids, maintain skin integrity, diet texture tolerance. RD to f/u PRN (follow-up as needed.) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is important to note there are no dietary progress notes from 12/29/22-4/16/23. There are no weights in February and March 2023. Rehabilitation Screen Change in status: 4/17/23 Findings: Dietician reporting significant weight loss, indicating SLP screen for diet: Puree textures appropriate at this time. Recommend continue current diet, provide assistance with eating (1:1) with slow pacing of presentation. Bring out R10 tray first and assist with feeding while food is warm to promote increased intake. Signed on 4/18/23. Surveyor reviewed R10's Nursing Progress Notes. Progress Note from 4/19/23 states, Note Text: Resident refused re-weigh, states they already got weight yesterday. Resident weight is down, NP (Nurse Practitioner) to be updated once re-weight is obtained. It is important to note there are no other attempts to be weighed documented in R10's Progress Notes. Surveyor reviewed R10's current Medication Administration Record/Treatment Administration Record (MAR/TAR) for 5/23. MAR/TAR states, in part. Mighty Shake one time a day for nutritional support start date 1/19/23. Push Po (oral) thickened fluids every shift, give extra cup with each med pass encourage resident to drink fluids every shift for hydration start date 7/6/21. Resident now is a 1:1 FEED. Please keep CNAs updated. Every day and evening shift for nutrition start date 3/29/23. It is important to note the additional supplement Registered Dietician had recommended on 4/17/23, Magic Cup was never added to R10's MAR/TAR. Surveyor reviewed R10's Nutrition Documentation for 2/1/23- current. Nutrition Documentation states, in part; No meal intake documented for 27 out of the 92 days reviewed. 34 days out of the 92 days reviewed did not document all meals. A review of snack documentation shows most days blank and several show resident refusal. A review of fluid intake from 2/1/23- current shows 35 of the 92 days reviewed were blank. On 5/3/23 at 11:05AM, CNA G (Certified Nursing Assistant) indicated there is no one on her hallway that requires 1:1 assistance with eating. (It is important to note CNA G works on R10's hallway.) On 5/3/23 at 11:30AM, Surveyor observed R10's lunch tray delivered to R10's room. Surveyor observed CNA G and a CNA in training leave R10's room. Surveyor observed R10's room door closed and no staff assisting R10 with meal. On 5/3/23 at 11:48AM, Surveyor went into R10's room. R10's hands were shaking while attempting to eat meal. R10 started to yell at Surveyor, but Surveyor was unable to understand R10. Surveyor asked R10 if R10 needs assistance with meal. R10 stated, Yes. On 5/3/23 at 11:50AM, Rehab Director L came into R10's room. Rehab Director L indicated Rehab Director L asked a staff to come into R10's room for supervision and support. Rehab Director L indicated R10's meal trays are to be delivered to R10's room before other trays and that staff should supervise and offer R10 assistance. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/23 at 12:20PM, Regional Dietician K indicated she is at the facility three days a week and acts as the Dietary Manager when she is at the facility until the facility hires for the position. RD K indicated she has been doing this for the last couple of months and Registered Dietician P is at the facility every Monday and assists with Dietary Manager tasks as well. Registered Dietician P is responsible for all things clinical. Surveyor asked RD K about R10 and the support that R10 requires with meals. RD K indicated she just got done writing a note for all staff regarding R10 and assistance. RD K provided Surveyor with the following communication to kitchen staff: Attention Staff: R10 tray needs to be the 1st one made and delivered prior to starting meal service for the rest of the residents. Cook is to deliver meal to his room and then notify CNA and nurse that it has arrived so they can assist with his meal as needed. Surveyor asked if this information was shared with the kitchen today (5/3/23). RD K indicated yes; it was just shared a few minutes ago. On 5/3/23 at 3:30PM, Rehab Director L indicated recommendations that Speech Therapy makes goes straight to Dietary Manager and Nursing. Rehab Director L indicated the recommendations for assistance for meals goes directly to nursing. Rehab Director L indicated the level of assistance needed and any recommendations made by Speech Therapy is documented in the resident Comprehensive Care Plan and the CNA Care Card. Rehab Director L indicated he is not sure if it would be on the resident meal ticket. Rehab Director L indicated it is standard practice that Rehab Director L assists with meal trays and ensures residents receive the correct assistance during meals. Rehab Director L indicated he is not sure about supper or the weekend hours, but that Rehab Director L will often assist for breakfast and lunch mealtimes. Rehab Director L indicated weight changes are discussed at the morning meeting that is held every day. Registered Dietician P is responsible for weight changes and offering recommendations. Registered Dietician P is the acting Dietary Manager on Mondays for the facility, and he is present at the morning meetings on Mondays. Rehab Director L indicated Registered Dietician P has been at the facility for around one month. On 5/4/23 at 7:15AM, Rehab Director L indicated to Surveyor that a spot check on R10's breakfast tray was completed this morning. R10 received his breakfast tray and supervision was provided. On 5/4/23 at 8:30AM, CNA M indicated R10's shower day was Thursdays, and that staff should weigh resident on shower days. On 5/4/23 at 9:15AM, NP D (Nurse Practitioner) indicated NP D first met R10 on 4/17/23. Previously, R10 was being seen by the Medical Director. NP D indicated R10's friend/POA requested R10 to switch providers. NP D indicated on 4/17/23 she noted R10 to have significant weight loss. NP D indicated R10 reported he hates the supplement Mighty Shake and will often decline it. NP D indicated there were malnutrition concerns and that R10 requires 1:1 assistance. NP D indicated she fed R10 dinner on 4/17/23 and that R10 ate around 50% of his meal and that he requested ice cream at that time. NP D indicated from what she is understanding R10's ability to self-feed has declined over the last several months. NP D indicated R10 reported that R10 hasn't been able to eat on his own. NP D indicated R10 didn't decline feeding assistance when she supported him on 4/17/23 and that R10 was able to verbally share with NP D what he wanted to eat and not eat. NP D indicated she has received no further updates on R10's weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R10's initial visit summary with NP D from 4/17/23, states, in part; .Underweight Weight loss Severe malnutrition. Weight 119.3 lbs. (1/25/23) 95 lbs. (4/14/23). Staff reports ongoing hydration encouragement Q (every) shift. Per chart review appears that R10 is ordered a mighty shake for nutritional support, though he reports to be during our visit that he hates that and declines to drink it when offered. Unclear if he is regularly receiving nutritional supplement R10 unable to self-feed and requires 1:1 assistance with all PO (oral) intake On 5/4/23 at 10:30AM, CNA M indicated R10 had a bed bath this morning and declined being weighed. Surveyor asked what the process is if someone declines. CNA M indicated she was going to talk to CNA G because she is the main staff down R10's hallway and has a good relationship with R10. CNA M indicated staff should reapproach and ask later if a resident declines being weighted. On 5/4/23 at 10:40AM, LPN O (Licensed Practical Nurse) indicated R10 is now a 1:1 assistance with eating and that sometimes R10 declines being assisted. R10's POA (Power of Attorney) is adamant that R10 needs assistance with eating and the POA will sometimes feed him during meals, but POA is not at the facility for every meal. LPN O indicated that possibly R10 has declined being weighed, but that LPN O only sees one note in the progress note of R10 declining being re-weighed. LPN O indicated typically if there is no specific order for a resident on being weighed, it should be completed on the resident's shower day. On 5/4/23 at 10:50AM, RD P (Registered Dietician) indicated, Unfortunately, R10 hadn't gotten weighed for a couple months. RD P indicated RD P saw R10's most recent weight of 95 lbs. from 4/14/23 because RD P reviews weights that are documented in Point Click Care. RD P indicated R10 was weighed again on 4/17/23 and was 102.1 lbs. and that is still considered a significant weight loss. RD P indicated RD P then wrote the Dietary note in R10's Progress Notes. RD P indicated he documents in Progress notes and emails out a summary as well. Surveyor asked who receives the email summary. RD P indicated DON (Director of Nursing), Administrator, Manager's, and corporate staff that are assisting. RD P indicated the additional supplement was recommended, prune juice added because R10 had no BM (Bowel Movement) documented, R10 indicated he hates his diet and Speech is working with him on that now, and that staff should weigh R10 weekly x4. Surveyor asked if RD P could see in Point Click Care if RD P's recommendations were followed through on for R10. RD P indicated It does appear that the recommendations have not been done. Surveyor asked RD P if he would expect staff to document all meal and fluid intake. RD P indicated he would expect staff to document. Surveyor asked RD P who is responsible for following through on getting orders for the additional supplements and weights. RD P indicated, Generally the DON (Director of Nursing) or nursing manager would place those orders, it got dropped. RD P indicated that possibly the error is due to all the staffing concerns. Surveyor asked RD P if RD P was the acting Dietary Manager when he is at the facility on Mondays. RD P indicated No, I would not say that I am acting as a Dietary Manager. On 5/4/23 at 11:14AM, Cook Q indicated he was told yesterday (5/3/23) to serve R10's meal trays first. Cook Q indicated previously he was not instructed to do this. On 5/4/23 at 12:00PM, R10 indicated he hates chocolate ice cream. Surveyor observed chocolate ice cream on lunch tray. R10 threw chocolate ice cream on floor. CNA G expressed understanding of R10 and his strong dislike of chocolate ice cream. Surveyor observed no supplements on R10's meal tray. CNA G indicated that R10 has agreed to get weighed. CNA G and CNA in training supported R10 in being weighed. CNA G indicated R10's current weight is 111.6 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R10's Meal Ticket, states, in part; Special Note: large portions for all meals. No spicy foods, no chocolate, no orange items, no cranberry. Send applesauce with all meals. Likes apple juice. Send prune juice with breakfast-add thickened packets with meal tray. Magic cup with lunch and supper. On 5/4/23 at 2:30PM, IDON B (Interim Director of Nursing) indicated she does not see a specific order for R10's weights, so it would need to be completed monthly. IDON indicated there does appear to be some communication break down and that she would add this to the facility performance plan for weight concerns. IDON indicated she would expect RD P's recommendations to be followed through on. IDON indicated all supplements come from nursing and not the kitchen. IDON indicated there should be an order for the magic cup supplements. IDON indicated she would expect staff to reapproach and document if someone declines being weighed. IDON indicated a re-weigh should have happened after 4/17/23. IDON indicated she will update R10's order that states 1:1 feed because it is a poor choice of words.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on staff interview and record review, the facility did not ensure that pain management was provided consistent with standards of practice for 1 of 1 sampled resident (R4) out of a total sample of 16. The facility did not thoroughly assess R4's pain according to standards of practice. R4 did not receive pain medications as ordered. Evidenced by: The facility's Pain Management policy, undated, states in part . Policy: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Policy Explanation and Compliance Guidelines: The facility will utilize a systematic approach for recognition, assessment, treatment, and monitoring of pain. Recognition: In order to help a resident, attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. Manage and prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. Facility staff will be aware of verbal descriptors a resident may use to report or describe their pain. Pain Assessment: The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. Review the resident's current medical conditions (e.g., pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, post CVA (cerebral vascular accident), venous and arterial ulcers, and multiple sclerosis). Identifying activities, resident care and treatment that precipitate or exacerbate pain and those that reduce and eliminate pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current prescribed pain medications, dosage, and frequency, including medication assisted treatment for OUD Additional symptoms associated with pain (e.g., nausea, anxiety). Pain management and Treatment: Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor, and revise as necessary interventions to prevent or mange each individual resident's pain beginning at admission. The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal. Non-pharmacological interventions will be included but are not limited to: Environmental comfort measures Loosening any constrictive bandage, clothing, or device Physical modalities Cognitive/behavioral interventions R4 was admitted to the facility on [DATE] with diagnoses including . Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, nontraumatic intracranial hemorrhage, reduced mobility, muscle weakness, dementia, psychotic disturbance, mood disturbance, anxiety, and acute kidney failure. R4's most recent Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview of Mental Status (BIMS) of 8, indicating R4 has moderate cognitive deficits. In R4's most recent MDS, section G0110 indicates extensive assist of one staff is needed with bed mobility, transfers, hygiene, and dressing. R4 is dependent of one staff member for toileting. R4 is always continent of bowel and bladder. M0150 - At Risk for Pressure Injury. Yes. M0210 - Unhealed Pressure Injury. Yes. M0300 - Stage 2. M1200 - Skin and Ulcer Treatments: Pressure reducing device for bed; Pressure reducing device for chair; Nutrition or hydration intervention to manage skin problems; pressure ulcer care; applications of dressing to feet (with or without topical medications). R4's most recent Pain Assessment was requested by Surveyor and not received from facility prior to exit. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Comprehensive Care Plan, initiated 9/9/22, revised 4/26/23, states in part . Focus: Resident has Impaired Skin Integrity: Right heel pressure injury non-stageable and right foot 2nd toe callous. Interventions: Keep Mepilex on coccyx to prevent potential wound, initiated 3/8/23; measure area weekly, initiated 9/9/22; monitor for s/sx (signs and symptoms) of infection, initiated 9/9/22; monitor for s/sx (Signs and Symptoms) of worsening skin tissue, initiated 9/9/22; monitor pain and offer PRN (as needed) analgesic as ordered, initiated 9/09/22; treatment as ordered, initiated 9/09/22; update MD (medical doctor) with changes in wound status and PRN, initiated 9/09/22. R4's Comprehensive Care Plan, initiated 11/13/21, states in part . Focus: PAIN: Potential for complications with pain r/t (related to) hx (history) of TIA (transient ischemic attack), DM2 (diabetes mellitus type 2). Interventions: Acceptable level of pain is 3; Encourage rest periods; Meds(medications)/Labs/Txs (treatments) as ordered, observe medications for effectiveness. If ineffective after following MD orders, need to review sx's (symptoms) with MD for recommendations; Position for comfort as needed; Seek residents' interpretation of pain and pain management for effectiveness of medications. R4's CNA Kardex states in part . - 5/3/23-acceptable pain level 5-6 - Report pain to nurse R4's Physician Orders include, in part: - On 3/26/23 - Lorazepam Tablet 0.5 MG. Give 1 tablet by mouth every 3 hours as needed for comfort, anxiety, nausea, restlessness. - On 4/2/23 - Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate). Give 0.5 tablet by mouth every 24 hours as needed for pain with wound care to be given daily, 1 hour prior to right heel wound care. - On 2/7/23 - Acetaminophen Oral Tablet 500 MG (Acetaminophen). Give 2 tablets by mouth three times a day for Pain. Take 2 tabs = 1000mg TID (three times a day). - R4 to be premedicated 1 hour PRIOR to (RIGHT heel) wound care with Morphine 7.5mg (milligrams) AND Lorazepam 0.5mg (Note: both medications are available under PRN medications) every shift for pain management. Start Date: 4/2/23. Review of R4's eMAR (electronic medication administration record) for April and May states in part . Lorazepam Tablet 0.5 MG. Give 1 tablet by mouth every 3 hours as needed for comfort, anxiety, nausea, restlessness. Lorazepam was not given as ordered prior to wound care on the following dates: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/3/23, 4/7/23, 4/9/23, 4/10/23, 4/12/23, 4/13/23, 4/14/23, 4/15/23, 4/16/23, 4/17/23, 4/18/23, 4/19/23, 4/21/23, 4/24/23, 4/25/23, 4/26/23, 4/28/23, 4/29/23, 4/30/23, 5/2/23, and 5/3/23. Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate). Give 0.5 tablet by mouth every 24 hours as needed for pain with wound care to be given daily, 1 hour prior to right heel wound care. Morphine Sulfate was not given as ordered prior to wound care on the following dates: 4/3/23, 4/5/23, 4/7/23, 4/9/23, 4/10/23, 4/13/23, 4/15/23, 4/17/23, 4/21/23, 4/24/23, 4/25/23, 4/26/23, 4/28/23, 4/29/23, 4/30/23, 5/2/23, and 5/3/23. Review of R4's eMAR pain rating are as follows . On 4/11/23, Days, pain rating of 3 On 4/14/23, Days, pain rating of 1 On 4/14/23, Evening, pain rating of 2 On 4/16/23, Evening, pain rating 2 On 4/19/23, Days, pain rating 7 On 4/19/23, Evening, pain rating 1 (Note: All other pain ratings are listed as 0.) Nurses Note dated 3/29/23 at 15:12 (3:12 PM), states, Writer updated POA (Power of Attorney) that the resident had been refusing his wound care related to pain and his refusal to get OOB (out of bed) at all. NP (Nurse Practitioner) also updated, and a request was made to pre-medicate for wound care. Resident has been angrier with people tending to me [sic], appears more despondent. Nurses Note dated 4/2/23 at 15:34 (3:34 PM), states, Received new order from NP (Nurse Practitioner) to start morphine 15mg tab: Take 0.5-tab (7.5mg) PO (by mouth) one-time daily PRN (to be given daily, 1 hour PRIOR TO right heel WOUND CARE). Also, R4 is to be premedicated 1 hour PRIOR to (RIGHT heel) wound care with Morphine 7.5mg AND Lorazepam 0.5mg (Note: both medications are available under PRN medications). Also Wound Care: Right foot, 2nd digit (scabbed area). Frequency: Daily, Cleanse with NS (normal saline), pat dry. Instructions: Paint 2nd digit with POCIDONE-IODINE 10% EXTERNAL SOLN (solution). Allow to dry. Keep open to air. Avoid pressure with medical devices. Orders to be placed in [electronic charting system name] and faxed to pharmacy. Nurses Note dated 4/2/23 at 22:30 (10:30 PM), states, Resident allowed writer to complete wound care to heel this shift and tolerated it well. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurses Note dated 4/9/23 at 16:10 (4:10 PM), states, R4 to be premedicated 1 hour PRIOR to (RIGHT heel) wound care with Morphine 7.5mg AND Lorazepam 0.5mg (Note: both medications are available under PRN medications) every shift for pain management. Pain medications not administered this shift d/t (due to) treatment to RLE (right lower extremity) not being completed. Resident denies pain, nonverbal indicators of pain not present by direct observation. Nurses Note dated 4/11/23 at 13:34 (3:34 PM), states, Resident daily heel dressing and toe wound care completed. Resident was premedicated 1 hour prior to treatment with ordered Morphine and Lorazepam. Resident tolerated wound care well and even stated I don't feel a thing. No facial grimacing noted until resident sock put back on. Nurses Note dated 4/17/23 at 14:48 (2:48 PM), states, The resident refused all treatments today. Writer did call residents POA at 1445 (2:45 PM) and informed him. Writer did explain that writer being new and not knowing the resident's routine may have affected residents' refusal. Writer expressed using a different strategy tomorrow. The resident is currently laying in his bed wake showing no signs of pain or distress. Not placed in 24-hour report. Nurses Note dated 4/17/23 at 15:01 (3:01 PM), states, NP notified and writer was instructed to ask oncoming shift to attempt dressing change with resident. Oncoming nurse notified. Hospice Note dated 4/6/23 at 10:57 AM, states in part . Pain Assessment: Is pain an active problem? No. Additional Comments: Patient denies pain at baseline during visit. Patient received prn morphine and prn lorazepam prior to wound care. He stated god damn it a few times during dressing change and reports area is sensitive. Encounter Notes: RN performed comprehensive assessment, medication reconciliation, and plan of care review. Writer contacted facility with ETA (estimated time of arrival) and requested patient be administered prn morphine and prn lorazepam at 0900 (9:00 AM) prior to visit. Receptionist reports she will pass on the information to RN. Writer checked in with RN prior to visit. She reports patient has not been administered prns (as needed) but will administer them right now. Hospice Note dated 4/13/23 at 11:34 AM, states in part . Pain Assessment: Is pain an active problem? Yes. Additional Comments: Pain is observed during wound cares only. Patient denied pain at rest and appeared comfortable. Encounter Notes: Writer attempted to call facility x3 (times three) to ask staff to give PRN Lorazepam and MSIR (Morphine Sulfate immediate release) prior to wound cares writer would be completing, writer unable to reach anyone. Team checked in with agency RN. Agency RN reports she had given PRN Lorazepam and MSIR about 45 minutes prior and had not done his wound care yet. Writer noted I will complete today, Agency RN appreciative. Agency RN reports patient had been lethargic and grumpy the past few days, but is in better spirits and ate a large breakfast this AM. No s/sx (signs or symptoms) of pain or discomfort, though patient does hang his R (right) heel off edge of bed. Writer completed wound care to R heel wound per orders with assistance. Patient noted to have some pain and anxiety throughout wound cares, though it is improved from prior to when pre-meds were being given. Patient denied pain after wound cares are completed and calmed immediately. Follow-up needed: Monitor pain/anxiety with wound care to R heel - should PRN doses of Lorazepam and MSIR be increased? (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice Note dated 4/20/23 at 11:30 AM, states in part . Pain Assessment: Is pain an active problem? Yes. Additional Comments: No noted signs of pain or discomfort upon writer's arrival/assessment. Patient denied any pain. Patient is severely agitated during wound care to R heel - when asked if he is having pain during wound care he states, 'Maybe a little.' Med Management: Per NP - PRN Morphine 8x (8 times) in April, PRN Lorazepam 6x (6 times) in April (PRN Morphine is ordered to be given daily prior to wound cares). Encounter Notes: Writer asked nurse to give PRN Morphine and Lorazepam so writer could complete wound cares - Nurse did so. Writer saw patient about one hour after this. Patient is sleeping in bed upon arrival, wakes to writer's presence and noted to be calm, cooperative, and pleasant. Writer completed physical assessment - no noted changes or concerns. Patient's mood quickly shifted when writer began to assess R heel wound, and patient became very agitated with writer, saying, 'Don't you know when to leave well enough alone?' During wound cares, writer asked patient if he was in pain, patient states, 'maybe a little.' Writer able to complete wound care, patient noted to shake his fist at writer after wound cares. Call placed to NP with update. NP reviewed facility PRN use and updated writer that PRN Morphine has been given 8x in April and PRN Lorazepam has been given 6x in April (PRN Morphine is ordered to be given daily prior to wound cares), and writer had recommended us of PRN Lorazepam prior to wound cares (NP states she will update orders for PRN Morphine 7.5mg and PRN Lorazepam 0.5mg to BOTH be given 1 hour prior to wound cares daily. NP would not like to make additional changes at this time since medications are not consistently being given prior to wound cares. NP sent orders to facility. No further needs or concerns. Hospice attending updated via fax. POA updated. Follow-up needed: Ensure facility is giving pre-medications prior to wound cares. Hospice Note dated 4/27/23 at 11:49 AM), states in part . Pain Assessment: Is pain an active problem? No. Encounter Notes: Focused visit performed d/t (due to): Weekly wound care and assessment. Upon arrival, writer asked facility nurse to administer PRN Lorazepam and PRN Morphine as patient has orders for pre-medication for wound care. Facility nurse states that patient does not need pre-medications and 'he has been fine for about the last week without pre-medications, as long as you talk to him and distract him.' Writer clarified that patient has orders in place to receive both PRN Lorazepam and PRN Morphine 1 hour prior to wound cares each day. Facility nurse stated, 'I know, but he doesn't need them.' Facility nurse noted she will give pre-medications if writer would like. Writer asked that she please give the medications as patient was very agitated at writer's last wound care visit and he has orders to receive these medications. Wound care performed to R heel wound per orders; R heel wound is greatly improved. Training Provided: Patient has orders for pre-medications prior to wound care, call Hospice with needs or concerns. Follow-up needed: Continue current plan of care. Hospice Note dated 4/28/23 at 8:27 (8:27 PM), states in part . Encounter Notes: Signs/sx (symptoms) of advanced disease or symptom burden: fatigue, refuses to get out of bed, oriented to person only, wound to R heel, pain associated with R heel wound, increased agitation with cares. On 5/03/23 at 8:42 AM, Surveyor observed RN E complete wound care with R4. As RN E was removing the old dressing and cleaning the pressure injury site. R4 stated on two occasions, Ouch that hurts as he attempted to pull his leg away from RN E. RN E stated to Surveyor, R4 has scheduled pain medication to be given prior to his wound treatment but he does not need them. I asked him if he is having any pain and if he states he is not then I do not give them. If you take your time and talk with him, he is fine. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/23 at 9:03 AM following wound care, Surveyor interviewed RN E (Registered Nurse). Surveyor asked RN E if she had time for a few questions. RN E stated, R4 did complain of pain during the treatment when the old dressing was removed, and the area was cleansed. On 5/3/23 at 2:02 PM, Surveyor interviewed NP D. Surveyor asked NP D (Nurse Practitioner) about R4's premedication orders for wound care. NP D stated, The staff in the facility may only document that they were given in the Narcotic Log, which I have been getting on them about. Staff should be updating Hospice prior to updating me. Medications ordered prior to wound care should be given every time. R4 will always say he is not in pain but when you go to complete wound treatment he comes very agitated. Medications need to be given every time, so he is comfortable. (Note: Surveyor reviewed R4's eMAR (electronic medication administration record) which indicates medication was given.) On 5/3/23 at 11:02 AM, Surveyor interviewed RN E. Surveyor showed RN E R4's eMAR and asked about her initials on the order for Morphine and Lorazepam one hour prior to wound care. RN E stated, That is just that I am acknowledging the order. When they are signed out as given, we do that under the PRN medication orders. I should have put a note in stating I didn't give it. I always ask if he wants it or is in pain. If he is not having pain, I don't give it. On 5/4/34 at 9:20 AM, Surveyor entered R4's room to see Hospice RN F just finishing wound care. Surveyor asked Hospice RN F how R4 tolerated his wound care. Hospice RN F stated, He was not happy with wound care today. I had talked with the nurse on duty and asked that the resident be pre medicated but it did not appear as if he was. I have talked with the NP numerous times about his pain with wound care. R4 is not able to indicate pain but when in pain expresses it with agitation. R4 needs to be premedicated as he does not have the ability to recognize pain and with diagnoses needs these medications. On 5/4/23 at 9:28 AM, Surveyor interviewed R4. Surveyor asked R4 if he was having any pain with heel wound care. R4 stated, I don't need pain medications. R4 then went on to talk about his age (which he stated incorrectly), being a veteran, and needing to try to get up and walk (resident unable to ambulate). On 5/4/23 at 9:54 AM, Surveyor was approached by RNC C (Registered Nurse Consultant). RNC C stated, I believe you have some concern with R4's pain. We wanted to follow up with him on wound care. With R4's BIMS he is good sometimes and not good other times. PAINAD being done on him today. Surveyor asked RNC C about nonpharmacological interventions used for R4. RNC C stated, As a nurse check, reassess and then do what is appropriate. 1:1 (one on one), sitting with him, help with repositioning for comfort. R4 does not like to accept pain medications. On 5/04/23 at 11:21 AM, Surveyor spoke with Hospice RN F. Surveyor asked Hospice RN F if she had spoken with someone at the facility prior to arrival about premedicating R4. Hospice RN F stated, I spoke with LPN T who stated R4 was premedicated. I found out he had not been. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/04/23 at 11:21 AM, Surveyor spoke with NP D. Surveyor asked NP D about R4's pain during wound care. NP D stated, R4 is not his own person and a poor historian. He us not able to understand which is reflected in his activation and cognitive assessments. He does not have the insight into the refusal of medications or treatments. Surveyor asked NP D what her expectations were if R4 is experiencing pain during wound care. NP D stated, Ideally staff would stop and offer nonpharmacological interventions and pharmacological interventions. On 5/03/23 at 12:06 PM, Surveyor interviewed IDON B (Interim Director of Nursing). Surveyor asked IDON B about R4's medications orders prior to wound care. IDON B stated, That is how I understand it. They need to offer it and they need to encourage him to take it. The expectation is for them to offer. Surveyor asked IDON B what staff expectations are if R4 refuses to take ordered medications. IDON B stated, Should be contacting NP or MD to notify of refusal. On 5/04/23 at 2:03 PM, Surveyor interviewed LPN T. Surveyor asked LPN T about R4's pain medications prior to wound care today. LPN T stated, I had asked R4 if he wanted the medications, and he didn't want anything for pain. On 5/04/23 at 2:13 PM, Surveyor interviewed IDON B. Surveyor asked IDON B what expectations were for staff if R4 is experiencing pain during wound care. IDON B stated, If resident is refusing staff should reapproach, report to the nurse, and someone should document if R4 is refusing medications or treatments. R4 has been experiencing pain with wound care. The facility failed to administer scheduled pain medication to control R4's pain during wound treatments.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 39713 Based on record review and interview, the facility did not ensure that Physician Orders were signed and dated timely for 6 of 16 resident records reviewed (R4, R6, R14, R15, R10 and R9). R4's monthly Physician Orders have not been signed or dated timely by the physician. R6, R14 and R15's monthly Physician's Orders have not been signed or dated timely by the physician. R10 has missing Physician Orders not signed or dated for February, March, and April 2023 The facility did not have signed Nurse Practitioner (NP) orders for new orders that were verbally given to the facility for R9. Evidenced by: The facility policy Medication Orders, undated, includes, in part, the following: Policy: This facility shall use uniform guidelines for the ordering of medication. Policy Explanation and Compliance Guidelines: Medications should be administered only upon the signed order of a person lawfully authorized to prescribe. Verbal orders should be received only by licensed nurses, or pharmacists, and confirmed in writing by the physician, on the next visit to the facility. Example 1 R4 has missing Physician's Orders not signed or dated as follows . February 2023 March 2023 April 2023 On 5/3/23 at 9:58 AM, Surveyor requested copies of R4's signed Physician's Orders since February 2023. IDON B (Interim Director of Nursing) stated, We have been having issues getting signed MD orders. On 5/3/23 at 10:44 AM, IDON B entered conference room to bring Surveyor R4's Physician's Orders. IDON B stated, We are out of compliance with this. Today I did have the NP who is following R4 sign and review the 'Order Summary Report.' On 5/3/23 at 2:02 PM, Surveyor interviewed NP D. Surveyor asked NP D if she reviews and signs monthly physician's orders and if not if she is aware who does. NP D stated, There have not been any signed Physician's Orders since October 2022. I do review medications on my end, but the facility does not know that. They are not printed for me or the residents PCP (primary care physician) to sign. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	29360 Example 2 R6 has missing Physician's Orders not signed or dated as follows: February 2023 March 2023 April 2023 Example 3 R14 has missing Physician's Orders not signed or dated as follows: March 2023 April 2023 Example 4 R15 has missing Physician's Orders not signed or dated as follows: March 2023 April 2023 On 5/4/23 at 3:30 PM Surveyor requested copies of R6's signed Physician's Orders since February 2023 and copies of R14's and R15's signed Physician's Orders since March 2023 from IDON B (Interim Director of Nursing). Surveyor did not receive any copies of the signed Physician's Orders. On 5/4/23 at 4:25 PM Surveyor interviewed IDON B. IDON B stated she was aware the facility was out of compliance for many months with signed Physician's Orders. IDON B stated no one has reconciled resident's Physician's Orders for many months. IDON B stated the facility needs to have resident's Physician's Orders reconciled and signed and dated. 44552 Example 5 R10 has missing Physician Orders not signed or dated for February, March and April 2023. On 5/3/23 at 9:58AM, Surveyor requested copies of R10's signed Physician's Orders from February 2023-current. Surveyor did not receive signed Physician Orders. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/4/23 at 5:30PM, IDON B (Interim Director of Nursing) provided Surveyor R10's Discharge Summary from when R10 was first admitted to facility from hospital in 2021. IDON B indicated, This is what I have for R10 .all I could find. 14305 Example 6 R9 was transferred to the hospital on 4/4/23. There was no signed provider order to reflect the transfer was ordered by the provider. On 5/3/23 at 2:20 PM, the Surveyor interviewed Nurse Practitioner D (NP). NP D verified she had given the above orders for R9. On 5/4/23 at 9:15 AM and at 11:10 AM, the Surveyor interviewed Interim Director of Nursing B (IDON) . IDON B verified signed provider orders were not located. IDON B stated she was unaware of how the facility received signed provider orders. IDON B indicated she did not know the facility process to receive signed provider orders and stated the facility was without a medical records person who usually monitors that process.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not ensure food was palatable and served at a safe and appetizing temperature. This practice has the potential to affect all 53 residents residing in the facility. The facility did not ensure hot foods were served hot to residents. Evidenced by: The facility policy titled, Maintaining a Sanitary Tray Line with no date, states, in part; Policy: This facility prioritizes tray assembly to ensure foods are handled safely and held at proper temperatures in order to prevent the spread of bacteria that may cause food borne illness. Compliance Guidelines: .During tray assembly, staff shall: .Use thermal bottoms, dome lids and equipment designed to maintain food temperature Cover all foods and beverages before transporting from the kitchen, unless the tray is being served in the dining room adjacent to the kitchen. (Napkins should not be used to cover food). Example 1 On 5/3/23 at 8:17AM, Cook I indicated the kitchen is incredibly short staffed. Cook I indicated they have not had a Dietary Manager for two months and there are two Regional Dieticians covering as Dietary Manager. Cook I indicated that most days it is Cook I and Dietary Aide J working alone in the kitchen. Cook I indicated they have a routine, and that the food is served on time and hot when they are working. Cook I and Dietary Aide J indicated when they are not working it is agency staff. Cook I and Dietary Aide J indicated they hear a lot of concerns regarding the food when it's agency staff in the kitchen. Dietary Aide J indicated they hear from residents and CNA's (Certified Nursing Assistants) that the meals are served very late, hot foods served cold, items do not have lids on them, and last week meals were served with no silverware. Example 2 R11 was admitted to the facility on [DATE] with a diagnoses including hypertension, diabetes, hyperlipidemia, kidney failure, chronic pain syndrome, pressure ulcer of sacral region, muscle weakness, other abnormalities of gait and mobility, and lack of coordination. R11's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 2/14/23, indicates R11 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R11 is cognitively intact. R11 is own person. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/23 at 8:45AM, R11 indicated when the facility does not use hot plates hot foods are served cold. R11 provided Surveyor pictures that R11 has on R11's cell phone of how meals were served. R11 shared with Surveyor pictures of nine meals served over the last month with no hot plates and that those meals were brought to R11 cold. R11 indicated R11 does not know why hot plates are sometimes used and other times not, but that it makes a huge difference in the temperature of his food. R11 indicated R11 could ask for meals to be heated up, but the facility is often so short staffed that it would take a long time to get the task completed. Example 3 On 5/3/23 at 12:15PM, RD K (Regional Dietician) indicated RD K has been assisting in the Dietary Manager role three days a week while the position has been vacant. RD K indicated that Registered Dietician P assists every Monday at the facility and is responsible for all things clinical. RD K indicated that the agency staff do not use the hot plates and that the food ends up being served cold. RD K said it is a work in progress to ensure agency staff are using the hot plates. RD K indicated that staffing has been terrible in the kitchen. RD K indicated RD K would expect hot foods to be served hot to the residents. Example 4 R12 was admitted to the facility on [DATE] with a diagnoses including malignant neoplasm of frontal lobe, expressive language disorder, traumatic subdural hemorrhage with loss of consciousness of unspecified duration, and major depressive disorder. R12's most recent MDS with ARD of 2/1/23, indicates R12 has a BIMS score of 15 indicating R12 is cognitively intact. On 5/4/23 at 7:15AM, R12 indicated when hot plates are not used the food is served cold. R12 indicated last Friday the staffing was terrible in the kitchen. R12 indicated there are times that food is served with no lids and no hot plates. R12 indicated to Surveyor last Friday there was a resident next to R12 for breakfast and this resident was served the wrong meal. R12 indicated the resident is a pureed diet and was served a regular diet. R12 indicated if that person was eating in their bedroom it could have been a different story. R12 indicated he told a Registered Nurse right away.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 14305 Based on record review and staff interview, the facility did not ensure the medical record were in accordance with accepted professional standards of practice for 1 (Resident 9) of 4 sampled residents. R9 was seen by a provider on 3/27/23 & 4/4/23. The medical record did not contain the provider notes. R9 was transferred to the hospital on 4/4/23. The medical record did not contain any progress notes that indicated R9's condition and the reason why R9 was being transferred to the hospital. Findings include: R9's Nursing Progress Notes dated 3/27/23 indicated R9 was seen by the Nurse Practitioner. The Progress Notes indicated: NP (Nurse Practitioner) here to look at the wound and follow up. New orders received. Please see Treatment Administration Record. The new orders were written in the medical record, but the NP's Progress Notes were not in the facility and not readily accessible. R9 was seen by the Surgeon on 4/4/23. The Progress Notes from the surgeon were not in the medical record and not accessible. On 5/3/23 at 2:20 PM, the Surveyor interviewed Nurse Practitioner D (NP). NP D stated she had seen R9 on 3/27/23 and facilitated the transfer to the hospital on 4/4/23. NP D indicated R9 was seen by the surgeon on 4/4/23 and the surgeon wanted R9 to be transferred to the hospital to receive a higher level of care. On 5/4/23 at 9:15 AM, the Surveyor interviewed Interim Director of Nursing B (IDON) regarding how the facility ensures provider Progress Notes are available. IDON B verified the Progress Notes with orders were not located and not accessible. IDON B indicated she was unaware on the facility ensures receiving Progress Notes from the providers as the facility currently did not have a Medical Records person employed. IDON B verified the medical record does not contain any documentation as to R9's condition or the reason R9 was transferred to the hospital or even that R9 had discharged from the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 14305 Based on observation, record review and staff interview, the facility did not assure an effective Infection Control program was being implemented for 1 (Resident 13) of 1 observation of cleaning a glucometer. Licensed Practical Nurse V (LPN) was observed to complete a blood glucose test for R13. LPN V wiped the glucometer with an alcohol pad and not with a registered Environmental Protective Agency (EPA) product. LPN V indicated she used the glucometer for all residents that required a blood glucose test in her care. Findings include: The facility's policy and procedure dated 10/24/23, indicated the purpose of this procedure is to provide guidelines for the disinfection of capillary blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against Human immunodeficiency virus, Hepatitis C and Hepatitis B virus. There was no information in the policy and procedure regarding COVID 19. Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. On 5/3/23 at 9:30 AM. the Surveyor observed LPN V perform a blood glucose test for R13. After the test was completed, LPN V was observed to quickly wipe the glucometer with an alcohol wipe. On 5/3/23 at 9:40 AM, the Surveyor interviewed LPN V. LPN V indicated she had no more residents to complete blood glucose monitoring for. LPN V stated the glucometer she was using she used for all residents in her care that required blood glucose monitoring. LPN V indicated she disinfected the glucose monitoring device after use on about 2 residents and that she utilized alcohol wipes to disinfect.