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	04/28/2021

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not promptly consult with the physician for 3 of 23 (R4, R27, and R15) sampled residents when they experienced significant changes in condition or met parameters set by the physician to be notified. The facility failed to promptly consult with R4's physician when R4 presented with worsening symptoms of CHF (Congestive Heart Failure) on [DATE], resulting in R4 being sent to the hospital with acute exacerbation of chronic diastolic CHF. The resident returned with orders to monitor weight and to consult with the physician when the resident had weight increases that exceeded the parameters established in the physician orders. The facility did not consult with the physician when R4's weights exceeded parameters on 5 dates in [DATE]. R4 was sent to the hospital again on [DATE] with wheezing and pitting edema with a final diagnosis of Acute on chronic HFpEF (Heart Failure with preserved Ejection Fraction) and Possible Type 2 demand MI (Myocardial Infarction) due to Heart Failure). The facility's failure to immediately consult with R4's physician when she was experiencing significant changes in condition created a finding of IJ (Immediate Jeopardy) beginning on [DATE]. The NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the IJ on [DATE] at 12:43 PM. The IJ was removed on [DATE]; however, the deficient practice continues at a scope and severity of a D (potential for harm/isolated) as the facility continues to implement their action plan and as evidenced by the following The facility did not consult with the physician and inform the MD that weekly weights were not being completed for R27 and R15. (Both residents have care plans directing staff to monitor weights.) R27 did not have weights taken between [DATE] and [DATE], between [DATE] and [DATE], and between [DATE] and [DATE]. R15 did not have weekly weights taken between [DATE] and [DATE] and between [DATE] and [DATE]. The weight taken on [DATE] showed a 24.6% increase in 7 weeks; the facility did not reweigh the resident and did not consult with the physician about this significant weight increase. Evidenced by: AMDA (American Medical Directors Association) definition of Acute Change of Condition (ACOC): An ACOC is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional domains. Clinically important means a deviation that, without intervention, may result in complication or death. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to an article by the Harvard Medical School, Fluid buildup indicates worsening heart failure .The buildup of excess fluid in your body can take a variety of forms from belly bloating and swollen ankles to nausea, persistent coughing and fatigue. You may be tempted initially to dismiss this hodgepodge of problems as having little to do with your heart. However, they all signal water retention, which can mean trouble for people with a history of heart failure. Fluid buildup can quickly escalate into a life-threatening situation . https://www.health.harvard.edu/heart-health/fluid-retention-what-it-can-mean-for-your-heart According to WebMD's Heart Failure Health Center, Sometimes your symptoms may get worse very quickly. This is called sudden heart failure. It causes fluid to build up in your lungs, causing congestion. (This is why the problem is often called congestive heart failure.) .Sudden heart failure is an emergency. You need care right away. http://www.webmd.com/heart-disease/heart-failure/tc/heart-failure-symptoms The facility policy titled Change of Condition, dated [DATE], states in part . When a change of condition occurs, assessments are updated to reflect the change (pain, fall, skin, elope, etc.). Physician and responsible party notified of changes. Change of condition documented on the 24-hour report sheet; discussed at the morning meeting with f/u (follow-up). Stop and Watch completed and reviewed. System is in place to identify resident who require monitoring, assessment, and intervention. Care plan revised to reflect changes in conditions. On [DATE] R4 was admitted to the facility with diagnoses that included edema, COPD (Chronic Obstructive Pulmonary Disease), HTN (Hypertension), dyspnea, Type 2 Diabetes Mellitus (DM), pleural effusion, CKD (Chronic Kidney Disease), and acute on chronic HF (Heart Failure). R4 is [AGE] years-old According to R4's most recent MDS (Minimum Data Set) dated [DATE], her BIMS (Brief Interview for Mental Status) is 7, indicating she has severe cognitive impairment. She requires limited assistance of two for transferring, dependent of one toileting, is independent with locomotion on unit and requires supervision of one with eating. R4 is frequently incontinent of bowel and always incontinent of bladder. R4 is not her own person with an AHCPOA (Activated Health Care Power of Attorney). R4 is a Full Code (resident would like CPR (Cardiopulmonary Resuscitation) performed in the event her heart stops). R4's CNA (Certified Nursing Assistant) Care Sheet, printed [DATE], indicates in part . Diet Orders: Frequent supervision, 2L (Liters) FR (Fluid Restriction)/24 hours, encourage to drink H2O (water) as long as within fluid restriction. ADL's (Activities of Daily Living): Showers Thursday AM (morning) and Sunday AM, weights on shower days. R4's comprehensive Care Plan, last reviewed on [DATE], includes the following focus areas: Focus: Therapeutic diet served due to DM 2 and obesity. [DATE] recent weight fluctuations due to fluid overload f/b (followed by) diuresis. Interventions: Fluids restricted to 2 liters/24 hours which is distributed at meals and by NSG (Nursing) staff. Monitor weights. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Focus: Alteration in cardiovascular status r/t (related to): HTN and CAD (Coronary Artery Disease). Interventions: Daily weights. Observe for edema or congestion. Resident will inform staff of chest pain or SOB (shortness of breath). Observe for signs of SOB. On [DATE], R4 was transferred to the ER (emergency room) for evaluation due to complaints of chest tightness. R4 returned the same day with new orders to monitor for edema. On [DATE] at 1:16 PM, NN's (Nurses Notes) written by LPN-J state the following: Report by CNA (Certified Nursing Assistant) on night shift that resident left top of hand was puffy. Noted this AM during AM cares that resident left hand, arm, bilateral legs and bilateral feet are 3+ (plus) pitting edema and hard to touch. No SOB. Lung sounds are clear. No cough. Doctor on call called and received order to send resident to the ER for evaluation of possible fluid overload. Son (AHCPOA) was called and informed of resident transport. Resident left per stretcher per ambulance at 12:00 PM. Hospital ER RN was called and given resident information. Also had 2 other nurses assess resident with initial assessment by this nurse. Temperature: 98. 1, O2 (oxygen) at 94% on room air. On [DATE] at 9:17 AM, Surveyor interviewed LPN J. Surveyor asked LPN J what she could tell Surveyor about R4 and her hospitalization s. LPN J stated, R4 went to hospital in March for fluid overload. NOC (night) shift CNA reported to me at shift change that R4's arm was swollen. When R4 got up for the day right before lunch I went and looked at it and called 2 other Nurses one being LPN H to come look with me. Surveyor asked LPN J if she got an RN to assess R4. LPN J stated, No, I didn't I had the other two LPN's in the building at the time come look at the R4 with me. Surveyor asked LPN J if she observed R4 immediately being informed of R4's hand being edematous. LPN J stated, I didn't get it in report from NOC nurse. The CNA reported it to me but R4 doesn't get up until later so I waited until staff got her up for the day around lunch time. Note: The CNA reported the change in R4 to the LPN during shift change and the LPN did not observe R4's condition until staff had gotten R4 up for lunch, did not get an RN to assess R4, and did not promptly consult with a physician regarding R4's changed condition. R4's Hospital discharge summary states in part Primary Discharge Diagnosis: Acute exacerbation of chronic diastolic CHF. R4 reports that over the last 2 weeks she has noticed increased lower extremity edema, dyspnea on exertion, orthopnea, and left upper extremity edema. Chest x-ray showed stable cardiomegaly with possible pulmonary venous congestion. A proBNP (N-terminal prohormone of brain natriuretic peptide is a lab test that monitors the non-active prohormone produced by the heart) with a value of 4100. The normal range for proBNP in someone under the age of 75 is 125pg/mL (picograms/milliliter). R4 received IV (Intravenous) Bumex (diuretic) while in the hospital. On [DATE], R4 discharged back to the facility with new orders for daily weights: Call the physician if weight gain of > (greater than) 3 lbs. (pounds) in a day or >5 lbs. in a week. Daily Weights: There were no weights taken on ,d+[DATE] or [DATE] [DATE]: 207.2 There are no weights taken from [DATE] to [DATE] (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]: 213.8 lbs. The facility did not immediately consult with R4's physician regarding a weight gain greater than 5 lbs. in one week. There were no weights taken on ,d+[DATE] or [DATE] [DATE]: 218.8 lbs. - increase of 5 lbs. in 3 days. The facility did not immediately consult with R4's physician regarding a weight gain greater than 5 lbs. in one week. [DATE]: 220 lbs. [DATE]: 218.8 lbs. [DATE]: 220.8 lbs. [DATE]: 222.8 lbs. [DATE]: 211.7 lbs. [DATE]: 217.8 lbs. Weight increase of 6 pounds in 1 day. The facility did not immediately consult with R4's physician regarding a weight gain greater than 3 lbs. in one day. [DATE]: 222.2 lbs. Weight increase of 4.4 lbs. in a day. The facility did not immediately consult with R4's physician regarding a weight gain greater than 3 lbs. in one day. [DATE]: No weight recorded [DATE]: 227 lbs. - increase of 4.8 lbs. in 2 days and 9.2 lbs. in 3 days. The facility did not immediately consult with R4's physician regarding a weight gain greater than 5 lbs. in one week. [DATE]: 227.8 lbs. On [DATE] at 10:09 AM, NN's for Daily Skilled / Comprehensive Review Completed (by an LPN): BP (Blood Pressure) ,d+[DATE], P (Pulse) 70, Temperature 98.1, Respirations 16. Edema: No, Chest Pain/Tightness: No. Individual Observation: No shortness of breath or trouble breathing noted when sitting at rest individual observed - No shortness of breath or trouble breathing noted when lying flat - no shortness of breath or trouble breathing noted with exertion (e.g., walking, bathing, transferring). Lung sounds: Clear. However, later that day R4 had an outpatient Nephrology appointment where she was sent to the ER by the Nephrologist due to fluid overload. Office Visit Note from Nephrology on [DATE] states in part . Recently discharged from Hospital on [DATE] after being treated for volume overload with IV diuretics. She is here for follow-up today. Exam: Lungs: wheezing. Extremities: ,d+[DATE]+ pitting edema all the way up her thigh. Assessment: Decompensated CHF, CKD (chronic kidney disease) Cirrhosis. She is grossly volume overloaded today. She will need IV diuretics to control volume status. I will send her to the Hospital ER to get admitted . Plan: Will refer to the ER. Will inform POA. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:38 PM, NN notes indicate, Spoke with RN, undetermined if and when they will be sending R4 back. C/o (Complaints of) SOB/satting (sic) at 100% on RA (room air). Lungs not clear but 'not bad' either per RN. R4 is still being worked up. They will call when they know more. Writer let them know that she was having hematuria and had a UA (urinalysis) done but that C&S (culture and sensitivity) was pending. On [DATE] at 1:03 AM, NN's note states, called hospital and informed that R4 was admitted , diagnoses CHF and fluid overload, and was going to be diuresed. Hospital Discharge Summary hospital stay [DATE] to [DATE] states in part .Primary Discharge Diagnoses: Acute on chronic HFpEF (Heart Failure with preserved Ejection Fraction) and Possible Type 2 demand MI (Myocardial Infarction) due to Heart Failure). Patient was sent to the ER by nephrologist with concern for decompensated heart failure volume overload - she has been with increasing shortness of breath and leg swelling for a month. Hospital Course: Diuresed with IV Bumex and metolazone (diuretic). BNP showed improvement from over 4000 to 3000 and improved clinically with resolution of shortness of breath. Possible type 2 demand MI - due to Acute Diastolic Heart Failure - troponin elevated but no symptoms of ACS (Acute Coronary Syndrome). Note: A Type 2 MI occurs secondary to an acute imbalance in myocardial oxygen supply and demand without atherothrombosis (clot). On [DATE] at 4:17 PM, Surveyor interviewed LPN H. Surveyor asked LPN H what she does when a resident's weights are up requiring MD notification. LPN H stated, I always update the physician with weight changes, especially for R4. R4 is independent when up in her wheelchair and will frequently get pop from the pop machine. Surveyor asked LPN H if she could provide documentation of physician notification. Documentation of physician notification was not provided to Surveyor prior to leaving the facility. On [DATE] at 8:49 AM, Surveyor interviewed DON B. Surveyor asked DON B if R4's weights showing an increase of >3 lbs. in a day or > 5 lbs. in a week if that should be reported to the physician. DON B stated, Absolutely. Surveyor asked DON B if she could provide Surveyor with documentation that the physician was notified of R4's weight changes. Surveyor was not provided with physician notification documentation prior to leaving the facility. On [DATE] at 09:56 AM, Surveyor interviewed NP T (Nurse Practitioner). Surveyor asked NP T if she would expect to be updated on weights not being completed. not following R4's FR, and weights of >3 lbs. in a day or >5 lbs. in a week. NP T stated, Yes. Surveyor asked NP T if not doing the above things could have contributed to her exacerbation of CHF. NP T stated, It certainly could be. The facility failed to promptly consult with the physician when R4 experienced a change of condition on [DATE] and afterwards when weights were outside the parameters set by the physician. This failure created a situation of Immediate Jeopardy, which was removed on [DATE] when the facility implemented the following action plan On [DATE], R4's record was reviewed to determine if there were any existing evidence of a change of condition which warrants an appropriate nursing assessment, notification to the physician, follow-up and subsequent documentation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], a full facility, physical review of all residents will be completed to determine if there were any residents that present with evidence of a Change of Condition that requires implementation of a thorough systems assessment, notification to physician of a change of condition and appropriate documentation of immediate follow-up. On [DATE], a general review of nursing documentation of all residents' statuses to include 24-hour report sheets to determine if there were any residents that present with evidence of a Change of Condition that requires implementation of a thorough systems assessment, notification to physician of a change in condition and appropriate documentation of immediate follow-up. Existing policies related to Change of Condition, Notification of Physician, Nursing Assessments, Documentation and Measuring Weights will be reviewed by the DON and clinical leadership to determine if they remain appropriate. Prior to the start of their next working shift, licensed nursing staff and certified nursing assistants will be provided education on policies procedures related to proper notification of changes to the PCP/POA/Family. Prior to the start of their next working shift, licensed nursing staff and certified nursing assistants will be provided education on identification of change of condition in accordance with the American Medical Directors Association's (AMDA) Acute Change of Condition in Long Term Care Setting Guideline, with special emphasis on acute exacerbation of Congestive Heart Failure (CHF). Prior to the start of their next working shift, licensed nursing staff and certified nursing assistants will be provided education on the requirement to follow physician's orders with respect to completing daily weights as ordered by the physician. Furthermore, the education will include the necessity to notify the physician if a weight increases by 3 lbs. in one day or 5 lbs. in one week. All licensed nursing staff will be checked for competency regarding identification of acute change of condition (emphasis on signs / symptoms of CHF exacerbation) and the appropriate response to include notification to the physician. The mechanism by which competency will be established is a quiz. The nurse care management under the oversight of the DON and clinical leadership team will review resident weights in Point-Click-Care to ensure compliance with physician's orders and to ensure proper follow-up if necessary. In addition, the nurse case managers will monitor changes of condition through daily rounding of all nurse areas and utilize the Sop-N-Watch tool for any acute changes. Resident care plans will be updated if resident has a diagnosis of congestive heart failure (CHF) to include monitoring for signs/symptoms of edema and collecting weights in accordance with the physician's orders. The DON or their designee(s) will conduct random audits of Change of Condition to ensure proper identification at the following rates: All residents daily x2 weeks; X10 residents daily x1 month; X3 residents weekly x2 weeks; X2 resident monthly x1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON or their designee(s) will conduct random audits of Point-Click-Care (PCC) nursing assessments to ensure proper care and treatment oat the following rates: X10 residents daily x1 month; X3 residents weekly x2 weeks; X3 residents monthly x1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. The DON or their designee(s) will conduct random audits of Physician's Notification of Resident Change of Condition to ensure timely reporting and appropriate follow-up at the following rates: All residents daily x2 weeks; X10 residents daily x1 month; X3 residents weekly x2 weeks; X3 residents monthly x1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. The DON or their designee(s) will conduct random audits of daily or weekly resident weights to ensure proper completion, as well as, to determine if any concerns identified required immediate follow-up with an assessment and / or notification to a physician at the following rates: X10 residents daily x1 month; X3 residents weekly x2 weeks; X3 residents monthly X1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. Audit trends will be reviewed at the monthly Quality Assurance / Performance Improvement (QAPI) meeting x 12 months to validate substantial compliance. On [DATE], the immediacy will be removed when all staff will be educated, policies reviewed and revised as needed and competency checks completed. Cross Reference F684 J The deficient practice continues at a scope/severity of D (potential for more than minimal harm that is not immediate jeopardy/isolated) as the facility continues to implement the above plan. 42482 Example 2 R27 was admitted [DATE] with diagnoses of vascular dementia with behaviors, hypothyroidism, weight loss, decreased oral intake, osteoporosis and anxiety. The facility failed to complete weekly weights for R27 and failed to report weights not being completed to the physician. R27's care plan dated [DATE] with revision date of [DATE] and target date of [DATE] has a focus of altered nutrition; resident having a recent weight loss. Stated goal of care plan, resident will have no significant weight loss. Interventions include: Monitor weights, encourage meal and beverage intake, provide meal set up, supervision and cues to eat. R27's care plan focus of alteration in cognition related to dementia initiated on [DATE], revised on [DATE] and target date of [DATE] has interventions that include MD notification as needed. The facility shower and weight schedule for R27, dated [DATE], indicates R27 should be showered, weighed weekly on Wednesdays. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Current standards of practice for nursing home residents include . weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as insidious weight loss. Weighing may also be pertinent if there is a significant change in condition, food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance. R27's weights were obtained only on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 4:55 PM, Surveyor interviewed DON B (Director of Nursing) regarding lack of weekly weights and lack of physician notification of weight changes. Surveyor asked DON B, what is your expectation in regards to residents being weighed and notification of the physician? DON B indicated, It is our expectation for residents to be weighed weekly on their shower day and that the nurse on duty ensure the weights are completed, recorded and the doctor updated as needed. Surveyor asked DON B, have there been any weights on R27 since [DATE]? DON B replied No. Surveyor asked DON B, are weights being monitored if not completed for a two month period? DON B answered, No. Surveyor asked DON B, who supervises that the weekly weights and showers are being completed? DON B indicated, I would expect the nurse on duty to ensure that weights are completed as ordered, recorded and the provider is notified of changes. On [DATE] 9:53 AM, Surveyor interviewed NP T (Nurse Practitioner) regarding the facility not notifying providers of weight changes & not weighing residents as ordered. NP T stated, Yes, I would expect the facility to notify me if weights were not done. Surveyor requested resident be weighed during survey; this was not completed. Example 3 R15 was admitted on [DATE] with the diagnoses of vascular dementia with behavioral disturbance, hypothyroidism, vitamin B12 deficient anemia, weakness & frequent falls. The facility failed to weigh and monitor R15's weight as ordered and report an increase to the physician. R15's care plan dated [DATE] with revision on [DATE] has a goal of resident will maintain weight range of , d+[DATE] pounds. Interventions include, .monitor weights, encourage meals and beverages, provide meal set up . R15's weights and vitals summary revealed weights were obtained on [DATE] at 111.4 pounds and [DATE] at 138.2 pounds. This is a 24.6 % increase in weight in seven weeks for R15. There is no evidence the facility consulted with the physician about this weight gain. R15's physician order summary dated [DATE] indicates weekly weight . and the facility shower and weight schedule for R15 dated [DATE], indicates R15 should be showered & weighed .weekly on Wednesdays. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dietary progress note of [DATE] for R15 states reweight to be requested. There was no facility documentation of reweight or physician notification of weight change in R15's record. On [DATE] at 4:55 PM, Surveyor interviewed DON B regarding lack of weekly weights, lack of physician notification of weight changes, lack of reweights. DON B, Yes, it is our expectation for residents to be weighed weekly on their shower day. Surveyor asked DON B, have there been any weights on R15 since [DATE]? DON B answered, No. Surveyor asked DON B, are weights being monitored if not completed in a two month period? DON B replied, No. Surveyor asked DON B, who supervises that the weekly weights and showers are being completed? DON B indicated, I would expect the nurse on duty to ensure that weights are completed as ordered, recorded and the provider is notified of changes. Surveyor asked DON B, should the physician have been notified of this weight change? DON B stated, Yes. Surveyor asked DON B, should the reweight have been completed? DON B replied, Yes, that is on us, it should have been done. On [DATE] at 9:53 AM Surveyor interviewed NP T regarding the facility not notifying providers of weight changes, not weighing residents as ordered. NP T, Yes, I would expect them to notify me if weights weren't done. Surveyor requested resident be weighed during survey; this was not completed.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review the facility did not provide written information to the resident or resident representative regarding the bed hold policy for 2 of 5 residents (R76 and R21) hospitalization s reviewed. R76 did not have a bed hold given to him or his representative for 3/27/21 hospitalization . The facility failed to notify the R21's activated power of attorney (POA) for health care of the bed-hold policy upon R21's transfer to the hospital. This is evidenced by: The Facilities Bed Hold and Re-Admission Policy and Procedure dated 11/16, documents in part: .Before a resident is transferred to a hospital or placed on therapeutic leave, written notification is provided to the resident, and/or resident representative that specifies: .Bed hold transfer: At the time of transfer for hospitalization or leave, written notice that specifies the duration of the facility bed hold period is provided to the resident and/or resident representative. A copy and/or documentation of the notice is placed in the resident's medical record . R76 was sent to the hospital on 3/27/21 and diagnosed with a kidney infection. R76 nor R76's representative were given a bed hold. On 4/21/21 at 8:20 AM, Surveyor interviewed SW S (social worker). Surveyor asked SW S if she could locate bed hold paperwork or documentation for R76's hospitalization from [DATE]. SW S left room, returned shortly and responded R76 does not have bed hold for 3/27/21. 42482 Example 2 R21 was admitted [DATE] with diagnoses of dementia without behavioral disturbance, anxiety and major depressive disorder. R21 was transferred to hospital on 1/19/21. Surveyor was unable to find notice of bed hold in R21's medical record or documentation of notice being discussed with the family or activated (POA) for healthcare. On 4/21/21 at 8:20 AM, Surveyor interviewed SW S (Social Worker) regarding the facility's bed hold notice process. SW S indicated, The nurses are supposed to give the bed hold packet when the resident leaves or if the resident is too ill or can't understand, the nurses are supposed to call the family to inform them. Surveyor asked SW S, do you follow up to ensure this was done? What is your process? SW S replied, Well yes, that is a broken process that I hope to fix, currently that is not done. Surveyor asked SW S, if a resident leaves on Friday evening, do you review the progress notes or check with the family to ensure the bed hold notice was explained to them? SW S stated, No. (continued on next page)

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility lacks a process for timely notification of the facility bed hold policy upon transfer.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on record review, resident and staff interviews, the facility did not develop and implement a Comprehensive Resident-Centered Care Plan for 2 of 23 sampled residents reviewed (R127 and R55). R127 has a diagnosis of schizoaffective disorder and a history of suicide attempts. The facility does not have a care plan in place or care plan interventions in place to ensure R127's safety. R55 has paraplegia and no feeling from his waist down. Per interview with R55, he stated he was admitted to the facility on [DATE] with a small pressure injury on his bottom that he has had for years. The facility did not have a care plan with skin interventions in place until 3/19/21. R55 has diagnoses including anxiety disorder, personality disorder, bipolar disorder, delusional disorders, behaviors including verbal outburst and refusals of care. R55 does not have a psychosocial care plan that addresses these mental health diagnoses and behaviors affecting cares. This is evidenced by: Example 1 R127 was admitted to the facility on [DATE] with diagnoses including, but not limited to, history of attempted suicide, schizoaffective disorder, and respiratory failure with hypercapnia, chronic respiratory failure with hypoxia, tachycardia, weakness, and diabetes mellitus type 2. R127's care plan indicates the following: R127 has a history of suicidal attempts. Goal: Will have no attempts at harming self. Interventions or monitoring: None Example 2 R55 was admitted to the facility on [DATE] with diagnoses including, but not limited to, paraplegia (no feeling from the waist down), left BKA (below the knee amputation), anxiety disorder, personality disorder, bipolar disorder, delusional disorders, behaviors, verbal outbursts, refusals of care, polyneuropathy, severe sepsis, rotator cuff tear or rupture right shoulder. R55's BIMS (Brief Interview of Mental Status) is 15/15, indicating he is cognitively intact. R55 is his own decision maker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's Admission MDS (Minimum Data Set) assessment, dated 3/13/21, Section C0200 Cognitive Patterns indicates that R55's BIMS (Brief Interview of Mental Status) is 15, indicating he is cognitively intact. Section G Functional Status, indicates that R55 is dependent on staff for bed mobility, Section M0150 Risk of Pressure Injuries indicates R55 is at risk for PI development. Section M0210 Unhealed Pressure Injuries indicates R55 has an unhealed PI. Section M0300 Current Number of Unhealed Pressure Injuries at Each Stage indicates R55's PI is a Stage 1: Intact skin with non-blanchable redness of localized area usually over a bony prominence (Note, this PI was noted to be higher on R55's back). Stage 2: 0 (zero), Stage 3: 0 (zero), Stage 4 0 (zero), Unstageable-slough/and/or eschar: 0 (zero), Unstageable-DTI (Deep Tissue Injury): 0 (zero). Section M1200 indicates Skin and Ulcer Treatments: A. Pressure reducing device for chair, B. Pressure reducing device for bed, C. Turning/repositioning program, E. Pressure ulcer care. Note, a care plan with skin interventions was not put in place until 3/19/21. R55 was admitted to the facility with one (1) known PI on his back, in addition to a PI on R55's left gluteal fold that the facility did not identify on R55's Admission Skin Assessment. The facility did not put a care plan with skin interventions in place until 3/19/21. The facility identified R55's left gluteal fold PI on 3/18/21 (9 days after admission). When the PI was discovered it measured 2.2 cm (centimeters) x 1.7 cm and the wound bed contained 85% slough and 15% granulation tissue (Unstageable PI/Stage 3). The facility did not have a care plan with skin interventions in place until 3/19/21. On 4/18/21 at 11:54 AM, Surveyor conducted a resident interview with R55. R55 stated he was admitted to the facility with a small pressure injury on his bottom that he has had for years. R55 does not have a care plan to address his anxiety disorder, personality disorder, bipolar disorder, delusional disorders, and behaviors of verbal outbursts and refusals of care). On 4/21/21 at 12:39 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, would you expect R127 to have a psychosocial care plan & in place that addresses mood, behavior, and interventions in place for suicide attempts. DON B stated, yes, she should have one done. DON B added, Absolutely, oh yes. Surveyor asked what is the process for this. DON B stated, we would get the SW S (Social Worker) involved to see if there's someone she sees for therapy and try to see if she has an appointment, make sure she can get to the appointment. DON B added, we would ask if she had thoughts about suicide and a plan so that staff would be aware of her diagnoses. Surveyor asked DON B why this is important. DON B stated, so we can make sure she stays safe and doesn't hurt herself. On 4/20/21 at 9:38 AM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B would you have expected R55 to have a care plan for skin upon admission. DON B stated, Yes, we're working on our admission system to make the process smoother (makes sure consents in place equipment in place, anticipate the needs of the resident.) Surveyor asked DON B, do you have a care plan for R55's Anxiety Disorder, Personality Disorder, Bipolar Disorder, Delusional Disorders, behaviors including verbal outbursts and refusals of care. DON B replied, no, we don't have one for psychosocial. Surveyor asked DON B is there a care plan for verbal outburst and refusal of care. DON B stated, no, but there's but there's definitely a space to put it in. Surveyor asked would you have expected this care plan to be in place. DON B stated, Yes, exactly.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation, interview and record review the facility did not ensure that residents' whom are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 5 of 5 residents (R76, R5, R37, R21, and R24) reviewed for ADL's. R76 did not have oral care or fingernail care completed, white build-up noted on teeth and gums, and fingernails noted to be long. R5 did not have fingernail care completed, noted to be long and dirty. R37 did not have fingernail care completed, noted to be long. R21 did not have fingernail care completed, noted to be long. R24 has diagnoses of aphasia (unable to speak) and stroke. She is fed only by a liquid formula through a tube in her stomach. R24 indicated staff do not perform any oral care or brush her teeth. This is evidenced by: The Facilities Oral Hygiene of Unconscious or Total Care Resident Policy and Procedure dated 4/1/08, documents in part: Residents who are unable to perform daily oral hygiene will receive assistance (resident in bed) . The Facilities Nail Care Policy and Procedure dated 4/1/08, documents in part: It is the facility's policy to keep a resident's fingernails and toenails cleaned and trimmed .1. Fingernails and toenails are checked daily and cleaned as necessary. 2. Fingernails are trimmed weekly during bathing or more often, if necessary. 3. A licensed professional does toenail trimming, calluses, and bunions on diabetic residents . The Facilities Bath in Shower Policy and Procedure, dated 3/1/14, documents in part: .19. Perform or assist with oral care . The Facilities Wing Nurse Roster sheet dated 4/18/21, documents in part: .Room #s (numbers) in red indicate nails, weight and skin check days . Example 1 R76 is a long term resident of the facility. R76 has the following diagnoses: Cerebral infarction, Paralytic syndromes, Functional quadriplegia, History of TIA (Transient Ischemic Attack), and Multiple sclerosis. R76's most recent MDS (minimum data set) dated 3/27/21, documents that he is moderately impaired cognitively and R76 requires total dependence for personal hygiene. R76's Physician Orders document on 3/8/21 Oral care, including tongue brushing, three times daily (may be completed by CNA) . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R76's MAR (Medication Administration Record) includes Oral care, including tongue brushing, three times daily (may be completed by CNA) . since 3/8/21 and is signed out as completed. R76's Care Plan SELF CARE DEFICIT AND RISK FOR FALLS RELATED TO MS (Multiple Sclerosis) AND WEAKNESS dated 3/25/20, documents in part: .Oral care after meals, encourage if refuses . R76's CNA Care Delivery Guide documents, in part: .Oral cares 3x (3 times) a day including tongue . Observation on 4/18/21 at 12:18 PM, Surveyor spoke with R76, R76 was noted to have white build-up on teeth near gum line. Observation on 4/19/21 at 12:03 PM, Surveyor again observed R76, noted to have white build-up on teeth near gum line. Observation on 4/19/21 at 12:28 PM, Nurse completing G/T (Gastrostomy Tube), noted R76's fingernails to be long. On 4/19/21 at 3:21 PM, Surveyor interviewed CNA V (Certified Nursing Assistant). Surveyor asked CNA V when nail care is completed, CNA V said nails for non-Diabetic residents are done by the CNA's on shower days and the nurses do the Diabetics. Surveyor asked CNA V when oral care is completed, CNA V replied oral care is done in AM and HS (bedtime). On 4/19/21 at 3:27 PM, Surveyor interviewed CNA W. Surveyor asked CNA W when oral care is done, CNA W said we offer oral care but sometimes residents refuse. Surveyor asked CNA W where she documents refusals, CNA W stated there is no place to chart refusals. On 4/20/21 at 7:54 AM, Surveyor interviewed LPN Q (Licensed Practical Nurse). Surveyor asked LPN Q when nail care is completed, LPN Q stated CNA's complete nail care if residents are not diabetic on shower day and if the resident is Diabetic the nurse completes nail care on shower day, or it can also be done by request. Surveyor asked LPN Q when oral care is completed, LPN Q said oral care should be done morning and night. Surveyor asked LPN Q what happens if a resident refuses oral care, LPN Q replied the CNA's verbally report to us if a resident refuses, if unable to brush, we can use toothettes. On 4/20/21 at 9:02 AM, Surveyor again observed R76, R76 was noted to have white build-up on teeth near gum line. Surveyor interviewed R76. Surveyor asked R76 if he wants his nails as long as they are, R76 stated no, they are too long now. Surveyor asked R76 if the staff brush his teeth, R76 stated some CNA's do, some don't. Surveyor asked R76 how often his teeth get brushed, R76 said couple times a week. Surveyor asked R76 if he would like his teeth brushed three times a day as it is ordered, R76 replied yes. On 4/20/21 at 9:10 AM, Surveyor interviewed LPN J. Surveyor asked LPN J when nail care is completed for R76, LPN J said just as needed when we notice he needs it. Surveyor asked LPN J when oral care is completed for R76, LPN J replied I don't know when or if it is done, they do know to do it, oral care is in MAR for nurses to answer (LPN J showed Surveyor on computer). Surveyor asked LPN J who they is, LPN J said the CNA's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/21 at 9:50 AM, Surveyor asked CNA X when R76 would receive oral care, CNA X stated once he is up. On 4/20/21 at 11:52 AM, Surveyor noted that R76 was up in his broda chair. Surveyor again observed R76, noted to have white build-up on teeth near gum line, with no change. On 4/20/21 at 5:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when she expected the residents to receive oral care, DON B said every day, on AM shift unless a resident wants in evening. Surveyor asked DON B when she expected the residents to have nail care, DON B said nail care should be done on shower day or anytime if noticed they are long. Surveyor asked DON B who is to provide nail care, CNA's for non-Diabetic residents and nurses for Diabetic residents. On 4/20/21 at 6:03 PM, Surveyor and DON B observed R76's nails and mouth together. DON B commented R76's nails are long and he definitely needs to have oral care completed. Example 2 R5 is a long term resident of the facility. R5 has the following diagnoses: Displaced fracture of medial condyle of right femur, Bilateral primary open-angle glaucoma, severe stage, Alcohol use, and Psychoactive substance abuse. R5's most recent MDS dated [DATE] documents a score of 11 on his BIMS (Brief Interview of Mental Status), which indicates he is moderately impaired cognitively and he requires limited assist of 2 staff for personal hygiene. Observation on 4/19/21 at 8:54 AM of R5's nails long and dirty. Surveyor asked R5 who does nail care here, R5 said the activity lady has been trying to get them done because the nurses can't do them or something. Observation on 4/20/21 at 1:49 PM of R5's nails, still long and dirty. On 4/20/21 at 5:59 PM, Surveyor and DON B observed R5's nails together. DON B commented R5's nails are long and dirty. Example 3 R37 is a long term resident of the facility. R37 has the following diagnoses; Type 2 Diabetes Mellitus and Injury of cauda equina. R37's most recent MDS dated [DATE] documents a score of 15 on his BIMS, which indicates he is cognitively intact and that he requires limited assist of 2 staff for personal hygiene. R37's Physician Orders include from 5/1/19 Dental, Eye, Podiatry, Audiology consult as needed with resident/designee permission Podiatry exam dated 3/3/21, documents the following, in part: .Initial Exam: presents with long, thick toenails and swelling of the lower extremities . On 4/18/21 at 3:20 PM, Surveyor interviewed R37. Surveyor asked R37 if there was anything the facility could do a better job for R37, R37 stated staff wouldn't cut his nails. Surveyor asked R37 if his nails could be viewed, R37 showed Surveyor fingernails which were noted to be long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/21 at 5:05 PM, Surveyor interviewed DON B. Surveyor asked DON B if podiatry had been in the facility since the pandemic started, DON B said no, they were not coming. Surveyor asked DON B what guidance was given to the staff regarding nail care for those that may need to see podiatry, DON B said the staff was to file the nails the best they could until podiatry could enter facility again. On 4/20/21 at 6:01 PM, Surveyor and DON B observed R37's's nails together. DON B commented R37's nails are long. Example 4 R21 is a long term resident of the facility. R21 has the following diagnoses: Anxiety disorder, Weakness, Alzheimer's disease, Dementia without behavioral disturbance and Type 2 Diabetes Mellitus. R21's most recent MDS dated [DATE] documents that he is severely impaired cognitively and that R21 requires extensive assistance from 1 staff for personal hygiene. Observation on 4/19/21 at 8:48 AM of R21's nails, they are long. On 4/19/21 at 12:31 PM, Surveyor interviewed R21's representative. Surveyor asked R21's representative how she feels the care at the facility is, R21's representative said Overall we feel the care at the facility is better than other places he has been, but to be honest and sincere, his hair and nails are too long and sometimes his clothes are dirty. 37091 Example 5 R24 was admitted to the facility on [DATE] with diagnoses of stroke, hemiplegia (weakness of a arm and or leg), diabetes and aphasia. R24 is fed only with a liquid formula through a tube in her stomach. R24's most recent MDS (Minimum Data Set) dated 2/6/21 indicates her cognitive level is modified independence. R24 requires extensive assistance with personal hygiene (as in brushing her teeth, and combing her hair). Her MDS indicates she has impairment on one side of her body and she is unable to speak. Section L on the MDS assesses the oral/dental status of the resident. Section L is not completed for R24. R24's care plan dated 4/13/21 indicates she is to have frequent oral care. On 4/19/21 at 10:00 AM, Surveyor spoke to R24. Surveyor asked R24 if anyone cleans her mouth. R24 shook her head side to side, indicating no. On 4/20/21 at 1:30 PM, Surveyor spoke to R24. Surveyor asked if anyone has helped her brush her teeth that day. R24 shook her head side to side, indicating no . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor asked R24 if she could look in her dresser and cabinet drawers. R24 shook her head in an up and down fashion, indicating yes. Surveyor looked in R24's dresser drawers, sink cabinet drawers, night stand drawers for oral supplies or tooth brush and toothpaste. Surveyor did not find any supplies to do oral care with. On 4/20/21 at 1:45 PM, Surveyor spoke to CNA N (Certified Nurse Assistant). CNA N said she performed oral care on R24 daily. Surveyor asked where the oral care supplies were kept. CNA N said in R24's dresser drawers. On 4/20/21 at 3:45 PM, Surveyor spoke to CNA P. CNA P said she performed oral care on R24 most days. CNA P said the supplies were always in the dresser. On 4/20/21 at 1:30 PM Surveyor spoke to LPN Q (Licensed Practical Nurse). LPN Q said the CNA's should be doing oral care on R24. On 4/21/21 at 3:30 PM, Surveyor spoke with DON B (Director of Nursing). DON B said the CNA's should be giving R24 oral care at least twice a day

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not ensure each resident received the necessary care and services in accordance with professional standards of practice to meet each resident's physical needs for 2 of 19 (R4 and R52) sampled residents. The facility failed to complete comprehensive assessments for R4 when R4 presented with changes of condition related to worsening symptoms of CHF (Congestive Heart Failure) on [DATE], [DATE], and [DATE], resulting in R4 being sent to the hospital on these dates. The facility did not monitor R4's weights as ordered and update the physician with weight increases to prevent exacerbation of CHF. R4 had physician orders for fluid restriction of 2000 ML (milliliters) per day; the facility did not have a system in place to adequately monitor R4's fluid intake to prevent fluid over-load and increased symptoms of CHF. The facility's failure to assess R4 when she was experiencing an exacerbation of CHF and its failure to monitor weights and fluid intake so that more immediate intervention could occur when symptoms of an exacerbation of R4's congestive heart failure presented created a finding of IJ (Immediate Jeopardy) beginning on [DATE]. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the IJ on [DATE] at 12:43 PM. The IJ was removed on [DATE]; however, the deficient practice continues at a scope and severity of a D (potential for harm/isolated) as the facility continues to implement its action plan and as evidenced by Resident 52. The facility failed to have a system in place to monitor daily weights and to assess R52, who has a history of CHF, for potential CHF exacerbation when weight increases were identified. Evidenced by: According to Chapter N6 of the Wisconsin Nurse Practice Act, An RN (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment: Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient, which includes goals and priorities derived from the nursing diagnosis . According to an article by the Harvard Medical School, Fluid buildup indicates worsening heart failure .The buildup of excess fluid in your body can take a variety of forms from belly bloating and swollen ankles to nausea, persistent coughing and fatigue. You may be tempted initially to dismiss this hodgepodge of problems as having little to do with your heart. However, they all signal water retention, which can mean trouble for people with a history of heart failure. Fluid buildup can quickly escalate into a life-threatening situation . https://www.health.harvard.edu/heart-health/fluid-retention-what-it-can-mean-for-your-heart (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to WebMD's Heart Failure Health Center, Sometimes your symptoms may get worse very quickly. This is called sudden heart failure. It causes fluid to build up in your lungs, causing congestion. (This is why the problem is often called congestive heart failure.) .Sudden heart failure is an emergency. You need care right away. http://www.webmd.com/heart-disease/heart-failure/tc/heart-failure-symptoms Example 1 On [DATE] R4 was admitted to the facility with diagnoses that included edema, COPD (Chronic Obstructive Pulmonary Disease), HTN (Hypertension), dyspnea, Type 2 Diabetes Mellitus, pleural effusion, CKD (Chronic Kidney Disease), and acute on chronic HF (Heart Failure). R4 is 66-years-old. R4's most recent MDS (Minimum Data Set) dated [DATE] indicates her BIMS (Brief Interview for Mental Status) is 7, indicating she has severe cognitive impairment. R4 requires limited assistance of two for transferring, is dependent on one for toileting, is independent with locomotion on unit, and requires supervision of one with eating. R4 is frequently incontinent of bowel and always incontinent of bladder. R4 is not her own person with an AHCPOA (Activated Health Care Power of Attorney). R4 is a Full Code (resident would like CPR (Cardiopulmonary Resuscitation) performed in the event her heart stops). R1's CNA (Certified Nursing Assistant) Care Sheet, printed [DATE], indicates in part . Diet Orders: Frequent supervision, 2L (Liters) FR (Fluid Restriction) /24 hours, encourage to drink H2O (water) as long as within fluid restriction. ADL's (Activities of Daily Living): Showers Thursday AM (morning) and Sunday AM, weights on shower days. R4's comprehensive Care Plan, last reviewed on [DATE], includes the following focus areas: Focus: Therapeutic diet served due to DM 2 (diabetes) and obesity. [DATE] recent weight fluctuations due to fluid overload f/b (followed by) diuresis. Interventions: Fluids restricted to 2 liters/24 hours which is distributed at meals and by NSG (Nursing) staff. Monitor weights. Note: There is no documentation that staff was accurately monitoring fluid intake each day to ensure R4 did not have more than 2000 cc fluid per day. Focus: Alteration in cardiovascular status r/t (related to): HTN and CAD (Coronary Artery Disease). Interventions: Daily weights. Observe for edema or congestion. Resident will inform staff of chest pain or SOB (shortness of breath). Observe for signs of SOB. Note: R4 has orders for daily weights. No weights were obtained between [DATE] and [DATE]. On [DATE], R4 was transferred to the ER (emergency room) for evaluation due to complaints of chest tightness. R4 returned the same day with new orders to monitor for edema. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:16 PM, NN's (Nurses Notes) state the following: Report by on night shift that resident left top of hand was puffy. Noted this AM during AM care resident's left hand, arm, bilateral legs and bilateral feet are 3+ (plus) pitting edema and hard to touch. No SOB (Shortness of breath). Lung sounds are clear. No cough. Doctor on call called and order received to send resident to the ER for evaluation of possible fluid overload. Son (AHCPOA) was called and informed of resident transport. Resident left per stretcher per ambulance at 12:00 PM. Hospital ER (emergency room) RN was called and given resident information. Also had 2 other nurses assess resident with initial assessment by this nurse. Temperature: 98.1, O2 (oxygen) at 94% on room air. This note was written by LPN J. Surveyor interviewed LPN J on [DATE] at 9:17 AM. Surveyor asked LPN J what she could tell Surveyor about R4 and her hospitalization s. LPN J stated, R4 went to hospital in March for fluid overload. NOC (night) shift CNA reported to me at shift change that R4's arm was swollen. When R4 got up for the day right before lunch I went and looked at it and called LPN H to come look with me. Surveyor asked LPN J if she got an RN to assess R4. LPN J stated, No, I didn't. I had the other two LPNs in the building at the time come look at the R4 with me. Surveyor asked LPN J if she observed R4 immediately after being informed of R4's hand being edematous. LPN J stated, I didn't get it in report from NOC nurse. The CNA reported it to me but R4 doesn't get up until later so I waited until staff got her up for the day around lunch time. Note: The CNA reported the change in R4 to the LPN during shift change (at approximately 6:00 AM) and the LPN did not observe R4's condition until staff had gotten R4 up for lunch. There is no evidence that a registered nurse (RN) was called to assess R4 and to determine the most appropriate course of action. There is also no documented assessment of R4's lung sounds, pulse or respirations. The above documentation was completed by a LPN (Licensed Practical Nurse) who is unable to assess. The two other nurses consulted by documenting LPN were also LPNs. R4's Hospital discharge summary states in part Primary Discharge Diagnosis: Acute exacerbation of chronic diastolic CHF. R4 reports that over the last 2 weeks she has noticed increased lower extremity edema, dyspnea on exertion, orthopnea, and let upper extremity edema. Chest x-ray showed stable cardiomegaly with possible pulmonary venous congestion. A proBNP (N-terminal prohormone of brain natriuretic peptide is a lab test that monitors the non-active prohormone produced by the heart) with a value of 4100. The normal range for proBNP in someone under the age of 75 is 125pg/mL (picograms/milliliter). R4 received IV (Intravenous) Bumex (diuretic) while in the hospital. On [DATE], R4 discharged back to the facility with new orders for daily weights: Call the physician if weight gain of > (greater than) 3 lbs. (pounds) in a day or >5 lbs. in a week. Daily Weights: There were no weights taken on ,d+[DATE] or [DATE] [DATE]: 207.2 There are no weights taken from [DATE] to [DATE](facility is not assessing resident's weights daily as per MD order) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]: 213.8 lbs. - weight is up 6.6 pounds. There is no indication R4 had a respiratory or cardiac assessment completed with this increased weight gain. There is no indication the staff assessed R4 for increased edema, a sign of CHF exacerbation. There is no evidence staff informed the physician of a weight gain of greater than 5 pounds in a week. There were no weights taken on ,d+[DATE] or [DATE] [DATE]: 218.8 lbs. - R4's weight has increased another 5 pounds. There is no indication R4 had a respiratory or cardiac assessment completed with this increased weight gain there is no indication the staff assessed R4 for increased edema a sign of CHF exacerbation or that staff informed the MD of a weight gain greater than 5 lbs. in a week. [DATE]: 220 lbs. R4's weight has increase another 1.2 pounds or 6.2 pounds in 4 days; there is no indication R4 had a respiratory or cardiac assessment completed with this increased weight gain there is no indication the staff assessed R4 for increased edema a sign of CHF exacerbation. [DATE]: 218.8 lbs. [DATE]: 220.8 lbs. R4 weight increased 2 pounds with no assessment completed for R4. [DATE]: 222.8 lbs. R4's weight increased another 2 pounds or 4 pounds in 2 days with no assessment completed. [DATE]: 211.7 lbs. [DATE]: 217.8 lbs. R4's weight has increased 6.1 pounds in a day with no assessment completed. [DATE]: 222.2 lbs. - R4's weight has increased 4.4 pounds in a day or 10.5 pounds in 2 days with no assessment completed [DATE]: No weight recorded [DATE]: 227 lbs. - R4's weight has increased 5 pounds in 2 days with no assessment. [DATE]: 227.8 lbs. The facility was not monitoring R4's fluid intakes accurately. Recorded fluids in March, during the timeframe in which R4's weight increased from 211.7 lbs. to 227 lbs. were: [DATE]. 480 cc (cubic centimeter) [DATE]. 480 cc [DATE]. 1630 cc [DATE]. 800 cc [DATE]. 480 cc (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The MAR's for February and March indicate no intakes were recorded for the following dates and times: There are no recorded fluid intakes from [DATE] to [DATE] and [DATE] to [DATE]. There are no recorded fluid intakes on day shift [DATE] to [DATE] and [DATE] and [DATE]. There are no recorded fluid intakes on PM (evening) shift on [DATE], [DATE], [DATE], [DATE] and [DATE]. There are no recorded fluid intakes on NOC (night) shift on [DATE], [DATE], and [DATE]. On [DATE] at 10:09 AM, NN's for Daily Skilled/Comprehensive Review Completed: BP (Blood Pressure) , d+[DATE]; P (Pulse) 70; Temperature 98.1; Respirations 16. Edema: No; Chest Pain/Tightness: No. Individual Observation: No shortness of breath or trouble breathing noted when sitting at rest. Individual Observed - No shortness of breath or trouble breathing noted when lying flat - No shortness of breath or trouble breathing noted with exertion (e.g., walking, bathing, transferring). Lung sounds: Clear. Note: This Daily Skilled/Comprehensive Review was completed by an LPN. Later in the day on [DATE], R4 had an outpatient Nephrology appointment. Office Visit Note from Nephrology on [DATE] states in part . Recently discharged from Hospital on [DATE] after being treated for volume overload with IV diuretics. She is here for follow-up today. Exam: Lungs: wheezing. Extremities: ,d+[DATE]+ pitting edema all the way up her thigh. Assessment: Decompensated CHF, CKD, Cirrhosis. She is grossly volume overloaded today. She will need IV diuretics to control volume status. I will send her to the Hospital ER to get admitted . Plan: Will refer to the ER. Will inform POA. On [DATE] at 4:17 PM, NN's notes state the following: Received call from Transport Company that resident was transferred to ER, call placed to determine why? On [DATE] at 5:38 PM, NN's notes indicate, Spoke with RN, undetermined if and when they will be sending R4 back. C/o (Complaints of) SOB/satting (sic) at 100% on RA (room air). Lungs not clear but 'not bad' either per RN. R4 is still being worked up. They will call when they know more. Writer let them know that she was having hematuria and had a UA (urinalysis) done but that C&S (culture and sensitivity) was pending. On [DATE] at 1:03 AM, NN's state, called hospital and informed that R4 was admitted , diagnoses CHF and fluid overload, and was going to be diuresed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hospital Discharge Summary hospital stay [DATE] to [DATE] states in part .Primary Discharge Diagnoses: Acute on chronic HFpEF (Heart Failure with preserved Ejection Fraction) and Possible Type 2 demand MI (Myocardial Infarction) due to Heart Failure). Patient was sent to the ER by nephrologist with concern for decompensated heart failure volume overload - she has been with increasing shortness of breath and leg swelling for a month. Hospital Course: Diuresed with IV Bumex and metolazone (diuretic). BNP showed improvement from over 4000 to 3000 and improved clinically with resolution of shortness of breath. Possible type 2 demand MI - due to Acute Diastolic Heart Failure - troponin elevated (lab showing heart muscle insult/injury) but no symptoms of ACS (Acute Coronary Syndrome). Note: A Type 2 MI occurs secondary to an acute imbalance in myocardial oxygen supply and demand without atherothrombosis (clot). On [DATE] at 4:17 PM, Surveyor interviewed LPN H. Surveyor asked LPN H how staff monitor fluid restrictions and weights. LPN H stated, I don't do any of that but I write down what the CNAs tell me they give the residents. As for weights I am good about making sure my staff get weights and report them to me. Surveyor asked LPN H what she does when a resident's weights are up requiring MD (Medical Doctor) notification. LPN H stated, I always update the physician with weight changes, especially for R4. R4 is independent when up in her wheelchair and will frequently get pop from the pop machine. On [DATE] at 4:53 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B who is responsible to ensuring weights are obtained and documented in the facility. DON B stated, They do a poor job. We give them the education. We are working on this. This is one of the systems that is broke and we are working on it. Surveyor asked DON B about daily weights. DON B stated, Daily weights are done by the CNAs. Nurse should update MD with weight. Surveyor asked DON B what assessments should be completed for a resident with CHF. DON B stated, Should be assessing VS including edema and lung sounds regularly. Surveyor asked DON B what the process was for monitoring intake and output for R4 with CHF. DON B stated, Not sure but someone with that diagnosis should have I&O (intake and output) recorded and monitored. She is on a FR (fluid restriction) which the nurse would implement. Don't need MD orders for FR. I believe they are doing I&O's for R4. Surveyor asked DON B who is responsible for ensuring staff are aware of a resident's fluid restriction and how much they allowed to consume at meals. DON B indicated, nursing staff are and the dietician doesn't have anything to do with I&O's. Surveyor asked DON B if a resident should have thorough systems assessment in a resident with CHF showing increased weight gain. DON B stated I would expect the nurses to complete a thorough assessment. On [DATE] at 8:47 AM, Surveyor interviewed Dietician I. Surveyor asked Dietician I what the facility process if for monitoring intakes and residents with a FR. Dietician I stated, Someone would let me know if someone is not drinking or eating. As for FR's we have chart as to what is to be served on meal trays and what should be given by nurses. I am not sure if on fluid restriction without looking in chart. The Dietary Manager sets that up and monitors FR's. On [DATE] at 8:49 AM, Surveyor interviewed DON B. Surveyor asked DON B about monitoring intakes. DON B stated, I don't think we monitor outside of meals. Surveyor asked DON B about monitoring output for R4. DON B stated, Resident is incontinent. She refuses to use the toilet but whatever fluids she takes in should be counted and monitored by staff. We should also be monitoring outputs. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 8:56 AM, Surveyor interviewed DM E (Dietary Manager). Surveyor asked DM E what the process for the facility was for fluid restrictions. DM E stated, Tray cards have fluid restrictions on them. The CNA's serve the drinks and follow the fluid restriction. We do not measure liquid taken in with meals. On [DATE] at 9:56 AM, Surveyor interviewed NP T (Nurse Practitioner). Surveyor asked NP T if she would expect to be updated on no weights, not following R4's FR, and weights of >3 lbs. in a day or >5 lbs. in a week. NP T stated, Yes. Surveyor asked NP T if she not doing the above things could have contributed to her exacerbation of CHF. NP T stated, It certainly could be. On [DATE] at 3:35 PM, Surveyor interviewed CNA K. Surveyor asked CNA K what the facility process is for monitoring a resident's fluid restrictions. CNA K stated, We CNAs do the fluid restriction for the residents. We have a chart that has pictures with numbers of cc's in each glass. I then put it in the log and tell the nurse. On [DATE] at 3:42 PM, Surveyor interviewed CNA L. Surveyor asked CNA L what FR stand for on the CNA care sheet. CNA L stated, I think it means fluid restriction. Dietary does it. The facility failed to assess R4 when she experienced a change in condition on [DATE] when R4 complained of chest tightness, on [DATE] with CHF exacerbation and again on [DATE] with CHF exacerbation. Weights were not completed as ordered per physician, the facility failed to recognize increased edema and weight gain as a potential significant change of condition and failed to complete a thorough systems assessment for potential CHF exacerbation. The facility failed to have a process in place to monitor R4's intake and output and ensure staff and R4 were following her fluid restriction. On [DATE], when notified of a change in R4's condition LPN J did not contact an RN (Registered Nurse) for a thorough systems assessment. Subsequently, R4 experienced a change of condition on [DATE] and again on [DATE], R4 was hospitalized for exacerbation of CHF with fluid volume overload. These failures created a situation of Immediate Jeopardy, which was removed on [DATE] when the facility implemented the following action plan. On [DATE], R4's record was reviewed to determine if there were any existing evidence of a change of condition which warrants an appropriate nursing assessment, notification to the physician, follow-up and subsequent documentation. On [DATE], a full facility, physical review of all residents will be completed to determine if there were any residents that present with evidence of a Change of Condition that requires implementation of a thorough systems assessment, notification to physician of a change of condition and appropriate documentation of immediate follow-up. On [DATE], a general review of nursing documentation of all residents' statuses to include 24-hour report sheets to determine if there were any residents that present with evidence of a Change of Condition that requires implementation of a thorough systems assessment, notification to physician of a change in condition and appropriate documentation of immediate follow-up. Existing policies related to Change of Condition, Notification of Physician, Nursing Assessments, Documentation and Measuring Weights will be reviewed by the DON and clinical leadership to determine if they remain appropriate. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prior to the start of their next working shift, licensed nursing staff and certified nursing assistants will be provided education on policies procedures related to proper notification of changes to the PCP/POA/Family. Prior to the start of their next working shift, licensed nursing staff and certified nursing assistants will be provided education on identification of change of condition in accordance with the American Medical Directors Association's (AMDA) Acute Change of Condition in Long Term Care Setting Guideline, with special emphasis on acute exacerbation of Congestive Heart Failure (CHF). Prior to the start of their next working shift, licensed nursing staff and certified nursing assistants will be provided education on the requirement to follow physician's orders with respect to completing daily weights as ordered by the physician. Furthermore, the education will include the necessity to notify the physician if a weight increases by 3 lbs. in one day or 5 lbs. in one week. All licensed nursing staff will be checked for competency regarding identification of acute change of condition (emphasis on signs / symptoms of CHF exacerbation) and the appropriate response to include notification to the physician. The mechanism by which competency will be established is a quiz. The nurse care management under the oversight of the DON and clinical leadership team will review resident weights in Point-Click-Care to ensure compliance with physician's orders and to ensure proper follow-up if necessary. In addition, the nurse case managers will monitor changes of condition through daily rounding of all nurse areas and utilize the Sop-N-Watch tool for any acute changes. Resident care plans will be updated if resident has a diagnosis of congestive heart failure (CHF) to include monitoring for signs/symptoms of edema and collecting weights in accordance with the physician's orders. The DON or their designee(s) will conduct random audits of Change of Condition to ensure proper identification at the following rates: All residents daily x2 weeks; X10 residents daily x1 month; X3 residents weekly x2 weeks; X2 resident monthly x1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. The DON or their designee(s) will conduct random audits of Point-Click-Care (PCC) nursing assessments to ensure proper care and treatment oat the following rates: X10 residents daily x1 month; X3 residents weekly x2 weeks; X3 residents monthly x1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. The DON or their designee(s) will conduct random audits of Physician's Notification of Resident Change of Condition to ensure timely reporting and appropriate follow-up at the following rates: All residents daily x2 weeks; X10 residents daily x1 month; X3 residents weekly x2 weeks; X3 residents monthly x1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. The DON or their designee(s) will conduct random audits of daily or weekly resident weights to ensure proper completion, as well as, to determine if any concerns identified required immediate follow-up with an assessment and / or notification to a physician at the following rates: X10 residents daily x1 month; X3 residents weekly x2 weeks; X3 residents monthly X1 month; monthly random audits will be instituted thereafter for a period of 9 months unless deemed otherwise by the QAPI committee. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Audit trends will be reviewed at the monthly Quality Assurance / Performance Improvement (QAPI) meeting x 12 months to validate substantial compliance. On [DATE], the immediacy will be removed when all staff will be educated, policies reviewed and revised as needed and competency checks completed. Cross Reference F580 J The deficient practice continues at a scope/severity of D (potential for more than minimal harm that is not immediate jeopardy) as the facility continues to implement its action plan. 38725 Example 2 R52 is a long term resident of the facility. R52 has the following diagnoses: cardiac arrhythmia, edema, nonrheumatic mitral (valve) insufficiency, atrial fibrillation, heart failure, and acute diastolic (congestive) heart failure. R52's Physician Order document the following: [DATE]-[DATE] Weight Daily in morning. Notify MD (Medical Doctor) of weight greater than or equal to 3 pounds in 24 hours. [DATE] Daily weight before breakfast R52's Weight record documents the following: [DATE]= 306.4 [DATE]= 307 [DATE]= 319.2 - this is a 12.2 lb. weight increase in 1 week and there is no evidence the facility completed a thorough systems assessment for R52 to rule out CHF exacerbation. [DATE]= 316.4 [DATE]= 312 [DATE]= 308.4 [DATE]= 298.2 [DATE]= 303.8 - this is a 5.6 lb weight increase in 1 day and there is no evidence the facility completed a thorough systems assessment for R52 to rule out CHF exacerbation. [DATE]= 303.6 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]= 300.4, [DATE]=304 [DATE]= 298.8 It is important to note that the dates documented are the only dates that weights are recorded in R52's medical record. From [DATE] through [DATE] there are 18 days of missed weights. R52's CNA Care Delivery Guide documents daily weights, document refusals. R52's Care Plan for Self-care deficit and risk for falls R/T (related to) recent hospitalization for UTI (Urinary Tract Infection) dated [DATE], documents the following in part: .Use wheelchair scale for weights. Resident often refuses to get weighed . R52's Care Plan for ALTERATION IN CARDIOVASCULAR STATUS R/T: CHF, HTN, A-Fib dated [DATE], documents the following in part: .OBSERVE FOR EDEMA OR CONGESTION .OBSERVE FOR SIGNS OF SOB. R52's CNA documentation was reviewed for 30 days with no documentation of refusals of weights. R52's Progress Notes were reviewed from [DATE] through [DATE] with no documentation of refusals of weights. The facility failed to have a system in place to monitor daily weights and to assess resident with a history of CHF for potential CHF exacerbation with weight increases.

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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** 30992 Based on observation, interview, medical and record review the facility did not implement professional standards of practice to prevent PIs (pressure injuries) from developing, worsening, or to promote healing of PIs, and assessments of PIs are not consistently being completed by a RN (Registered Nurse), for 1 of 3 resident reviewed for PIs out of a sample of 23 residents (R55). R55 has paraplegia and no feeling from his waist down. Per interview with R55, he stated he was admitted to the facility on [DATE] with a small pressure injury on his bottom that he has had for years. The facility did not identify R55's PI on the Admission Skin Assessment. The facility identified R55's PI on 3/18/21 (9 days after admission). When the PI was discovered it measured 2.2 cm (centimeters) x 1.7 cm and the wound bed contained 85% slough and 15% granulation tissue (Unstageable PI/Stage 3). The facility did not have a care plan with skin interventions in place until 3/19/21. Per interview with staff, R55 refuses repositioning about 50% of the time on AM and PM shifts and 100% of time when sleeping. The facility did not document R55's refusals to reposition or that staff provided the risks and benefits of refusing repositioning. The facility did not provide education to R55 related to the risk of sheering with slide board transfers, particularly due to his decreased trunk strength. Surveyor observed R1 lying directly on his back in bed putting pressure on his buttocks and left gluteal fold; CNA O (Certified Nursing Assistant) stated R55 refused repositioning that morning, however, she did not document R55's refusal or notify the nurse or DON B. There is no documentation that R55 refused repositioning or that staff provided the risks and benefits of refusing repositioning or slide board transfers that can increase the risk of sheering, particularly due to R55's decreased trunk strength. This is evidenced by The facility's policy, Pressure Injury/Skin Integrity/Wound Management, revised November 2016, states, in part, as follows: Policy: A system is in place for the prevention, identification, treatment, and documentation of pressure injuries and non-pressure wounds. Evaluate the resident's clinical condition and pressure injury risk factors; Define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; Monitor and evaluate the impact of the interventions; and/or revise the interventions as appropriate. Eschar/slough: Slough is necrotic/avascular tissue in the process of separating from the viable portions of the body and is usually light in colored, soft, moist, and stringy (at times). Friction/Shearing: Friction is the mechanical force exerted on skin that is dragged across any surface. Shearing is the interaction of both gravity and friction against the surface of the skin. Friction is always present when shear force is present. Shear occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stages of Pressure Injuries: The staging system is one method of summarizing certain characteristics of pressure injuries, including the extent of tissue damage. Stage 3 Pressure Injuries: Full-thickness skin loss - Full-thickness of loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of the tissue damage varies by anatomical location, areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Procedure: 1. Wound Assessment ii. All residents are preventatively placed on a pressure reduction mattresses and cushions in wheelchairs based on the skin assessments. Those residents who represent a high risk will have further preventative interventions put in place. Appropriate turning and repositioning schedules will also be put in place per assessment. An initial/immediate care plan will be initiated. NPIAP (National Pressure Injury Advisory Panel) defines a pressure injury (PI) as: Any skin lesion, usually over a bony prominence, caused by unrelieved pressure resulting in damage of underlying tissue. Major Risks Factors for Developing Pressure Injuries: Alterations in sensation or response to discomfort: Degenerative neurological disease, cerebrovascular disease, Central nervous system (CNS) injury, depression, drug that adversely affect alertness. Alterations in mobility: Neurological disease/injury, fractures, pain, restraints. Significant changes in weight (greater than 5% is 30 days or greater than 10% in the previous 180 days): Protein -calorie malnutrition, edema. The NPIAP classifies a pressure injuries as follows: Stage 3: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts may be associated with Stage 4 pressure ulcers. This is evidenced by: R55 was admitted to the facility on [DATE] with diagnoses including, but not limited to, paraplegia (no feeling from the waist down), left BKA (below the knee amputation), anxiety disorder, personality disorder, bipolar disorder, delusional disorders, polyneuropathy, severe sepsis, rotator cuff tear or rupture right shoulder. R55's BIMS (Brief Interview of Mental Status) is 15/15, indicating he is cognitively intact. R55 is his own decision maker. On 3/9/21 at 4:11 PM, R55's Admission Skin Assessment documented the following: Site: Back Type: healing pressure Measurements: 0.8 x 0.5 x 0 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R55's Admission MDS (Minimum Data Set) assessment, dated 3/13/21, Section C0200 Cognitive Patterns indicates R55's BIMS (Brief Interview of Mental Status) is 15, indicating he is cognitively intact. Section G Functional Status, indicates R55 is dependent on staff for bed mobility, Section M0150 Risk of Pressure Injuries indicates R55 is at risk for PI development. Section M0210 Unhealed Pressure Injuries indicates R55 has an unhealed PI. Section M0300 Current Number of Unhealed Pressure Injuries at Each Stage indicates R55's PI is a Stage 1: Intact skin with non-blanchable redness of localized area usually over a bony prominence (Note, this PI was noted to be higher on R55's back). Stage 2: 0 (zero), Stage 3: 0 (zero), Stage 4 0 (zero), Unstageable-slough/and/or eschar: 0 (zero), Unstageable-DTI (Deep Tissue Injury): 0 (zero). Section M1200 indicates Skin and Ulcer Treatments: A. Pressure reducing device for chair, B. Pressure reducing device for bed, C. Turning/repositioning program, E. Pressure ulcer care. Note, a care plan with skin interventions was not put in place until 3/19/21. R55's Braden Score (Risk factor for PI development) on 3/10/21 and 3/18/21 = 19, indicating R55 is not at risk of skin breakdown. Note, R55 was admitted with two pressure injuries. One PI is on his back (documented) and the PI on his left gluteal fold was present, however, it was not documented on admission. R55's Care Plan for Skin Integrity and pressure injury interventions was not put in place until 3/19/21. Note, this is one (1) day after the PI was discovered by staff and ten (10) days after admission. The facility did not have a temporary care plan in place. R55's CNA (Certified Nursing Assistant) Care Delivery Guide, dated 4/18/21, indicates the following: LAL (low air loss) mattress, Encourage/assist repositioning Q2 (every two) hours and PRN (as needed), Reposition side to side, not on back, Encourage to lay down after lunch. Mobility: w/c (wheelchair) 2 assist for bed mobility; Transfer: 1 assist with slide board On 3/18/21 at 9:24 PM, RN F (Registered Nurse) completed the Weekly Skin Check Tool indicating the following: Pressure sore noted to left buttock measuring 1.7 cm (centimeter) x 2.0 cm, has yellowish slough in wound bed. Will pass it on shift report for PCP (Primary Care Provider) to be notified/updated in the morning 3/19/21. On 3/19/21 at 3:40 PM, R55's Nurse Progress Notes indicates the following: Wound observation today resident has a wound to left gluteal fold with a yellow wound bed. Resident did not have any pain during assessment however he has no feeling from the torso down due to paraplegia [sic]. He has been sitting up in his w/c (wheelchair) from morning till evening getting his room and computures [sic] situated. Resident agreed to lay down in bed after lunch and to lay and turn side to side. Resident was given an air mattress. Care plan and staff updated. Treatment order obtained. Note, there was no care plan with skin interventions in place until 3/19/21. There is no evidence that the facility offered to assist R55 with repositioning. There is no documentation that R55 refused repositioning or staff provided the risks and benefits of refusing repositioning or slide board transfers that can increase the risk of sheering, particularly due to R55's decreased trunk strength. On 3/19/21 R55's Physician Telephone Order: Apply Bordered gauze change every 3 days and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/23/21 at 8:31 PM, the facility's Weekly Wound Round Documentation indicates the following: 1. Reason for assessment a. New Wound, Date of Onset: Blank, 2. Notifications c. Individual/Self, Physician notified, Additional Information: Notified on 3/19/21 of wound new orders. Message left for MD (Medical Doctor) requesting new TX (treatment) order due to moderate/large drainage. 3. Type of Wound: Pressure Wound - Left gluteal fold, a. Acquired 3/18/21, Site: Left Gluteal Fold. Type: Pressure, Measurements 2.2 cm x 1.7 x? Stage Unstageable, 2. Wound base/bed: Granulation 85%, Slough 15% (Note, RN M later corrected to 85% slough & 15% granulation). Additional Information: Serosang (Serosanginous) drainage moderate to large amount, soft slight maceration to periwound. Undermining/Tunneling Present: Unable to visualize. Current treatment: Clean and apply bordered gauze q3 days (every 3 days) and PRN (as needed). Progression/Interventions: Improving, slough appears to be thinner than first observation on 3/19/21. Positioning Plan: Off left side. Nutrition: RD (Registered Dietician). Pressure Relieving Mattress/Device: Air mattress ROHO. On 4/16/21 at 2:33 PM, R55's Nurse Progress Notes indicate the following: Occupational Therapy screen due to return from day surgery s/p (status post) right shoulder arthroscopy, debridement. Pt (Patient) relates less pain than anticipated right shoulder, declines to get OOB (out of bed) this date, and is positioned supine in bed with HOB (head of bed) up, lap top over bed table. Pt states PT (Physical Therapy) provided pt. with recommended ROM (range of motion) exercise for the weekend. OT recommends screen pt. on 4/19 - Monday when pt. is ready to participate in self-cares and functional mobility tasks. Note, R55 declined to get out of bed on 4/16/21 and was lying prone (on his back) for the day. There is no evidence that facility staff provided education related to refusing skin interventions and repositioning. On 4/18/21 at 11:54 AM, Surveyor conducted a resident interview with R55. R55 stated he was admitted to the facility with a small pressure injury on his bottom that he has had for years. On 4/20/21 at 1:35 PM, RN G (Registered Nurse) documented the following Progress Note: Skin - new or worsening skin concerns-No, Current Skin interventions: Resident has a dressing on his back/buttocks area according to him but would to let me look at it. [sic] Resident got upset when I asked to look at it and told me to leave his room. Note, there is no evidence the facility educated R55 related to refusing skin assessments, interventions, and treatments. Measurements - Left Gluteal Fold - Onset 3/18/21 3/18/21: 1.7 x 2.0 yellowish slough in wound bed Note, this PI was a Stage 3 when discovered by the facility. 3/23/21: 2.2 x 1.7 x? Unstageable, 85% granulation, 15% slough Slough appears to be thinner than first observation on 3/19. *Note correction to this entry below. 3/25 wound tx changed *3/28/21 Correction to wound round documentation (above) wound is 85% yellow slough and 15% granulation. MD (Medical Doctor) was updated on wound this week ad new treatment orders this week from MD. 3/30/21: 1.6 x 1.0 x less than 0.1 Unstageable 100% granulation 4/7/21: 2.0 x 1.5 x less than 0.1 decreased drainage, 100% granulation (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4/13/21: 2.4 x 2.0 x less than 0.1 100% granulation - Updated MD, let her know it was a little bit bigger, macerated around edges, not being changed enough d/t drainage. The treatment was changed to daily. 4/20/21 2.4 x 1.4 x less than 0.1 100% granulation R55's Care Plan for Skin was not implemented until 3/19/21, the day after R55's Stage 3 left gluteal fold PI with 85% slough was noted by staff. The facility's matrix indicates R55 has a Stage IV, facility acquired PI. Note, based on interview with RN M, this wound is unstageable versus a Stage 4. On 4/20/21 10:23 AM, Surveyor spoke with RN M. RN M stated initially the nurse found the PI on the skin check & she assessed it. RN M stated she would call it unstageable RN M stated, there was slough- a lot of slough and she could not see the wound bed. On 4/20/21 at 8:20 AM, NHA A (Nursing Home Administrator) stated, When nurses ask to take a look at his skin he flips out. The moment he gets out of bed he does not want to get back in bed. Nurses do dressing changes first thing in AM (before R55 gets out of bed.). Everything has to be on his time at his schedule. On 4/20/21 at 8:50 AM Surveyor observed R55 lying in bed on his back. R55 declined to have Surveyor observe PI dressing change and PI. On 4/20/21 at 8:57 AM Surveyor interviewed CNA O (Certified Nursing Assistant) who is the assigned CNA on R55's unit. Surveyor asked CNA O to tell Surveyor about R55's skin interventions. CNA O stated she repositions him from bed to his chair. CNA O stated R55 is capable of communicating and she listens to what he says because it's his body. CNA O added, she looks at the Care Delivery Guide. CNA O stated, my Care Deliver Guide says reposition him from side to side not on back & encourage him to lay down after lunch. CNA stated I encourage repositioning every 2 hours but he has his own ideas. If he's cool with you he'll be open minded (clarified cooperative). CNA O stated, I think the people that position him side to side is on 3rd shift. CNA O added, on the AM shift he is repositioned from bed to chair, he will sometimes lay down. CNA O stated R55 does not like to acknowledge his disability. CNA O stated she is working from 6:00 AM - 2:00 PM today. Surveyor asked CNA O did you offer to reposition R55 this morning. CNA O stated yes, this AM he didn't want me to touch him, due to the pain he was aggravated. He was extremely upset due to pain; the pain is in his back. He'll say, I'm f***ing in pain. I'll tell the nurse to go see R55. Surveyor asked CNA O does R55 refuses repositioning. CNA O stated, Yes. Surveyor asked what percentage of the time R55 refuses to reposition. CNA O stated he refuses repositioning 50% of the time. CNA O stated if he refuses I'll ask him why. If he gives me a why, I work with him. He'll say I already done it, I don't need it. He didn't want me to touch him this morning. Do you know what position R55 is in right now. CNA O stated, he is on his back currently. I just give him cues & remind him. He uses a GB to pull himself up. He can do things without assist. Surveyor asked CNA O if a resident refuses repositioning what do you do. CNA O stated, I report to the RN. If it's an issue I could tell DON B (Director of Nursing). It's becoming a serious issue & not helping his sore - I would talk to DON B. Have you spoken with DON B about R55 not wanting to reposition. CNA O stated, No. Surveyor asked CNA O is it ok for R55 to lay on his back. CNA O stated, Not for a long extent of time. CNA O stated, He doesn't have a PI on his backside. Note, the CNA caring for R55 is unaware that he has a PI and should not be laying on his back. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/20/21 at 5:30 PM, Surveyor spoke with NHA A and DON B regarding this R55. NHA A added they think the PI may have been due to shear from the slide board R55 requested to use for transfers. R55 refused to use the Hoyer for transfers. NHA A added R55 was using his wheelchair from home at the facility. This wheelchair was missing the right side arm. The facility obtained a new arm for the wheelchair. NHA A feels the PI may have been due to shear from slide board, and/or the w/c was from his house that was missing the right side arm, causing R55 to lean to the left, thus putting pressure on R55's left buttock and left gluteal fold. NHA A added Therapy increased pressure on R55's Roho to account for this. NHA A added there were great interventions on Therapy's side and not great on the Nursing side. Note, there was no care plan with any skin interventions in place until 3/19/21. There is no evidence the facility offered to assist R55 with repositioning. There is no documentation R55 refused repositioning or staff provided the risks and benefits of refusing repositioning. There is no evidence staff educated R55 related to the use of slide board transfers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/20/21 at 9:38 AM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B has the facility provided R55 the risk and benefits to refusing repositioning. DON B stated, We do not have any risk and benefits. DON B added she spoke with RN G (Registered Nurse) and she can complete the risks and benefits with R55. Surveyor asked DON B can you tell me when R55's air mattress was put in place. DON B looked this information up in R55's medical record and stated the air mattress was added 3/19/21 and R55 was admitted to the facility on [DATE]. DON B added upon admission R55 had a Panacea mattress. Surveyor asked DON B would you have expected R55 to have a care plan for skin upon admission. DON B stated, Yes, we're working on our admission system to make the process smoother (makes sure consents in place equipment in place, anticipate the needs of the resident.) Surveyor asked DON B is R55 currently a 2A (2 assist) for turning and repositioning. DON B stated, No, he should be a 1 assist for this (turning and reposition). R55 had a rotator cuff (debridement) on 4/15/21. R55 told us it was a rotator cuff tear but reading the notes it was a debridement that was done. Surveyor asked is R55 able to use his arms. DON B stated, absolutely. R55's paralysis is from the chest down. Surveyor asked DON B what the root cause of R55's PI is. DON B stated, I want to say because he doesn't like to get off his butt until he's ready. DON B added, He's not compliant with getting off his rump; he will let us know in no uncertain terms. Surveyor asked DON B do staff document R55's refusals to turn and reposition. DON B stated, it should be charted by the nurse. CNA's should be able to document, but currently that feature is not available for CNA's to document refusals. Should staff have provided risk/benefits of refusing turning and repositioning? DON stated, Absolutely! That is definitely on my radar now. Surveyor asked DON B why this is important. DON B stated, so he's aware of the consequences of not being repositioned and what that entails. Should staff have provided risk/benefits of slide board transfers? DON B states, yes. Surveyor stated the matrix indicates that R55 has a Stage IV facility acquired pressure injury. Surveyor asked DON B was R55's pressure injury to his left gluteal fold facility acquired. DON B stated, I believe he came in with it but we didn't get it documented, that's our responsibility. DON B added, Because we missed it we have to own it. Surveyor asked DON B does R55 refuse to reposition. DON B stated, Yeah, he does. DON B stated since admission R55 was adamant about staff not coming in his room when he was sleeping not even to empty his urinal; he doesn't like to be disturbed. DON B added, R55 is not being repositioned at night if he doesn't want to be disturbed. DON B stated she will see if that is documented anywhere. Note, no further information was provided. Surveyor asked DON B has anybody discussed the risk and benefits with R55 related to his refusals of repositioning. DON B stated, No, I don't believe they have. DON B stated the PI was discovered on 3/18/21 at 9:21 PM, the Physician was notified 3/19/21 at 9:41 AM. On 3/19/21 R55 agreed to lay down, R55 was given an air mattress, staff were updated, and treatment orders obtained. On 4/20/21 at 10:02 AM, Surveyor spoke with RN G. Surveyor asked if she is Wound Care Certified. RN G stated, No. Surveyor asked if any nurses in the building are Wound Care Certified. RN G stated she believes their Corporate Consultant who is not in the building is Wound Care Certified. Surveyor asked RN G how you identified the PI as a Stage 4. RN G stated when I came in it was already identified as a Stage 4. Note, the wound documentation indicates the wound is unstageable. RN G stated, I don't know what the PI looked like originally. RN G added, when I first saw it, it was 100% granulation tissue. Surveyor asked RN G how you would describe the appearance of the PI today. RN G stated, it was 100% granulation tissue, nice red, beefy tissue, and measured 2.4 cm x 1.4 cm x less than 0.1. Surveyor asked RN G can you see the wound bed. RN G stated, Yes. Surveyor asked could you see any bone. RN G stated, No. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 4/20/21 at 1:10 PM, Surveyor spoke with PT Y (Physical Therapist). PT Y stated he worked with R55 within a day or so of after R55's initial evaluation. PT Y stated some things I documented is R55 stated, We'll do things my way. PT Y stated, R55 has a strong personality. R55 is a max (maximum) t4 (fourth thoracic vertebra) spinal injury of [AGE] years. PT Y stated, it wasn't the rolling piece it was the trunk stability. R55 refused the Hoyer lift multiple times, which limits him to a plywood transfer. PT Y added R55 needs two (2) shoulder surgeries. PT Y stated he listed R55 as a maximum assist due to his spinal injury. Note, PT Y added, R55 is plenty strong enough with his arms to roll, however, the pain in his shoulders prevents him from rolling. Note, this is why offering turning and reposition for R55 is of critical importance. R55 was able to roll but with his lack of trunk control he needs assistance to get to the edge of the bed; that's where he would need the help and to sit at the edge of the bed. PT Y added R55 doesn't want to be in bed much and he'll fight it. On 4/21/21 at 2:41 PM, Surveyor spoke with Interim MDS Z (Minimum Data Set) / Director of Therapy. MDS Z documented the timeline of events since R55's admission. PT (Physical Therapy) recommended to the pt. (patient) (R55) he be a Hoyer transfer which pt. (R55) stated he would not do. He want to use a slide board since this is what he had done at home. Limiting factors for slide board - BLE (bilateral lower extremity) spasticity and bad shoulders needing RTC (rotator cuff) repair surgery. Decision was made not to put an air mattress in place for the following reasons: 1. He does not use an air mattress at home. 2. He has decreased trunk stability 3. He has decreased UE (upper extremity) strength because of the need to have the RTC repair surgery and pain 4. Using a slide board on an air mattress with the decreased trunk stability and decreased BUE strength make those problems even worse. Doing a slide board without an air mattress was still not the #1 recommendation. There was a risk of sheering because his arm strength was not what it should be and his decreased trunk strength caused a balance deficit that could be more of a challenge. PT wanted to work with him for a period of time before transitioning to slide board, but his refusal of the Hoyer forced it to be the mode of transfer. Other things we did to help with his immobility r/t (related to) his paraplegia: 1. Assessed and adjusted his ROHO cushion in the chair (3/12/21) 2. Added straps with his direction to the foot of the bed which helped him to mobilize better on his own. This was set up like he has at home. (3/12/21) 3. Pursuit of the arm rest for his w/c. When he came in he informed us it was on order. We were then told by the vendor/care management team that it had come in but since he is in a SNF (Skilled Nursing Facility) it could not be delivered until he discharged . We continued to pursue it being delivered here as it assisted him being able to independently unweight himself, allow for equal UE support when seated (won't lean more toward the left to put LUE (left upper extremity) on the arm rest) and provided safety on the right side of the chair (deficits in trunk control). (3/10/21 and 3/2/21) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	MDS Z stated PT Y couldn't complete R55's evaluation. R55 told PT Y he was not willing to do a Hoyer transfer because of the location of his spinal cord injury and lack of trunk control, shoulder pain & weakness. MDS Z stated we were hesitant to do slide board transfers because of those things. MDS Z stated we were hesitant to put him on an air mattress being a paraplegic. He didn't have one at home, an air mattress is going to make his balance issues more difficult, and because of his pain and decreased shoulder strength, we did think a slide board with air mattress would be difficult and put him more at risk. Bottom line we wanted to do a Hoyer and not a slide board. It's ok for him to not be on an air mattress. We wanted to work on strengthening and pain management (shoulder strength). If you're not lifting someone on a slide board there's shearing. On 3/12 we adjusted the inflation on ROHO cushion. On the day of admission we added straps to the end of his bed per his request (Documentation indicates this was done 3/12/21). We wanted him to be able to be better with bed mobility. We asked about his missing right wheelchair arm. R55 stated it was on order. We were able to get the wheelchair arm here (around the first week in April 2021). He uses it to unweight (shift) without it he tends to lean more to the left because that's where his arm rest would be. When he uses his right upper extremities he stabilizes himself and shifts left. I don't feel the skin issue is related to the bed (not having an air mattress). A gluteal fold issue is more of a sitting than a bed issue. We never documented on his rolling abilities. He had enough trunk strength to partial range on a gravity eliminate plane, so he isn't able to get up from a supine to a sitting position because that's against gravity but in a gravity eliminate position (supine) he is able to move his trunk through a partial range. That's tested and assessed without using his hands. So then you add a side rail he can grab onto (positioning bars) he would be able to rotate his trunk that he could unweight a great deal of his pelvis. 2/5 is a full range on gravity related plane (meaning he can completely go through a full rom on his own). (Highlighted). MDS Z stated R55 refused to leave the wheelchair during the day and would say I've been a para for [AGE] years, I don't need your crap. Note, there is no evidence the facility offered to assist R55 with repositioning. There is no documentation R55 refused repositioning or staff provided the risks and benefits of refusing repositioning or slide board transfers that can increase the risk of sheering, particularly due to R55's decreased trunk strength.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review the facility did not ensure that residents with limited mobility receive appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence for 4 of 6 residents (R76, R52, R24 and R25) reviewed for ROM (Range of Motion)/ambulation. R76 is not receiving passive ROM. R52 is not being ambulated consistently. R24 is flaccid (unable to move) on one side of her body. Physical therapy has ordered a splint for her right hand so she does not develop a contracture (stiffening of a joint). R24 indicates staff have not been placing her splint on her hand or doing range of motion exercises. R25 has PT (physical therapy) recommendations to walk with stand by assist at least one time a day. R25 indicates staff do not walk with her. This is evidenced by: The Facilities Mobility- Ambulation Policy and Procedure dated 11/16 documents, in part: Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence, unless a reduction in mobility is demonstrated unavoidable .1. All resident who are declared safe for ambulation with nursing staff should be mobilized by this method, using appropriate device assigned by physical therapy (if on physical therapy program) to the individual (e.g., walker, cane). The Facilities Restorative Program Policy and Procedure dated 4/1/08 documents, in part: While in this facility, all residents are supported to maintain or attain their highest level of functioning. All residents are assessed upon admission and at each care plan meeting for possible inclusion in restorative programs. Restorative programs are individualized to meet resident needs with short- and long-term achievable goals documented. Restorative programs as noted: Range of motion (ROM), active and passive, splint or brace use . Example 1 R76 is a long term resident of the facility. R76 has the following diagnoses: Cerebral infarction, Paralytic syndromes, Functional quadriplegia, History of TIA (Transient Ischemic Attack), and Multiple sclerosis. R76's most recent MDS (minimum data set) dated 3/27/21, documents that he is moderately impaired cognitively, R76 requires total dependence for transfer and locomotion, and R76's section for Functional Limitation in ROM is not filled in. Therapy Recommendations: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R76 has recommendation from Physical Therapy dated March-April 2019 for Daily PROM (Passive Range of Motion) to legs when in W/C (wheelchair). R76's care plan does not include PROM. R76's CNA (Certified Nursing Assistant) Care Delivery Guide documents Daily ROM: Stretch out legs 1x (1 time) daily when in w/c Review of 30 days of CNA documentation under Task NURSING REHAB: Passive ROM (specify): Restorative ROM: Stretch out legs 1x daily when in w/c has 2 dates documented; 3/26/21 for 20 minutes and 4/19/21 for 10 minutes. On 4/19/21 at 3:21 PM, Surveyor interviewed CNA V. Surveyor asked CNA V if they have a restorative program, CNA V said she wasn't sure. Surveyor asked CNA V if they have walking or ROM to do for residents, CNA V stated we have walking in our charting if it is to be completed but not ROM. On 4/19/21 at 3:27 PM, Surveyor interviewed CNA W. Surveyor asked CNA W if they have walking or ROM to do for residents, CNA W replied walking is in our charting but I'm one CNA and I have to make sure the residents are clean and safe, so I don't usually have time for that, I've not seen any ROM in our charting, I believe therapy does that. On 4/20/21 at 7:54 AM, Surveyor interviewed LPN Q (Licensed Practical Nurse). Surveyor asked LPN Q when R76's ROM should be done, LPN Q said ROM should be done with cares, but it's not scheduled unless the resident has a restorative program. On 4/20/21 at 9:02 AM, Surveyor interviewed R76. Surveyor asked R76 if the staff stretch out his legs every day, R76 said no. Surveyor asked R76 if the staff do any type of exercise with him daily, R76 replied none are done with me. On 4/20/21 at 9:10 AM, Surveyor interviewed LPN J. Surveyor asked LPN J when ROM should be done with R76, LPN J said with cares and showers. On 4/20/21 at 5:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if PROM should be completed as ordered for any resident with order/recommendation including R76, DON B stated yes it should be completed. DON B returned to Surveyor awhile later and stated we had R76's ROM in as PRN (as needed) that's why they didn't see it to do it. Surveyor asked DON B if the CNA's should be following their Care Delivery Guide, DON B said yes. It is important to note R76's Care Delivery Guide spells out that he is to receive Daily ROM. Example 2 R52 is a long term resident of the facility. R52 has the following diagnoses: Varicose veins of lower extremities, Osteoarthritis of hip, Pain in hip, Edema, and Obesity. R52's most recent MDS dated [DATE] documents a score of 15 on her BIMS (Brief Interview of Mental Status), which indicates she is cognitively intact, R52 requires supervision of 1 staff for ambulation, and section for Walk in Corridor is documented as did not occur. Therapy Recommendations: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R52 has recommendation from Physical Therapy dated January-March 2021 for Walking program 4WW (4 wheeled walker), standby assist, with W/C follow for 1 time daily. Wear O2 nasal cannula. R52's Self-care deficit and risk for falls R/T (related to) recent hospitalization for UTI (Urinary Tract Infection) dated 2/15/21, documents in part: .1 assist with FWW (four wheeled walker) .Restorative walking program as ordered, Date Initiated: 7/10/19, Revision on: 8/1/19 . R52's CNA Care Delivery Guide documents Amb (Ambulate) w/4WW (with 4 wheeled walker) & w/c to follow with SBA (stand by assist)/CGA (contact guard assist) daily up to 100' (feet) 1-2x (times) daily [SIC] Review of 30 days of CNA documentation under Task Restorative: Amb w/4WW & w/c to follow with SBA/CGA daily up to 50 documents the following: N/A (not applicable) = 40 Refused= 12 Total dependence= 8 Supervision= 1 Independent= 3 On 4/18/21 at 10:25 AM, Surveyor interviewed R52. Surveyor asked R52 if the facility could do anything better for her, R52 stated I'd like to walk but they just don't have the time. On 4/20/21 at 7:54 AM, Surveyor interviewed LPN Q. Surveyor asked LPN Q where the CNA's would locate walking programs for a resident, LPN Q said walking programs are on the CNA's Care Delivery Guide. On 4/20/21 at 9:06 AM, Surveyor interviewed R52. Surveyor asked R52 if the staff have been walking her at all, R52 replied they've not been walking me, I have to ask for it. Surveyor asked R52 if there have been some times where the staff have asked and she has declined, R52 stated in the last month I haven't felt great all the time and have refused when not feeling well. On 4/20/21 at 9:10 AM, Surveyor interviewed LPN J. Surveyor asked LPN J if R52 was being ambulated on AM shift, LPN J stated it is not happening on our shift for the last month at least. Surveyor asked LPN J if R52 is being ambulated on any other shift, LPN J said she could not answer that. On 4/20/21 at 3:20 PM, Surveyor interviewed CNA K. Surveyor asked CNA K if R52 was ambulated on PM shift, CNA K replied she wasn't sure if she is walked, but would get back to Surveyor. CNA K did not return with an answer. On 4/20/21 at 5:05 PM, Surveyor interviewed DON B. Surveyor asked DON B if ambulation should occur for those it is ordered for, DON B stated yes it should be completed. 37091 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 3 R24 was admitted to the facility on [DATE] with diagnoses of stroke, hemiplegia (weakness of an arm and or leg), diabetes and aphasia. R24's most recent MDS (Minimum Data Set) dated 2/6/21 indicates her cognitive level is modified independence. R24 requires extensive assistance with personal hygiene (as in brushing her teeth, and combing her hair). Her MDS indicates she has impairment on one side of her body and she is unable to speak. R24's Physical Therapy progress note dated 5/24/2018 indicates right hand splint on 10 am, off 2 pm, on 6 pm, off 10 pm, skin check and gentle PROM (passive range of motion) wrist and hand after removal. R24's Care Plan dated 8/1/2019 indicates R (right) hand splint as recommended. R24's CNA (Certified Nurse Assistant) Care Plan dated 4/21/2021 directs Rt (right) brace on at 1000, off at 1400 (2:00 pm), on at 1800 (6:00 pm), off @ 2200 (10:00 pm). On 4/20/21 at 1:00 PM, Surveyor spoke to R24. Surveyor asked R24 if staff put on her right hand splint. R24 pulled back her blanket with her left hand and showed there was no splint on her hand. Surveyor asked her if she wants her splint on her right hand. R24 nods her head in an up and down motion, indicating yes. Surveyor asked R24 if staff do range of motion on her hand and move her hand and wrist gently to exercise it. R24 shook her head in a side to side motion, indicating no. Surveyor observed R24's hand in a relaxed position, with skin intact. On 4/21/21 at 9:30 AM, Surveyor spoke to CNA N. CNA N said R24 has her splint on her hand only when she gets up. CNA N said she does not do range of motion to any part of R24's body. On 4/21/21 at 2:05 PM, CNA P said R24 gets the splint on her hand when she is up and out of bed. CNA P said she does not do range of motion on any resident. Example 4 R25 was admitted to the facility on [DATE] with diagnoses of anemia, diabetes, and kidney failure with hemodialysis. R25 started physical and occupational therapy for conditioning and strengthening on 11/5/20. R25's care plan dated 4/13/21, indicates staff to walk R25 with stand by assistance as far as she tolerates on non-dialysis days. R25's physical therapy note dated 2/24/21 indicates R25 is independent with transfers, independent ambulation with wheeled walker in room. Ambulation program: ambulate with four wheeled walker with stand by assistance one time Tuesday, Thursday, Saturday and Sunday in hallway distance as resident tolerates with wheel chair to follow. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/21 at 10:00 AM, Surveyor spoke with R25. R25 said staff do not walk with her at all. R25 said she walks in her room with her walker. R25 said she knows physical therapy gave orders to walk with her on non-dialysis days. R25 said she asks staff to walk with her, but they say they don't have time. On 4/21/21 at 9:30 AM, Surveyor spoke with CNA N. CNA N said she does not walk with R25, but she knows R25 is allowed to walk in her room by herself. CNA N said she always gets her work done, but sometimes walking with people and range of motion is missed. On 4/21/21 at 11:30 AM, LPN J (Licensed Practical Nurse) said we don't have time to do range of motion or walk with these residents. On 4/21/21 at 2:10 PM, Surveyor spoke with DON B (Director of Nursing). DON B said staff should be following the care plan for range of motion, ambulation and splint application.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42482 Based on observation, interview and record review the facility failed to ensure psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) are used only when appropriate to treat a resident's specific, diagnosed , and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication for 2 (R21 and R27) of 5 sampled residents reviewed for unecessary medications. R21 has been prescribed anti-psychotic and pyschotropic medications without proper indication for use, monitoring or adjustment of dosage. R27 was prescribed anti-psychotic and pyschotropic medications without proper indication for use. This is evidenced by: The facility policy titled, Unnecessary Drugs-Psychotropic Drugs, dated 4/1/2008 with last revision on 9/22/17, states in part: .psychotropic drug therapy shall be used only when it is necessary to treat a specific condition as diagnosed and documented in the clinical record .anti-psychotic drugs should not be used unless the resident's medical record clearly indicates one or more of the following specific conditions: Schizophrenia, schizo-affective or schizophreniform disorders, delusional disorder, psychotic mood disorders ., acute or brief reactive or atypical psychosis, demented illnesses with associated behavioral symptoms, medical delirium . The facility policy continues with .use of an antipsychotic medication must meet the criteria and applicable, additional requirements .since diagnoses alone do not warrant the use of antipsychotic medications; the clinical condition must also meet at least one of the following criteria: Symptoms are identified as being due to mania, psychosis .hallucinations or delusions .behavioral symptoms presenting a danger to the resident or to others .or the symptoms are significant enough that the resident is experiencing one or more of the following: Fear, inconsolable or persistent distress .continual yelling, screaming, distress associated with end-of-life .substantial difficulty receiving care .not eating resulting in weight loss .skin breakdown or infection. The facility policy further warns, Antipsychotic drugs should not be used if one or more of the following is/are the only indications: Wandering, poor self- care, restlessness, impaired memory, anxiety (mild), depression, insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, behaviors . which do not represent danger to the resident or others. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to the introduction of a psychotropic medication .establish target behavior sheet which must include quantitative and objective information .each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used . is duplicative therapy, without adequate monitoring, without adequate indications for its use . Example 1 R21 was admitted [DATE] with diagnoses of Alzheimer's, dementia without behavioral disturbance, anxiety, major depressive disorder and dysphagia. R21's Minimum Data Set (MDS), a comprehensive, clinical assessment for each resident, dated 11/1/20 (initial admission assessment) does not include schizophrenia, bipolar, psychosis, delusions or hallucinations on the diagnosis list. There are no indications of behavioral disturbance on the MDS either. R21's MDS dated [DATE] does not indicate any behavioral disturbance, psychosis, hallucinations, delusions or medical delirium. The resident face sheet does not outline psychosis, hallucinations, delusions or dementia with behavioral disturbance as diagnoses. R21's care plan diagnoses include Alzheimer's disease and dementia without behavioral disturbance. Per the facility's treatment administration records (TAR) which captures behavior documentation for tearfulness, restlessness, exit seeking and combativeness with cares, the following was indicated for February 2021: R21 had restlessness on 4 of 84 shifts (shift defined as 8 hours) with interventions of 1:1 interactions, providing food, changing position and encouraging rest demonstrating improvement in symptoms. There was no documentation of R21 having tearfulness, exit seeking or combativeness with cares. No documentation of psychosis, hallucinations, delusions or dangerous behavior to self or others. Per R21's facility medication administration records, (MAR) in February 2021, R21 was prescribed the following psychotropics: Lorazepam 0.5 mg every 2-3 hours as needed for restlessness, no parameters for administration indicated; Haldol 1 mg every 4 hours as needed for agitation and anxiety, no parameters for administration indicated; Seroquel 12.5 mg twice daily-no diagnosis provided; Trazodone 25 mg at bedtime-no diagnosis indicated and Citalopram 10 mg daily with an increase to 20 mg on 2/26/21 also no diagnosis defined. R21's March 2021 TAR behavioral tracking indicates R21 had restlessness on 4 of 93 shifts and exit seeking on 2 of 93 shifts; there were no episodes of tearfulness or combativeness indicated. There was no documentation of psychosis, hallucinations or delusions. There was no documentation R21 was a danger to self or other residents. There was also no documentation of non-pharmacological interventions attempted for the restlessness or exit seeking. R21's MAR for March 2021, indicates R21 was receiving Citalopram 20 mg daily for Major Depressive Disorder (diagnosis added on 3/20/21), Seroquel 12.5 mg twice daily for psychosis (diagnosis added on 3/20/21) and Seroquel 12.5 mg twice daily as needed for anxiety psychosis. R21's April 1-20, 2021 TAR indicated R21 had 8 of 60 shifts with restlessness, 2 of 60 shifts with exit seeking, 1 of 60 shifts with combativeness with cares and zero episodes of tearfulness. There was no documentation of non-pharmacological interventions used or their effectiveness. There was no documentation of signs or symptoms of psychosis, hallucinations, delusions or dangerousness to self or others (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's MAR indicates for April 2021, R21 was receiving Seroquel 12.5 mg twice daily for psychosis and Citalopram 20 mg daily for Major Depressive Disorder. . On 4/21/21 at 12:14 PM, Surveyor interviewed CNA R (Certified Nursing Assistant). Surveyor asked CNA R, what type of behaviors do you watch for in R21? CNA R stated, Nothing really, he is a sweetheart. Surveyor asked CNA R, is R21 aggressive toward staff or other residents? CNA R indicated, No, not at all. Surveyor asked CNA R, is R21 resistive to care? CNA R replied, sometimes, but we just talk softly and call him [NAME] and he settles down. On 4/21/21 at 2:00 PM, Surveyor interviewed LPN (Licensed Practical Nurse) Q in regards to behaviors they are monitoring for R21? LPN Q stated, No behaviors, just restlessness, but R21 can usually be redirected with food. On 4/21/21 at 2:12 PM, Surveyor interviewed DON B, What diagnoses justify the use of anti-psychotics? DON B stated, Bipolar and schizophrenia. Surveyor asked DON B, if a resident has vascular dementia without behaviors, would that be an appropriate diagnosis for the use an antipsychotic? DON B indicated, No, hospice put R21 on that for restlessness as R21 tries to get up and falls. Surveyor asked DON B, could Seroquel also contribute to falls? DON B stated, I suppose, hospice likes to use Lorazepam, Haldol and Seroquel. I will talk to hospice. Of note the facility did not have written consent for R21's Citalopram and Zyprexa. On 4/12/21 at 2:12 PM, Surveyor asked DON B, have you given me all the medication consents? DON B, yes. The facility lacks a process to document residents' behaviors and provision of non-pharmacological interventions to ensure residents who need dementia care are not treated unnecessarily with antipsychotic/psychotropic medications. Example 2 R27was admitted [DATE] with diagnoses of vascular dementia with behaviors, major depressive disorder and anxiety. R27's Minimum Data Set (MDS), a comprehensive clinical assessment performed at intervals for each resident, dated 8/11/20 (initial admission assessment) does not include schizophrenia, bipolar, psychosis, delusions or hallucinations on the diagnosis list. R27's MDS's dated 11/11/2020 and 2/11/21 do not indicate any new diagnoses of psychosis, hallucinations, delusions or medical delirium. The resident face sheet does not outline psychosis, hallucinations or delusions. R27's care plan includes diagnoses of vascular dementia with behaviors, anxiety and depression. It does not list psychosis, hallucinations or delusions. R27's treatment administration records (TAR) which records behavior documentation for tearfulness, restlessness and combativeness with cares indicated the following for February 2021: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27 had no episodes of tearfulness or exit seeking. 1 of 84 shifts (shift defined as 8 hours) R27 was combative with cares. Non-pharmacological interventions or their effectiveness were not charted. R27 had 2 of 84 shifts with verbal aggression; 1:1 support & redirection was provided but effectiveness of these interventions was not documented. R27 had 4 of 84 shifts with documented restlessness. On these four shifts, non-pharmacological methods for anxiety reduction included redirection, 1:1 activities, and prn medication. The effectiveness of these were not documented. R27's medication administration record (MAR) indicates R27 may have Lorazepam 0.5 mg every 4 hours as needed (PRN) for anxiety; no parameters provided for administration. Of note, R27 received Lorazepam on 2/2/21 and 2/24/21 when there were no behaviors documented. R27's March 2021 TAR which records captures behavior documentation for tearfulness, exit seeking, restlessness and combativeness with cares, indicated: No episodes of tearfulness or exit seeking; 1 of 93 shifts of verbal aggression and 3 of 93 shifts of combativeness with cares. R27's MAR for March 2021 has documented administration of Quetiapine 25 mg (an antipsychotic medication) in the morning and 75 mg in the evening for vascular dementia with behaviors. R27 also receives Sertraline 100 mg daily for major depressive disorder. R27 also has Lorazepam 0.5 mg every 4 hours PRN anxiety, no parameters for administration provided. Of note, although Surveyor asked for the entire MAR, the PRN medication administration documentation was not provided. R27's TAR for April 2021 has the following behaviors recorded: Unknown as this information was asked for by Surveyor but not provided. R27 's MAR for April 2021 indicates administration of Citalopram 10 mg daily for depression (started April 19, 2021), Sertraline 75 mg daily for major depressive disorder, Zyprexa 7.5 mg (an antipsychotic medication) daily (start date 4/14/21) for vascular dementia with behavioral disturbance, Seroquel (an antipyschotic medication) 25 mg every morning and Seroquel 75 mg every evening and Lorazepam 0.5 mg twice daily as needed for anxiety, no written parameters for administration provided; start Lorazepam on 4/12/21 and staff are to update provider of the PRN use and effectiveness and behaviors on 4/26/21 for renewal. Of note, Surveyor asked for all medication consents. The facility did not obtain medication consents for R 27's Citalopram or Zyprexa prior to starting the medication. Medication consents were present for Seroquel; start date 1/28/21 and consent signed 3/22/21. The Lorazapam is PRN can you tell me if the facility had the PRN readdressed every 14 days. PRN's need to be addressed 14 days after starting the psychotropic medication and then every 14 days thereafter, unless the prescriber states after the 1st 14 days to continue for a longer period of time? On 4/12/21 at 2:12 PM, Surveyor asked DON B, have you given me all the medication consents? DON B, yes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/21 at 12:14 PM, Surveyor interviewed CNA R (Certified Nursing Assistant). Surveyor asked CNA R, what type of behaviors do you watch for in R27? CNA R stated, Attitude, getting judgmental, hating everything. R27 can go at it verbally with another resident and we have to separate them. Five minutes later, they are best friends. Surveyor asked CNA R, is R27 aggressive toward staff or other residents? CNA R indicated, verbally aggressive or with cares, sometimes it takes two to do it. One to distract her and the other to change her. On 4/21/21 at 2:00 PM, Surveyor interviewed LPN (Licensed Practical Nurse) Q in regards to what behaviors they are monitoring for R27? LPN Q stated, complaining about everything, pacing, restless. On 4/21/21 at 2:12 PM, Surveyor interviewed DON B, What diagnoses justify the use of anti-psychotics? DON B stated, Bipolar and schizophrenia. Surveyor asked DON B, if a resident has vascular dementia with behaviors, would that be an appropriate diagnosis for the use of an antipsychotic? DON B indicated, I don't know, I will have to follow up. Surveyor asked DON B, what type of behaviors justify the use of anti-psychotics? DON B, I will have to follow up. The facility lacks a process to document residents' behaviors, provision of non-pharmacological interventions to ensure residents who need dementia care are not treated unnecessarily with antipsychotic medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on observation, interview, and record review, the facility did not ensure drugs and biologicals used in the facility were labeled in accordance with current accepted professional principles and were not discarded after the expiration date for 3 of 6 medication carts observed, 2 of 3 medication room, affecting 4 (R127, R54, R37 and R4) out of 23 sampled residents and 7 (R58, R59, R26, R61, R29, R279, R278) of 13 supplemental residents. R58 and R127 had expired medications During the Medication Storage task, Surveyor observed the following expired medications: 1 bottle of Vitamin D3 (house stock) was expired; 1 Pneumovax 23 multi-dose vial was expired. Cedar Hall medication cart served 14 residents. Five residents (R54, R59, R26, R61, and R37) had expired/or medications opened with no open date. Stock Ibruprofen expiration date was 3/21. The back medication room refridgerator temperature was 50 degrees. R29, R4, R278 and R279 had expired medications This is evidenced by: The facility policy, Medications - Labeling, dated 3/1/14, states in part, as follows: Policy: Medications are labeled in accordance with state and federal laws. Procedure: 1. Drug container labels are completed by a pharmacy, including label changes. 2. Label includes the resident's name, drug name, dose, frequency, route instructions for use, and expiration date. 3. Label change stickers should be utilized to identify any medication dose changes until a new pharmacy label is obtained. The facility policy, Drugs and Biologicals Storage - Labeling, dated 4/1/08, states, in part, as follows: Drugs and biologicals are labeled in accordance with current accepted professional standards, including the appropriate accessory and cautionary instructions and the expiration data when applicable. The manufacturer guidelines for Lantus Solostar Single-Patient-Use Prefilled Insulin Pen indicates the following: Once you take your SoloStar out of cool storage, for use or as a spare you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86 degrees Fahrenheit. Do not use it after this time. The facility's policy, Storage of Medications, revised April 2007, states in part, as follows: 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be retuRN BBed to the dispensing pharmacy or destroyed. According to the CDC (Center for Disease Control's) website at: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. What is a multi-dose vial? A multi-dose vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that contains more than one dose of medication. Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria. The preservative has no effect on viruses and does not protect against contamination when healthcare personnel fail to follow safe injection practices. 5. When should multi-dose vials be discarded? Medication vials should always be discarded whenever sterility is compromised or cannot be confirmed. In addition, the United States Pharmacopeia (USP) General Chapter 797 [16] recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. If a multi-dose vial has not been opened or accessed (e.g., needle-punctured), it should be discarded according to the manufacturer ' s expiration date. The manufacturer ' s expiration date refers to the date after which an unopened multi-dose vial should not be used. The beyond-use-date refers to the date after which an opened multi-dose vial should not be used. The beyond-use-date should never exceed the manufacturer ' s original expiration date. On 4/19/21 at 8:28 AM, during the Medication Storage and Labeling task, Surveyor observed the following expired medications with RN BB (Registered Nurse-Agency) on the Aspen medication cart. Example 1 R58's Physician Orders signed 4/5/21 indicate the following: Refresh Tears 0.5% Instill 1 drop to dry irritated eyes four times daily as needed for dryness. On 4/19/21 at 8:28 AM, Surveyor observed R58's Refresh Tears , Dispensed 11/6/19; Date Opened: No open date; Surveyor asked RN BB is there an open date on the eye drops. RN BB stated, No. Surveyor asked RN BB should eye drops be dated when opened. RN BB stated, Yes. Surveyor asked RN BB are the eye drops expired. RN BB stated, Yes. Example 2 R127's Physician Orders signed 3/25/21 indicate the following: Victoza 18 gm (grams) / 3 ml (milliliters) inject 0.6 mg (0.1 ml) sub-q (subcutaneous) daily for 1 week On 4/19/21 at 8:29 AM, Surveyor observed R127's Victoza Insulin Pen (liraglutide injection), Dispensed 11/10/20; Date Opened: No open date; Surveyor asked RN BB is there an open date on this insulin pen. RN BB stated, No. Surveyor asked is the insulin pen expired. RN BB stated, Yes. Example 3 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/19/21 at 8:33 AM, Surveyor observed an opened bottle of [NAME] Oxymetazdine HCL 0.5% Nasal decongestant. There was no label, no name, and no bag to identify which resident receives this medicaiton. Surveyor asked RN BB do you know who this belongs to. RN BB stated, No. Surveyor asked RN BB should this medication be labeled with a resident name and instructions. RN BB stated, Yes. Surveyor asked RN BB what will you do with this medication. RN BB stated she will send it back to the pharmacy. Surveyor asked RN BB what is the facility policy regarding how often staff go though med carts to check for expired medicaitons. RN BB stated, It should be daily when they're doing stuff. Survyeor asked RN BB what is your process before you pass a medication. RN BB stated the 5 rights. Srveyor asked should you check expiration dates prior to administration. RN BB stated, Yes. On 4/20/21 at 5:22 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B if staff should be using medications that are expired. DON B said that staff should not be using medications that are expired. Surveyor asked DON B if eye drops and multi-dose vials should be dated when opened. DON B stated that eye drops should be dated when opened. How long are eye drops good once opened. DON B stated, I want to say 28-30 days. Surveyor asked DON B should insulin be dated when it's opened. DON B stated, Absolutely, yes. DON B added, everything should be dated when opened. If there is no open date on eye drops or insulin is it considered expired. DON B stated, I would think so because we don't know when we opened it. Surveyor asked DON B should nose spray be dated when opended. DON B stated, Yes. Surveyor asked DON B what it the process to check medication rooms and carts for expired medications. DON B stated, It's another broken system. I would think the nurses would be sure to look at the expiration date on the medication. As the nurse is using the medication they should make sure the med is not out of date and when a medication is opened it should be dated. There's currently no set schedule for this but going forward there will be. On 4/21/21 at 12:36 PM, DON B stated she found the policy for insulin bt couldn't find the policy for eye drops. DON B stated once insulin is open we keep it for 28 days but it has to be labeled. DON B added, I'm going to do some medication cart audits. Suveyor asked DON B should eye drops, insulins and nose sprays (any multi-dose vials) be labeled when opened. DON B stated, Absolutely. 37091 Example 4 On 4/19/21 at 8:47 AM, Surveyor reviewed the medications in the Cedar Hall medication cart. Expired medications include: -R61 with two medication cards of Phosphate Binder with expiration date of 3/21; -Stock bottle of Ibruprofen open with expiration date of 3/21. Medications open with no labeled open date include: -R54 insulin pen and Humalog insulin vial; -R59 Timololmale;ate 5% eye drops; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-R26 Liquid tears; -R37 Magnesium oxide. Example 5 The back medication room refridgerator therometer was measuring 50 degrees. The refridgerator held multiple unopened insulin vials and insulin pens, along with unopened tuberculin testing vials. The American Diabetes Association recommends that unopened insulin be stored between 36 and 46 degrees. 39713 Example 6 On 04/19/21 at 8:03 AM, Surveyor observed medication cart and medication room on Birch Wing with LPN H. In the Birch Wing medication room Surveyor observed the following: TB (Tuberculin) with no open or expiration date. Example 7 In the Birch Wing medication cart Surveyor observed the following: R29 had 2 blister cards of Cetirizine 10mg with an expiration date of 7/20 and 9/20. Note: The 9/20 card had no doses removed from it. Example 8 R4 had Aspart insulin, Lantus insulin and Fluticasone nasal spray with no open or expiration date. Example 5 R278 had Lantus insulin, Lispro insulin and Fluticasone nasal spray without open or expiration dates. Example 6 R279 had Fluticasone nasal spray without an open or expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/19/21 at 8:21 AM, Surveyor interviewed LPN H. Surveyor asked LPN H how long TB and Insulin are good for once opened. LPN H stated, They are good for 28 days I think once opened. Surveyor asked LPN H if TB, Insulin, and Fluticasone should have open and expiration dates labeled on them. LPN H stated, Yes, they should. I will get rid of them and order new. Surveyor asked LPN H if expired oral medications should be destroyed and not used after the expiration date. LPN H stated, R29 has not used the Cetirizine since November. Note: R29 received Cetirizine in November which is 4 months past the expiration date of the 7/20 blister card with medication dispensed from it.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37091 Based on observation, interview and record review, the facility did not follow proper sanitation and food handling practices in accordance with professional standards for food service safety. This has the potential to affect all 73 residents. The facility did not air dry plastic dishes, juice containers connected to a gun drink system not dated when opened, supplement drinks not dated when removed from freezer, food not labeled when made, and opened bottles of juices and thickened juices were not labeled with open date. Low temp chemical dishwasher chloride level test strip did not register when tested . The facility's Food-Sanitary Conditions policy revised date November 2016: -Food is stored, prepared distributed, and served in accordance with professional standards for food service safety. The facility's sign on refrigerator, undated: -All items that are opened need an open date and a use by date; -All items pulled from the freezer to thaw need a pull date and use by date; -Leftovers in cooler-3 days; -Use by dates are as follows: Juice-3 days after pouring-thickened juice-5 days after opening/pouring. -Use by date after pulling from freezer-Mighty Shakes (supplement drinks) 14 days; -Juice boxes must be used within 14 days of opening-All juice boxes must be labeled when opened with open and use by date. The facility's policy on 3 sink dishwashing system dated 2010, includes: -Allow clean items to air dry before storing. -Low Temp Dishwasher Guidelines include: - Acceptable range 50-100 ppm chlorine for dishwasher water. On 4/18/21 at 8:55 AM, Surveyor observed: -In cooler, a large bowl of lettuce, carrots, red cabbage and other vegetables mixed together. The bowl was covered with clear plastic wrap and was not labeled with a use by date; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Individual portion cups of gelatin and fruit mix, made by the facility, were not dated with used by date; -Open 4 ounce container of yogurt, not labeled with open date; -14 Mighty Shakes not labeled with pull date or use by date; -Apple and cranberry juices connected to a gun drink system not labeled with a received date or an open date; -Cranberry juice bottles opened were not labeled with a use by date; -Two opened bottles of thickened juice were not labeled with a use by date. On 4/18/21 at 9:20 AM, Surveyor spoke to DA C (Dietary Aide). DA C said the Mighty Shakes had been removed the night before. Surveyor asked DA C if he worked the night before. DA C said no. Surveyor asked DA C when food is to be labeled. DA C said when the food is opened. On 4/18/21 at 9:25 AM, Surveyor observed in the kitchen: -Clear small plastic bowls stacked with water droplets inside/wet stacked. -Plastic food storage square bins stacked with water droplets inside. On 4/18/21 at 11:45 AM, Surveyor observed: -Main dining room clear plastic glasses stacked with water droplets inside; -Aspen Hall beverage cart with two cranberry juices not labeled when opened; -Cedar Hall beverage cart with clear plastic glasses stacked with water droplets inside and two cranberry juice bottles opened with no open date labeled; -Birch Hall beverage cart with clear plastic glasses stacked with water droplets inside. On 4/19/21 at 11:30 AM, Surveyor spoke with DM E (Dietary Manager). DM E said all items should be air dried before storing and no items should be stacked wet. On 4/19/21 at 3:30 PM, Surveyor observed DA D doing dishes in the dishwasher. Surveyor asked DA D to check the chlorine level when finished with that load of dishes. DA D tested the dishwasher water with a test strip to measure the chlorine level. The test strip indicated there was no chlorine level in the water. DA D tested a different sample of dishwasher water. The test strip indicated there was no chlorine in the water. DA D spoke to DM E. DM E sampled the dishwasher water with a chlorine test strip. The test strip indicated no chlorine in the water. On 4/19/21 at 3:40 PM, Surveyor spoke with DM E. DM E said she was not sure what the chlorine test strip should measure, but she thought it was 50 to 100 ppm. DM E said she would find out what the chemical should test at. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/19/21 at 4:10 PM, Surveyor spoke with NHA A (Nursing Home Administrator) and DM E. Surveyor discussed the dishwasher test strip indication of no chemical in the water. NHA A said they would make a plan to use disposable dishes, cups and cutlery until the dishwasher company could thoroughly check out the dishwasher.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39713 Based on interview and record review, the facility did not ensure that its Infection Control Program investigates, controls, and prevents the spread of infection in the facility and maintains a record of incidents and corrective actions related to infections. This has the potential to affect 73 of 73 residents. The facility did not review and update infection control policies and procedures. The facility did not complete contemporaneous infection surveillance including tracking and trending of all illnesses, potential infectious agents, or monitoring of resident and staff signs and symptoms of infection or potential infection. The facility's monthly Infection Report surveillance logs are incomplete; enhanced barrier precautions were not used when indicated. The facility failed to analyze infection data concurrently, which would help the facility to recognize a trend or patterns of infections. R56 has a multidrug resistant organism (MDRO) staff did not clean the restroom in between resident use to prevent the potential spread of the MDRO. R37's catheter port was not cleansed prior to replace into urinary drainage bag. Staff did not wear all appropriate PPE when entering R130, R131 and R13's room. This is evidenced by: The facility's policy Infection Prevention and Control (General), dated 11/2016 state in part: Policy: An infection control program is designed and implemented in order to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable disease and infection. IPCP (Infection Prevention and Control Program): 1. A system is in place that prevents identifies, reports, investigates, and controls infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement and following accepted national standards. 2. A system is in place for the following: a. Surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. b. When and whom to report incidents of communicable disease of infection. c. Standard and transmission based precautions. 4. A system for recording incidents identified under the community's IPCP and the corrective actions taken by the facility. 5. The community will conduct an annual review of its IPCP and update their program as necessary. The Infection Prevention and Control Program (IPCP): Investigates, controls, and prevents infections in the facility. Maintains a record of incidents and corrective actions related to infections. The facility's policy Implementation of Personal Protective Equipment in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs), dated 7/26/19 states in part: Enhanced Barrier Precautions expands the use of PPE (Personal Protective Equipment) beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It is important to note that the facility's monthly Infection Control Antibiotic Log that list symptom monitoring were unable to be located by the facility for the months of January and February. The Infection Report for December only lists one resident and does not provide any further information. Surveillance forms or other data collection forms indicating the facility completed tracking and trending for all illnesses, potential infectious agents or monitored resident symptomology for sign and symptoms of infection or potential infection were not completed contemporaneously. The staff line listings did not continuously contain well dates and return to work dates. Facility Policies were not reviewed annually. Example 1 Review of the facility's monthly Infection Report log notes that key infection data was not tracked, with omissions as noted below: Note: The Infection Control Antibiotic Log were unable to be located for the months of January and February. December only listed one residents with no other information provided. The facility was unable to locate previous month's logs and rates. On 3/26/21, R56's urine culture report indicates VRE (Vancomycin Resistant Enterococcus) (a multi drug resistant organism). R56 shared a restroom with 3 other residents. Though R56 has a catheter staff utilize the toilet to empty R56's catheter and do not disinfect after doing so. The Infection Control Antibiotic Log indicates the need for use of standard, contact and droplet precautions for R56. On 4/20/21 at 1:12 PM, Surveyor observed CNA U (Certified Nursing Assistant) complete catheter care on R56. Surveyor observed the catheter being emptied by CNA U. CNA U emptied graduate of urine into the toilet. CNA U rinsed graduate and also poured that into the toilet. When finished CNA U left R56's room without cleaning or sanitizing the toilet. On 4/20/21 at 1:25 PM, Surveyor asked CNA U if there are any precautions for R56. CNA U stated, Not that I know of. The facility policies have not been reviewed or updated annually: Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, last revised 9/2017. Hand Washing/Hand Hygiene, last revised 8/2015. Personal Protective Equipment, last revised 1/2012. Implementation of Personal Protective Equipment in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms, updated 7/26/19. Infection Prevention and Control (General), last revised 11/2016. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Infection Prevention and Control: Antibiotic Stewardship Program, created 10/14/17. Hand Washing, created 1/01/2008. Immunizations: Influenza, revised 3/01/2014. Immunizations: Pneumococcal Vaccine, revised 11/24/2014. On 4/21/21 at 1:38 PM, Surveyor interviewed DON B (Director of Nursing) and IP M (Infection Preventionist) about the facility's Infection Control Program and surveillance monitoring. IP M stated that the facility uses CDC (Centers for Disease Control) and APIC (Association for Professional in Infection Control and Epidemiology) for their standards of practice. IP M stated she started at the Facility in March and she was unable to locate any previous data and logs for infection monitoring. Logs and tracking are incomplete due to her recent start. IP M stated she is not sure what happened to the data but she has moved on and is trying to adjust to her new position and this is very new to her. Surveyor asked if policies and procedures are reviewed annually. DON B stated, I have went through some of them with the NHA A but I am not sure they all have been reviewed. Surveyor asked what the process is for a resident (R56) with VRE. IP M stated, she was unaware R56 had VRE and a catheter. IP M stated, she would immediately place R56 on precautions. Note: R56's culture report indicating VRE was dated 3/26/21. Surveyor asked IP IM regarding infection surveillance, tracking and trending. IP M stated if there was a cluster of symptoms that developed on a unit, the team would make a plan. IP M indicated this was not consistently completed on each unit and should be. DON B explained the facility uses the McGeer's criteria but staff are not good about documenting the signs and symptoms. We are doing education and trying to improve these processes. Surveyor asked if the facility's monitoring of resident symptoms and infections were completed contemporaneously. IP M indicated they were not and the facility would be working on improving the process. The facility did not have a system in place to accurately complete surveillance tracking and trending for resident infections, contemporaneous symptoms monitoring, analysis of infection surveillance data, staff tracking of well dates and return to work dates and not completing reviews and revisions of policies and procedures. 38725 Example 2 R37 is a long term resident of the facility. R37 has the following diagnoses: injury of cauda equine, neuromuscular dysfunction of bladder, bacteremia, MSSA (methicillin-susceptible Staphylococcus aureus), and presence of urogenital implants. R37's most recent MDS (minimum data set) dated 2/19/21 documents, R37 scored 15 on his BIMS (Brief Interview of Mental Status), which indicates that he is cognitively intact. On 4/18/21 at 3:20 PM, Surveyor interviewed R37. Surveyor asked R37 if he has any concerns with his catheter, R37 replied they don't flush it like they're supposed to and they don't always empty it every shift. (continued on next page)

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	525074	A. Building B. Wing	04/28/2021

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/19/21 at 11:07 AM, Surveyor observed CNA O (Certified Nursing Assistant) empty R37's UDB (urinary drainage bag) into a clear triangular graduate, CNA O commented there was 1000 mL (milliliters) that she measured. CNA O set graduate to side and put spout back into UDB sheath without cleaning with alcohol. Surveyor asked CNA O if she should use alcohol to clean the spout before returning it into the UDB sheath, CNA O said yes. On 4/20/21 at 5:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if the spout on the UDB should be cleaned with alcohol before being put back into the UDB sheath, DON B stated absolutely it should cleaned with alcohol before putting it back into the UDB. 30992 Example 3 Surveyor observed DOM AA (Director of Maintenance) passing beverages on a cart to the following isolation rooms; Surveyor observed DOM AA wearing a surgical mask and face shield. DOM AA was not wearing a gown or gloves and did not sanitize his shield or change out his shield or mask while moving from room to room. DOM AA did not sanitize or wash his hands between rooms. On 4/21/21 at 7:48 AM, Surveyor observed DOM AA enter R130's room to pass water and orange juice. The isolation sign on the door indicates R130 is on Contact/Droplet/Airborne precautions. There is an isolation cart outside R130's door. R130 is a new admission on observation for COVID-19. Example 4 On 4/21/21 at 7:50 AM, Surveyor observed DOM AA enter R13's room and delivered water and juice. R13 is on contact isolation for ESBL in her urine. There is an isolation cart outside R13's door. DOM AA was not wearing all appropriate PPE. Example 5 On 4/21/21 at 7:52 AM, Surveyor observed DOM AA entered R131's room with apple juice and water. The isolation sign indicates R131 is on contact/droplet/airborne precautions. There is an isolation cart outside of R131's door. R131 is a new admission on observation for COVID-19, and also has a diagnosis of c-diff. DOM AA was not wearing all appropriate PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/21/21 at 7:55 AM, Surveyor spoke with DOM AA. Surveyor asked if DOM AA how often he passes beverages. DOM AA stated not often today is an exception. DOM AA stated this is his first time passing beverages. Surveyor asked DOM AA what you should wear before entering an isolation room. DOM AA stated, gowns, masks, goggles, and gloves. Surveyor asked DOM AA do you know how to tell if a resident is on isolation? It's posted on the door. Surveyor asked DOM AA, did you notice the isolation rooms you went into. DOM AA stated, I did not. Surveyor asked DOM AA, what should you have worn in addition to your mask & shield? A gown and gloves I believe. Surveyor asked DOM AA do you know who's on isolation for what. DOM AA stated, no, however, he knows some residents are new admissions on observation for COVID-19. Surveyor asked DOM AA do you know what R130, R13 or R131 are on isolation for. DOM AA stated, I do not. Surveyor asked DOM AA would the facility inform you if a resident was COVID+. DOM AA stated, I would know that because I put up the barrier. DOM AA stated he puts on a new mask each day. DOM AA indicated he does not change out his mask during the day. Surveyor asked DOM AA when you would disinfect your face shield. DOM AA stated, if you interact with somebody without a mask or in an infected areas I guess. DOM AA stated he went over this in online videos but cannot recall the specifics. Surveyor asked DOM AA, should you have worn a gown in gloves in each room? DOM AA stated, Yes On 4/21/21 at 12:47 PM, Surveyor spoke with DON B (Director of Nursing). When staff enter the room of a new admission (14 day isolation) what should they wear? DON B stated, staff should wear full PPE - goggles, N95, surgical mask, gown and gloves. Surveyor asked DON B what should staff wear went entering a resident's room with c-diff. DON B replied, Of course they would wear the gown, gloves, and shield or goggles and mask. Surveyor asked what should staff wear when they enter a room of a resident with ESBL. DON B stated, a gown, gloves, face mask, shield/goggles. DON B stated staff should dispose of all PPE (Personal Protective Equipment) when exiting any isolation room. DON B stated it is her expectation that staff don clean PPE for each isolation room. Surveyor reviewed observation with DON B and asked DON B if she would have expected DOM AA to remove PPE and put on new PPE with each new isolation room he entered. DON B stated, Yes.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, the following elements: An Antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 resident (R13) and 3 supplemental residents (R56, F280 and R11). R56, R11, R13 and R280 received antibiotics for UTI (Urinary Tract Infection.) The facility did not track specific antibiotic use or review pathogen results from urine culture and sensitivities, for treatment and the facility did not follow Standards of Practice (SOP) for Antibiotic Stewardship for antibiotic use for these residents. This is evidenced by: The facility's Infection Prevention and Control: Antibiotic Stewardship Policy dated 10/14/17, states in part: The World Health Organization has reported that antibiotic resistance is one of the major threats to human health, especially because some bacteria have developed resistance to all known classes of antibiotics. According to the CDC (Centers for Disease Control), Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Policy: It is the policy of the organizations communities to implement an Antibiotic Stewardship Program (ASP), which promotes appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. 2. Accountability: iv. Monitor antibiotic resistance patterns (MRSA, VRE, ESBL, CRE, etc.) and Clostridium difficile infections. 4. Action: a. ii. Optimize the use of diagnostic testing. iii. Utilize established infection criteria to educate and guide antibiotic prescribing. Tracking: a. DON or IP will be responsible for infection surveillance and MDRO tracking. b. DON or IP will collect and review data such as: iii. Whether appropriate tests such as cultures were obtained before ordering antibiotic The facility uses the McGeer's Criteria for its definition of infection and treatment of infection. The Standard of Practice entitled Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer's Criteria, dated October 2012, states, in part: .Surveillance Definitions for Urinary Tract Infections (UTIs): Criteria A. For residents without an indwelling catheter (both criteria 1 and 2 must be present): 1. At least 1 of the following sign or symptom subcriteria: a. Acute dysuria or acute pain .b. Fever or leukocytosis and at least 1 of the following localizing urinary tract subcriteria: I. Acute costovertebral angle pain or tenderness; ii. Suprapubic pain; iii. Gross hematuria; iv. New or marked increase in incontinence; v. New or marked increase in urgency; vi. New or marked increase in frequency. c. In the absence of fever or leukocytosis, then 2 or more of the following localizing urinary tract subcriteria: I. Suprapubic pain; ii. Gross hematuria; iii. New or marked increase in incontinence; iv. New or marked increase in urgency; v. New or marked increase in frequency. 2. One of the following microbiologic subcriteria: a. At least 100,000 cfu/ml (colony forming units/milliliter) of no more than 2 species of microorganisms in a voided urine sample. b. At least 100 cfu/ml of any number of organisms in a specimen collected by in and out catheter. Example 1: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R56 was admitted to the facility on [DATE] with diagnosis of Calculus of Kidney, UTI, and Severe Sepsis with Septic Shock. Review of the facility's Infection Control line listing noted on 3/25/21. R56 is not on the computer generated line listing for 3/25/21. The hand written Infection Control Antibiotic Log indicates the following: admitted with UTI on 3/10/21. Source of Infection: Urine, stone in stent fistula. Diagnostic test. UA (Urinalysis). Organism Identified: E.coli and VRE (Vancomycin Resistant Enterococcus). Precautions implemented: Standard, Droplet and Contact. Antibiotic Ordered: Cipro 500 mg bid (twice a day) thru 4/04/21. Resolved Date: Ongoing. Note: There is not any evidence to show this met McGeer's criteria. Note: The information is captured on one form but not the other and there is inconsistent data between the forms. Example 2: R11 was admitted to the facility on [DATE], with neurogenic bladder and Schizophrenia. The facility's Infection Control line listing noted on 3/24/21, R11 had an unknown origin UTI, under Symptoms: ADL (Activities of Daily Living) decline was noted, under Pathogen it was noted No culture, under Treatment noted Cefuroxime 250mg daily: Under Collection Date noted At Hospital. Note: The facility did not obtain culture reports to ensure R11 was on the correct antibiotic therapy. Note: The facility did not utilize McGeer's criteria or ensure that R11 met McGeer's criteria. Example 3: R13 was admitted to the facility on [DATE]. The facility's Infection Control line listing on 3/22/21, noted R13 UA done pre procedure at the hospital Pathogen noted Klebsiella pneumonia, E.coli and yeast under Treatment noted Bactrim DS 2 tabs BID (twice daily) 3/9 to 3/15, under Criteria met Yes was documented UTI in resident with an indwelling catheter. The facility hand written Infection Control Antibiotic Log for March admitted with? Acquired In House? notes admitted /Acquired, under Source of Infection noted Urine Foley, under Organism Identified noted Klebsiella, E.coli and yeast, under Antibiotic ordered, noted Amoxicillin 1000 mg tid (three times daily) x (times) 7 days, 3/27/21. The culture and sensitivity report for R13 indicates the identified organisms are resistant to Amoxicillin/Clavulanate. Note: The computer generated and hand written infection logs do not match and the R13 was placed on an antibiotic that was resistant to the organisms identified in the culture report. Example 4: R280 was admitted to the facility on [DATE]. The facilities Infection Control line listing indicates onset date of 3/05/21. R280 presented with symptoms of decline in function, pelvic pain, fatigue and low grade temperature, under Pathogen noted yeast, under Treatment noted Macrobid 400mg, change to Fluconazole daily x10 days, under Criteria Met noted Yes. According the Infection Control line listing, Macrobid was prescribed from 3/6/21 to 3/8/21 and Fluconazole was prescribed from 3/8/21 to 3/10/21. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/21 at 1:38 PM, Surveyor interviewed DON B (Director of Nursing) and IP M (Infection Preventionist). Surveyor asked what standard of practice (SOP) the facility follows for treatment of infections, DON B stated McGeer's Criteria was followed. Surveyor reviewed the facility's line listing with DON B and IP M noting R56, R11, R13 and R280 were treated for UTI's with antibiotics without meeting criteria, a pathogen resistant to prescribed antibiotics, no culture or sensitivity noted and no notation of what antibiotics was used. IP M stated she is new to her role since March. IP M stated that antibiotics and urine pathogen should be obtained, antibiotics should be followed up on and staff should ensure residents are meeting criteria for antibiotic use. IP M stated the nurses are to notify IP M if residents are started on antibiotics. DON B and IP M both indicated a discussion with the doctor should have taken place and been documented with start of these antibiotics regarding the SOP the facility follows and there was no indication this was done. Surveyor asked IP about precautions used for R56 diagnosis of VRE. IP stated, R56 is not on precautions. I was not aware she had a catheter or a diagnosis of VRE. I will ensure she is on precautions right away.