STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525108	A. Building B. Wing	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not provide the opportunity for 5 (R23, R50, R65, R74, R92) of 6 Residents reviewed to participate in the development and implementation of their person-centered plan of care process. *R23 had an initial care conference on 10/25/21 and there is no documentation any other care conferences were held for R23. *R50's electronic medical record (EMR) contains no documentation a care conference was held for R50. *R65 had a care conference on 2/4/22 and there is no documentation any other care conference was held for R65. *R74 had a care conference on 1/7/22 and there is no documentation any other care conference was held for R74. *R92's EMR contains no documentation a care conference was held for R92. Findings Include: Surveyor reviewed the facility's policy entitled: Resident Participation-Assessment/Care Plans, revised: 12/16, and notes the following: Policy Statement The Resident and his/her representative are encouraged to participate in the Resident's assessment and in the development and implementation of the Resident's care plan. Policy Interpretation and Implementation 1. The Resident and his/her legal representative are encouraged to attend and participate in the Resident's assessment and in the development of the Resident's person-centered care plan. (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The Resident/representative's right to participate in the development and implementation of his/her plan of care includes the right to: a. Participates in the planning process b. Identify individuals to be included in the planning process c. Request meetings e. Participate in establishing his/her goals and expected outcomes of care f. Participate in the type, amount, frequency and duration of care g. Receive the services and/or items included in the care plan h. Refuse, request changes to and/or discontinue care or treatment offered or proposed i. Be informed, in advance of the risks and benefits of the care or treatment proposed j. Have access to and review the care plan k. Be informed of, review and sign the care plan after any significant changes are made 4. The care planning process will: a. Facilitate the inclusion of the Resident and/or representative b. Include an assessment of the Resident's strengths and his/her needs c. Incorporate the Resident's personal and cultural preferences in establishing goals of cares. 7. A 7 day advance notice of care planning conference is provided to the Resident and his/her representative. Such notice is made by mail and/or telephone. 8. The Social Service Director or designee is responsible for notifying the Resident/representative and for maintaining records of such notices. Notices include: a. The date, time and location of the conference b. The name of each person contacted and the date he/she was contacted c. The method of contact (mail, telephone, email) d. Input from the Resident or representative if they are not able to attend e. Refusal of participation f. The date and signature of the individual making the contact. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) R23 was admitted to the facility on [DATE], with diagnoses of Adult Failure to Thrive, Dyspagia, Pain, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. R23 is her own person at this time. R23's Quarterly Minimum Data Set (MDS) assessment, dated 4/10/22, documents R23's cognitive status was not assessed. R23's MDS also documents R23 requires extensive assistance for bed mobility, toileting, dressing, and hygiene. Surveyor reviewed R23's EMR (Electronic Medical Record) and notes on 10/25/2021, it is documented an initial care conference was held for R23. Surveyor was unable to locate any other documentation R23 was given the opportunity to participate in the development and implementation of R23's person-centered plan of care including making decisions and changes in care and treatment since the initial care conference. On 6/21/22, at 3:20 PM, Surveyor shared with Nursing Home Administrator (NHA-A) Surveyor was unable to locate any documentation R23 has had a care conference since the initial conference was held on 10/25/21. 2) R50 was admitted to the facility on [DATE], with diagnoses of Type 2 Diabetes Mellitus, Hemiplegia Affecting Right Dominant Side, Unspecified Atrial Fibrillation, Cerebral Infarction, Dyspagia, and Expressive Language Disorder. R50 currently has a legal guardian appointed. R50's Annual MDS (Minimum Data Set) assessment, dated 4/22/22, documents R50 has short and long term memory impairment and demonstrates moderately impaired skills for daily decision making. R50 requires extensive assistance with bed mobility, toileting, dressing, and hygiene. R50's MDS documents transfers did not occur. Surveyor notes on 5/7/2021, the following was documented: Writer attempted to call guardian to schedule a care conference however, the phone was disconnected and writer was unable to leave a voicemail. Writer attempted to call 3 times each time the phone would ring and then the call will be dropped. Surveyor notes the facility did not document other methods attempted to reach R50's legal guardian to schedule a care conference. Surveyor was unable to locate any other documentation that R50 was given the opportunity to participate in the development and implementation of R50's person-centered plan of care including making decisions and changes in care and treatment. On 6/21/22, at 3:20 PM, Surveyor shared with Nursing Home Administrator (NHA)-A Surveyor was unable to locate any documentation the facility had coordinated a care conference for R50 with the input of R50's legal guardian. 3) R65 was admitted to the facility on [DATE] with diagnoses of Hypertension, End Stage Renal Disease, Diabetes Mellitus, Hyperlipidemia, and Depression. R65 is currently her own person. R65's Quarterly Minimum Data Set (MDS) assessment, dated 5/6/22, documents R65's Brief Interview for Mental Status (BIMS) score of 14, indicating R65 is cognitively intact for daily decision making. R65's MDS also documents R65 requires limited assistance for bed mobility and transfers. R65 requires extensive assistance for toileting and supervision for hygiene. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor notes R65's Electronic Medical Record (EMR) contains documentation a care conference was held on 2/4/2022 and R65 was in attendance. Surveyor was unable to locate any other documentation R65 was given the opportunity to participate in the development and implementation of R65's person-centered plan of care including making decisions and changes in care and treatment since the initial care conference. On 6/20/22, at 1:21 PM, Surveyor spoke to R65 who does not recall having a care conference and would like to talk about R65's discharge plans. On 6/21/22, at 3:20 PM, Surveyor shared with Nursing Home Administrator (NHA)-A that Surveyor was unable to locate any documentation R65 has had a care conference since an initial care conference held on 2/4/22. 4) R74 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Dyspagia, Chronic Viral Hepatitis C, Hemiplegia Affecting Left Dominant Side, Ataxia, and Dementia. R74 currently has a legal guardian appointed. R74's Quarterly Minimum Data Set (MDS) assessment, dated 4/15/22 documents R74's BIMS score to be a 9, indicating R74 demonstrates moderately impaired skills for daily decision making. R74's MDS also documents R74 requires extensive assistance for bed mobility, dressing, toileting, and hygiene. Surveyor notes that R74's Electronic Medical Record (EMR) contains documentation that an initial care conference was held on 12/6/2021 and another care conference is documented as being held on 1/7/2022. It is documented R74 was in attendance for both care conferences. Surveyor was unable to locate documentation that R74 was given the opportunity to participate in the development and implementation of R74's person-centered plan of care including making decisions and changes in care and treatment since the 1/7/22 care conference. On 6/21/22, at 3:20 PM, Surveyor shared with Nursing Home Administrator (NHA)-A that Surveyor was unable to locate any documentation that R74 has had a care conference since 1/7/22. 5) R92 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Hemiplegia and Hemiparasis Following Cerebral Infarction, Dyspagia, Chronic Obstructive Pulmonary Disease, Heart Failure, Vascular Dementia, and Major Depressive Disorder. R92 currently has a legal guardian appointed. R92's Quarterly Minimum Data Set (MDS) assessment, dated 5/22/22, documents R92's cognitive status was not assessed. R92's MDS documents that R92 requires extensive assistance for bed mobility, toileting, and hygiene. R92 requires total assistance for transfers and bathing. Surveyor notes R92's (Electronic Medical Record) EMR contains no documentation a care conference was held for R92 since 12/20/20. Surveyor was unable to locate any other documentation R92 or their legal [NAME] was given the opportunity to participate in the development and implementation of R92's person-centered plan of care including making decisions and changes in care and treatment. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/21/22, at 1:55 PM, Surveyor spoke to R92 who confirmed R92 has not been invited to any care conference meetings and would like to be apart of the meeting. R92 stated that no one informs R92 about any changes with R92's plan if care. Surveyor observed R92 to be alert and oriented x 3 (person, place and time) at this time. On 6/21/22, at 3:20 PM, Surveyor shared with Nursing Home Administrator (NHA)-A that Surveyor was unable to locate any documentation the facility has arranged a care conference for R92 since 1/7/22. On 6/22/22, at 9:37 AM, NHA-A informed Surveyor NHA-A has no information or documentation to provide related to care conferences being held on a consistent/at least quarterly basis for R23, R50, R65, R74, and R92. Social Service staff were not available to be interviewed during the survey process. On 6/22/22, at 3:37 PM, Surveyor shared the concern with NHA-A of R23, R50, R65, R74, and R92 that these 5 Residents were not given the opportunity to participate in the development and implementation of their person-centered plan of care including making decisions and changes in care and treatment on a consistent basis. NHA-A acknowledged the concern and provided no additional information at this time.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03444 Based on observation, interview, and record, the facility failed to ensure personal privacy of a resident (R) for 4 of 22 sampled residents (R91, R356, R64 and R50). R91 was observed sitting on the commode in room and visible from the hallway. R356 was observed to be exposed from the waist down and visible from the hallway. R64 was observed uncovered from the waist down, gown is pushed up and R64 is wearing a brief. R64 was visible from the hallway. R50 was undressed with only a brief on and was visible from the hallway. This is evidenced by: Based on a reasonable person concept, a person whom is unable to provide for their own personal privacy of their body, would want their privacy to be provided by staff. This would include ensuring that a persons body be covered in a way to protect them from view of others; including the private, normally covered areas of their body. 1) R91 was admitted to the facility on [DATE] with diagnoses of Schizoprenia, Acute and Chronic Respiratory failure with Hypercapnia, and Anxiety Disorder. Surveyor was unable to interview R91 because she refused to be interviewed. Observation on 6/23/22, at 10:40 AM, Surveyor observed R91 from the hallway. R91 was observed using the commode in room visible from the hallway. R91's back and buttocks were visible to anyone in the hallway. Respiratory Therapist (RT)-WW was observed in the room with the resident. On 6/23/22 at 10:45 AM, Surveyor interviewed RT-WW and asked what was expected of her or staff if a resident was using a commode or staff were doing cares. RT-WW indicated the door should be closed or curtains should be pulled. 2) R356 was admitted to the facility on [DATE] with diagnoses of Chronic Respiratory Failure with Hypoxia, Major Depressive Disorder, Anxiety Disorder, and Encephalopathy. Observation was made on 6/22/22, at 7:08 AM, of R356 in his room. R356 wore an adult brief type incontinence product. R356 was laying on top of the covers at the time and was exposed to anyone in the hallway. Surveyor noted the door was open and no curtain pulled. On 6/23/22, at 10:45 AM, Surveyor interviewed Respitory Therapist (RT)-WW and asked what was expected of her or staff if a resident was using a commode or staff were doing cares. RT-WW indicated the door should be closed or curtains should be pulled. On 6/22/22, at 10:53 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-VV and she stated, The curtains should have been pulled or the door should be closed. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38829 4) On 6/22/22, at 7:59 AM, Surveyor observed R64 in bed and visible from the hallway. R64 was observed to be uncovered from the waist down, gown is pushed up and R64 was observed wearing a brief. Surveyor observed no sheet or blanket covering R64. 5) On 6/22/22, at 8:00 AM, Surveyor observed R50 in bed awake and visible from the hallway. R50 was observed to be undressed with just a brief on, and no sheet or blanket covering R50. Surveyor observed multiple staff going up and down the hallway, walking past R64's and R50's room. Surveyor did not observe any staff stop and assist R64 and R50 with covering up, pulling a privacy curtain or closing the room door to provide the residents with privacy. Both R64 and R50 are non-interviewable. On 6/23/22, at 3:37 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the dignity concerns for R64 and R50 and the observations made from the open doorway with residents wearing just a brief on and no sheet or blanket covering. No further information was provided at this time.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35928 Based on observation, interview, and record review the facility did not ensure a clean homelike environment, this noncompliance had the ability to affect all of the residents on the second floor. -R106 had a concern of Care and room cleanliness per the facility grievance document. The facility action taken shows Education, room cleaned. -A rubber glove and an alcohol swab wrapper were observed on the floor of R64's room. -A dried brown substance was observed splattered on the wall outside of R50's room which appears to have dripped down the wall. A rubber glove and other garbage was observed on the floor of R50's room. -R74 had two plate covers stacked on the floor at the end of R74's bed. Evidenced by: Surveyor reviewed a facility grievance form dated 3/28/22, which documented, R106 expressed a concern related to Care and room cleanliness to Occupational Therapist Registered (OTR)-UU. The facility's March grievance log documents: Nursing is the responsible party and the Action Taken: was Education, room cleaned, and the grievance was signed as completed on 4/01/22. 1) R106 was admitted to the facility on [DATE] and had diagnoses that include: acute respiratory failure with hypoxia. R106's Minimum Data Set assessment, dated 3/22/22, indicated that R106 is cognitively intact. On 4/12/22, a complaint was filed for R106 which documented, R106 was at the facility for approximately one month and she had a concern with grievances. Note: Surveyor identified multiple grievances from R106 in the facility Grievance Log and on 3/28/22, R106 complained about the cleanliness of her room to OTR-UU. On 6/22/22, at 2:01 PM, Surveyor observed the floor outside of room [ROOM NUMBER], a piece of paper with R17's name and room number printed on it along with a cookie. By room [ROOM NUMBER], Surveyor observed multiple areas of coffee that were spilled and dried on the floor. Surveyor observed a Direct Supply blood pressure machine that had a black dried substance with other dark dried liquids on the frame and the machine base. Observed by room [ROOM NUMBER], Surveyor observed a dirty metal butter knife, a toilet plunger, and a dried red sticky substance on the floor. Surveyor observed multiple staff working and walking through the hallway without addressing the dirty environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/22/22, at 2:11 PM, Surveyor interviewed the Housekeeping Supervisor (HS)-QQ who observed the concerns of the piece of paper, cookie, dried coffee, butter knife, toilet plunger, and red sticky substance in the hallway. HS-QQ stated se has been working at the facility for about 4 months and that he had already cleaned the hallway once earlier that day but will take care of the concerns noted above right away. On 6/23/22, at 9:10 AM, Surveyor observed the facility hallway outside of room [ROOM NUMBER]. The hallway had a pair of used, soiled rubber gloves in the hallway. Next to the rubber gloves Surveyor observed a brown substance that was smeared and dried on the floor. The brown substance continued down the hallway toward the door at the end of the hallway to the door where garbage is taken. Surveyor observed three staff members walk past the soiled gloves and the brown substance without picking up the soiled gloves or addressing the brown substance. Surveyor also observed a toilet plunger sitting in the hallway outside of the room [ROOM NUMBER], the shower room. The toilet plunger was observed in the hallway in the same location the previous day. On 6/23/22, at 9:23 AM, Surveyor observed three separate staff walk past the soiled rubber gloves on the floor and the brown smeared substance on the floor. None of the three staff addressed the soiled gloves or the brown substance. On 6/23/22, at 9:27 AM, Surveyor interviewed Restorative Nursing Aide (RNA-XX) who states the brown substance appears as if it was garbage that was spilled and streaking, as the brown substance heads toward the garbage door. RNA-XX was observed putting on a pair of clean gloves and picking up the soiled gloves and speaking with a member of housekeeping to notify them of the brown substance on the floor. On 6/23/22, at 9:40 AM, Surveyor interviewed Registered Nurse/Unit Manager (RN-O) who viewed the brown substance on the floor by room [ROOM NUMBER], RN-O stated she is not sure what the brown substance is but she will have it cleaned up right away and stated the soiled gloves left on the floor and garbage should be cleaned up as soon as staff find it. 38829 On 6/20/22, at 9:57 AM, Surveyor observed the following unsanitary and dirty environmental conditions: 2) A rubber glove and an alcohol swab wrapper on the floor of R64's room. 3) A dried brown substance splattered on the wall outside of R50's room which appears to have dripped down the wall. A rubber glove and other garbage on the floor of R50's room. 4) R74 had two plate covers stacked on the floor in R74's room at the end of R74's bed. On 6/21/22, at 9:34 AM, Surveyor observed the two plate covers still stacked on the floor in the same spot in R74's room. On 6/21/22, at 1:40 PM, Surveyor observed R64 in bed with R64's head touching the wall as R64's bed was pushed against the wall. Surveyor observed a red dried substance on the wall in R64's room that appears to have dripped down. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/22/22, at 7:59 AM, Surveyor observed, a red dried substance on the wall in R64's room. On 6/22/22, at 8:00 AM, Surveyor observed the same dried brown substance splattered and dripped down on the wall outside of R50's room. On 6/23/22 at 9:12 AM, Surveyor made the following observations: Surveyor notes the red dried substance on R64's wall next to the bed is still on the wall. Surveyor notes the brown dried substance located on the wall outside of R50's room has been cleaned. On 6/22/22 at 3:33 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the unsanitary and dirty environmental concerns Surveyor has observed during the survey process. No further information was provided at this time.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35928 Based on interview and record review, the facility did not make a prompt effort to resolve grievances for 4 of 4 residents (R106, R40, R97 and R105) residents who had voiced a grievance/concern to the facility. R106 had filed multiple grievances, these concerns were reported to the Nursing Home Administrator (NHA-A), however the facility did not ensure there was resolution to R106's concerns. R40 had filed a grievance related to the smell of his roommate, NHA-A was aware of R40's concerns however the facility did not ensure there was a resolution to R40's grievance. R97 had expressed concerns related to another resident in the facility that would yell at the staff at night and with food concerns. The NHA-A was aware of R40's concerns however the facility did not ensure there was a resolution to R97's concerns. R105 stated he has a concern about the call light response time. R105 stated it sometimes take 2-3 hours before the call light is answered. R105 stated he understands the facility is sometimes short of staff but feels the wait time to get his call light answered is excessive. R105 stated he complained to management and stated he feels nothing gets done about it. Evidenced by: The facility policy, entitled Grievance/Concern Process, dated 4/14/2020, states in part: Purpose: To establish a process for responding to a resident or resident representative to resolve grievances a resident may have. Procedure: 1. The facility must notify the resident individually or through postings in prominent locations throughout the facility of the right to file a grievance orally or in writing; the right to file grievances anonymously; the contact information of the grievance officer with whom a grievance can be filed, that is his or her name, business address and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances can be filed, that is pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long Term Care Ombudsman program or protection and advocacy system. 3. The Executive Director will be the designated Grievance Officer. 4. The Grievance Officer is responsible for overseeing the grievance process, receiving, and tracking grievances through to their conclusion, leading any necessary investigations by the facility and maintaining the confidentiality of all information associated with grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. The Grievance Officer will ensure that all written grievance decisions include the date the grievance was received, a summary statement of the grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents concern (s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as result of the grievance, and the date the written decision was issued. 9. The Grievance Officer forwards the grievance/concern form to the appropriate department head for investigation, follow-up and resolution and tracks the concern on the electronic grievance log. 10. The assigned department head investigates the identified concern timely to identify root cause of the issue or concern. 11. Once the root cause of the concern is identified, corrective action is taken to resolve the issue for the identified party as well as potential systemic changes to reduce risk of recurrence or occurrence for others. 17. The facility will maintain evidence demonstrating the resolution of complaints and grievances for at least 3 years. Surveyor reviewed the Grievance Log for the months of March, April, and May of 2022. Surveyor identified in the month of March there were four complaints with concerns of call light response time or availability of assistance. In the month of April there were three complaints with concerns of call light response times or availability of assistance. In the month of May there were four complaints with concerns of call light response times or availability of assistance. 1) R106 was admitted to the facility on [DATE] and had diagnoses that include: acute respiratory failure with hypoxia. R106's Minimum Data Set (MDS) assessment, dated 3/22/22, indicated R106 is cognitively intact. The Facility's Grievance Log indicated on 3/18/22, R106 had expressed a concern of call light wait time to the facility social worker, and the Action Taken was identified as Assistance Provided. The grievance log did not show how the facility identified the Root Cause and what action was taken to address the root cause as well as looking at the potential systemic changes to reduce the risk of recurrence or occurrence for others. The Facility's Grievance Log indicated on 3/28/22, R106 complained of Care and room cleanliness to the Occupational Therapist (OTR-UU). The log indicated the action taken was education, room cleaned. The grievance log did not show how the facility identified the Root Cause and what action was taken to address the root cause as well as looking at the potential systemic changes to reduce the risk of recurrence or occurrence for others. The Facility's Grievance Log indicated on 4/12/22, R106 complained of wait time to the Supervising Registered Nurse (RN-BBB). The log indicated that the action taken was Social Services purposely timed wait and the grievance was listed as unsubstantiated. The grievance log did not show how the facility identified the Root Cause and what action was taken to address the root cause as well as looking at the potential systemic changes to reduce the risk of recurrence or occurrence for others. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/12/22, a complaint was filed for R106. The complaint identified R106 was at the facility for approximately one month and that she had a concern with grievances. Note: Surveyor identified multiple grievances from R106 in the facility Grievance Log and on 3/28/22, R106 complained about the cleanliness of her room to her therapist. Surveyor reviewed a Complaint, dated 4/12/22, indicating that R106's family member tried to call the facility's Social Worker and Director of Nursing (DON-B) to relay their concerns, but all the calls resulted in being directed to a general voice mailbox for the facility, no follow up was provided to R106. 2) R40 was admitted to the facility on [DATE], and has diagnoses that include: pain, weakness, anxiety, and a history of COVID-19. R40's Minimum Data Set, dated dated [DATE], indicated R40 is moderately impaired cognitively but is understood when he is speaking and able to understand others when he is spoken to. On 6/23/22, at 10:57 AM, Surveyor interviewed R40 who stated he previously filed a grievance related to staff leaving his bathroom door open, it has been better, but nothing has ever been said to me about it. R40 stated his only concern right now is my roommate. My roommate smells bad, and he cannot control his body. The staff tell me that it is his right to be here, but I have rights too. No one from management ever comes back to me to discuss my concerns with grievances. The Facility's Resident Council Minutes, dated 3/2/22, at 2:30 PM, document in Old Business: R40 wants a different roommate because his roommate smells. The facility did not make an effort to solve R40's grievance and no follow up was provided to R40 related to his grievance. 3) R97 was admitted to the facility on [DATE] and has diagnoses that include orthopedic condition and anxiety disorder. R97's Minimum Data Set assessment, dated 5/25/22, indicates R97 is cognitively intact and has the ability to understand when spoken to and is able to understood when speaking. On 6/20/22, at 10:55 AM, Surveyor interviewed R97 who stated the temperature of the food is cold and there is not much of a selection. The food taste is just so-so, I usually just leave it. On 6/23/22, at 2:02 PM, Surveyor interviewed R97 who indicated he had a grievance with the kitchen and another related to a resident that was yelling all night. R97 stated the resident was rude to staff and I spoke to the previous social worker and I was only given a list of what they (facility) cannot do, not what has been done. On 6/22/22, at 11:10 AM, Surveyor interviewed Dietary Manager (DM)-AA), who stated, when food is sent out to the residents we have it at a certain temperature, when it is served to the residents it is out of our control. I have taken menus upstairs and go to some of the residents and show them the menu and ask for their preferences. I also go to the monthly food committee meetings. DM-AAA stated he doesn't hear a lot of concerns just a lot of requests. When I do hear concerns, I deal with the individual resident and take care of the concern. I do this informally I do not keep a log showing the concerns that I have received and how I addressed the concerns. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted the facility did not track any food related grievances through to conclusion. The facility did not ensure all grievance decisions included the date the grievance was received, a summary statement of the grievance and the steps taken to investigate the grievance. The facility did not have evidence that shows the root cause of the concern and the action taken to resolve the issue. The facility did not maintain this evidence demonstrating the resolution of complaints and grievances for at least 3 years. On 6/23/22, at 1:01 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated she is the designated Grievance Officer for the facility. NHA-A stated the facility did a Quality Assurance and Performance Improvement (QAPI) plan to address grievances and we discussed them in the morning meetings. At one point we trialed folders for each grievance that was received and the department head would take folders and complete the follow-up on the grievances. The department head would than come back to the morning meeting to follow-up on the concerns. As far as call light wait time concerns received, NHA-A stated those concerns were run through QAPI almost weekly. NHA-A stated, we looked at call light response times and had completed audits. We found the longest call light times were upstairs. NHA-A stated, we do not always have a formal sit down with the residents in response to their grievances. I will ask if their TV or phone was fixed or if the door was left open, it is not a formal process. It is not an excuse, when we touch base with the resident it is not a formal process to help the resident to understand what the concern is and how it was fixed. 20025 R105 was admitted to the facility on [DATE] with diagnoses of left femur fracture, quadriplegia and cerebral palsy. R105's Admission Minimum Data Set (MDS) assessment, dated 5/8/22 indicates R105 is cognitively intact. On 6/21/22, at 11:24 a.m., Surveyor interviewed R105. R105 stated he has a concern about the call light response time. R105 stated it sometimes take 2-3 hours before the call light is answered. R105 stated he understands the facility is sometimes short of staff but feels the wait time to get his call light answered is excessive. R105 stated he complained to management and stated he feels nothing gets done about it. Surveyor reviewed a grievance made by R105 dated 5/11/22. The grievance states general wait times; wants to confirm appt (appointment) for tomorrow. The grievance findings of investigation indicate talked with (R105) and his wife about recruiting and overall challenges in the industry. Appt time confirmed for 5/12 at 10:30 a.m. On 6/27/22, at 10:30 a.m., Surveyor interviewed Director of Nursing (DON)- B and Nursing Home Administrator (NHA)- A. Surveyor explained the concern R105 voiced to Surveyor regarding the call light response time and voiced this concern was brought to management's attention and R105 feels nothing gets done about his concerns. Surveyor explained the grievance made by R105 on 5/11/22 indicate he had a concern with the call light response time and all R105 was told was there are challenges with recruiting staff. Surveyor explained to DON-B and NHA-A that while R105 appreciates the challenges with staffing it does not resolve F105's issued with long call light response times. DON-B and NHA-A understood the concern but had no additional information.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure 1 (R25) of 1 allegations of sexual abuse was reported to the Nursing Home Administrator immediately and to the State Survey Agency within 2 hours of being made aware of the allegation. Findings Include: Surveyor reviewed the facility's policy and procedure entitled: Freedom from Abuse and Neglect Policy, effective 10/30/19, which documents: .Training: 2. Each new employee will be informed of his/her responsibility to immediately report any violations or alleged violations to the (Nursing Home Administrator) NHA. Identification: 1. Staff will immediately report any suspicious event or injury that may constitute abuse, neglect, exploitation or misappropriation to the NHA. 2. The Resident will be immediately assessed and removed from any potential harm. 3. The facility will report the allegation to the State Survey agency in accordance with state law. Reporting and Response: 1. Allegations will be reported to the NHA immediately. 2. The facility will report all alleged violations and substantiated incidents to the State Agency and to all other agencies as required. 3. The facility and/or staff will report suspicion of a crime to local authorities and/or agencies as required. Reporting to Law Enforcement of crimes occurring in federally funded long-term care facilities If the events that cause suspicion and or result in serious bodily injury, the facility shall report the suspicion immediately, but no later than 2 hours after forming the suspicion. Surveyor reviewed the facility's policy and procedure entitled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised April 2021, which documented: Policy Interpretation and Implementation . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting Allegations to the NHA-A and Authorities 1. If Resident abuse, exploitation, misappropriation of Resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the NHA and to other officials according to state law. 2. The NHA immediately reports to: a. The state licensing/certification agency responsible for surveying/licensing the facility b. Local/state ombudsman c. Resident's representative d. Adult Protective Services e. Law enforcement officials f. Resident's attending physician g. Medical Director 3. Immediately is defined as: a. Within 2 hours of an allegation involving abuse or result in serious bodily injury. R25 was admitted to the facility on [DATE] with diagnoses of Chronic Respiratory Failure with Hypoxia, Dysphagia, Cerebrovascular Disease, Encephalopathy, Chronic Atrial Fibrillation, Cerebral Infarction, and Major Depressive Disorder. R25 has an activated Health Care Power of Attorney(HCPOA). R25's Annual Minimum Data Set (MDS) assessment, dated 4/1/22, documents R25's cognitive skills were not assessed. R25's MDS also documents R25 requires total assistance for bed mobility, transfers, dressing, and eating. R25's medical record documents, a Brief Interview for Mental Status (BIMS) was completed on 10/21, which documents a score of 14, indicating R25 is cognitively intact for daily decision making. A BIMS was also documented on 1/3/22, with a score of 14, indicating R25's cognitively intact for daily decision making. Surveyor reviewed R25's comprehensive care plan and notes: R25 has targeted behaviors of refusing cares, non compliance with activities of daily living and displaying periods of anxiety and anxiousness, initiated on 7/7/21. On 4/8/21, R25's care plan documents: [R25] has a psychosocial well-being problem due to anxiety with inability to problem solve, ineffective coping, and lack of acceptance of current medical condition and stating in the past [R25] did not want to live but has no plan. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/20/22, R25's care plan documents: [R25] has alleged sexual assault from caregiver. On 3/11/22, the intervention of: no male caregivers to provide cares or enter [R25's] room was initiated. Surveyor reviewed the facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, which documents: [R25] reported a concern of a male CNA (Certified Nursing Assistant) touching [R25] inappropriately. Surveyor notes the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documents Nursing Home Administrator (NHA) was notified of R25's allegations on 12/29/21. The initial 24 hour report was submitted to the State Survey Agency on 12/30/21, at 12:08 AM. Surveyor noted this time frame does not meet the requirements of reporting sexual abuse within 2 hours of the allegation. Surveyor notes the completed facility Misconduct Incident Report was submitted to the State Survey Agency within 5 working days per regulation. Surveyor reviewed the facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report summary which documents: [R25] alleged a male caregiver touched [R25's] vagina and inserted fingers inside of [R25's] vagina and it happened multiple times. Per facility documented summary of the allegation, NHA-A was notified by a nurse whom stated [R25] appeared to be fearful when [R25] saw the caregiver (in question). It is also documented [R25] had reported the allegation previously to a respiratory therapist. Surveyor reviewed all the statements the facility obtained during the investigation of R25's allegation. Surveyor notes on 12/19/21, the respiratory therapist was alerted by R25 of feeling distress when around the caregiver. [R25] repeatedly kept mouthing to the respiratory therapist I have to get out of here, Don't leave me, and [R25] was trying to get out bed to leave. The statement documents the respiratory therapist informed [R25's] charge nurse of the concern noted at the time. Surveyor notes documentation on 12/19/21, of staff within the facility being aware of R25's allegation of sexual abuse. The allegation was not reported to NHA-A until 12/29/21 and not submitted to the State Survey Agency until 12/30/21. Surveyor notes a thorough investigation was completed by the facility including notification of the police. On 6/28/22, at 1:25 PM, Surveyor shared with NHA-A a concern R25's allegation of sexual abuse had not been reported to NHA-A on 12/19/21, when facility staff documented first being aware of the allegation and the allegation was not submitted to the State Survey Agency within 2 hours of the facility staff being made aware of the allegation. No further information was provided at this time.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interview, the facility did not ensure all allegations of abuse, neglect, and misappropriation of Resident property were thoroughly investigated for 2 (R74 and R108) of 3 residents reviewed for allegations of neglect/abuse and misappropriation. *On 1/27/22, R74 reported staff is rough when turning and providing cares. The facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was submitted to the State Survey Agency. However a thorough investigation was not completed as no staff or Resident interviews were obtained in regards to the allegation of abuse. *On 3/25/22, R108 reported $1,000 dollars missing. The facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was submitted to the State Survey Agency. However, a thorough investigation was not completed as no staff or Resident interviews were obtained in regards to the allegation of misappropriation and there was a delay in calling the police (6 days after the allegation). Findings Include: Surveyor reviewed the facility's policy and procedure entitled: Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, revised April 2021, which documents: .Investigating Allegations 1. All allegations are thoroughly investigated. The Administrator initiates investigations. 3. The Administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. 4. The Administrator is responsible for keeping the Resident and his/her representative informed of the progress of the investigation. 7. The individual conducting the investigation as a minimum: a. Reviews the documentation and evidence e. Interviews any witnesses to the incident f. Interviews the Resident j. Interviews other Residents k. Reviews all events leading up to the alleged incident l. Documents the investigation completely and thoroughly (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. The following guidelines are used when conducting interviews: . d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement or the investigator may obtain a statement. 9. The investigator notifies the ombudsman that an abuse investigation is being conducted. The ombudsman is invited to participate in the review process. 11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the Administrator. Surveyor reviewed the facility's policy and procedure entitled: Freedom from Abuse and Neglect Policy, effective 10/30/19, which documents: .Investigation: 1. The facility will conduct an internal investigation and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within 5 working days of the incident or according to state law. 2. The facility will thoroughly investigate all alleged violations and take appropriate actions. 3. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions. The investigation will include, but is not limited to the following: . e. Interviews and or written statements from individuals with first hand knowledge of the incident. h. All material and documentation of the pertinent data to the investigation is collected, maintained, and safeguarded by the facility. 1) R74 was admitted to the facility on [DATE] with diagnoses of Dementia, Hemiplegia Affecting Left Dominant Side, Pain, Unspecified Fall, Type 2 Diabetes Mellitus, Dysphagia, Ataxia, and Cocaine Dependence in Remission. R74 has a legal guardian. Surveyor reviewed R74's Quarterly Minimum Data Set (MDS) assessment, dated 4/15/22, which documents R74's Brief Interview for Mental Status (BIMS) score of 9, indicating R74 demonstrates moderately impaired skills for daily decision making. R74 requires extensive assistance for bed mobility, dressing, toileting, and hygiene. R74's MDS documents R74 requires supervision for transfers. Surveyor reviewed R74's electronic medical record and noted the following documentation: On 1/26/2022, at 1:03 PM, Social Service Progress Note: Writer visited [Resident's name] at 12:30 PM today and washed [Resident] up. [Resident] had on 2 briefs that were soaked with urine. [Resident] allowed writer to freshen [Resident] up. The pad underneath [Resident] was soaked in urine. [Resident] states staff are rough with [Resident] when they change [Resident] and at times [Resident]states [Resident] does tell them no because they hurt [Resident]. Grievance filed this afternoon. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility's Misconduct Incident Report and summary dated 2/3/22, concerning R74's allegation of staff being rough when turning and with cares. The facility investigation documents R74 was unable to name a specific day or time the alleged incident occurred. Surveyor noted on 1/26/22, R74's EMR documents R74 was found soaked in urine with 2 briefs on and states staff are rough at times when they change him. The date and time the progress note was written could have been use by the facility as a starting point to begin their investigation with interviews of the staff that have provided care to R74. However, the facility did not include staff statements as part of the investigation of R74's allegations. The summary of the concern investigation indicates other Residents were interviewed. However, there is no documentation of resident interviews provided with the facility investigation. The report does not have documentation indicating R74's physician and responsible party were notified of the abuse allegation. On 6/21/22, at 3:03 PM, Surveyor requested from Nursing Home Administrator (NHA)-A any additional information of the facility's investigation of R74's allegation of rough treatment. On 6/22/22, at 11:06 AM, Surveyor was provided no additional information from NHA-A. On 6/23/22, at 9:23 AM, NHA-A informed Surveyor there is no further information available in regards to the facility's investigation of R74's allegation of rough treatment. NHA-A was unable to provide documentation of any staff or resident interviews conducted during the investigation. On 6/28/22, at 1:40 PM, Surveyor shared the concern with NHA-A that a thorough investigation had not been completed for R74's allegation of rough treatment. No further info was provided at this time. 2) R108 was admitted to the facility on [DATE] with diagnoses of Morbid Obesity, Heart failure, Chronic Respiratory Failure with Hypoxia, Peripheral Vascular Disease, and Chronic Kidney Disease. R108 was his own person while residing at the facility. R108 was discharged to the hospital on 4/20/22 for shortness of breath and did not return to the facility. Surveyor reviewed R108's Admission (Minimum Data Set) MDS assessment, dated 3/15/22, which documents R108's Brief Interview for Mental Status (BIMS) score to be a 14, indicating R108 is cognitively intact related to daily decision making. R108's MDS also documents R108 requires extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. Surveyor reviewed the facility's Misconduct Incident Report and summary provided by the facility dated 4/1/22 as related to R108's missing money. The report documents: On 3/25/22, a family member of R108 reported R108 was missing $1,000. On 3/30/22, the family member of R108 called the facility again and reported only some of the money was found and R108 was still missing some money. The police were not notified of the missing money until 3/31/22. The facility did not include staff and other Resident statements as part of the investigation of R108's missing money. On 6/21/22, at 3:03 PM, Surveyor requested from Nursing Home Administrator (NHA)-A any additional information of the facility's investigation of R108's missing money. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/22/22, at 11:06 AM, Surveyor was provided no additional information from NHA-A. On 6/23/22, at 9:23 AM, NHA-A informed Surveyor there is no further information available in regards to the facility's investigation R108's missing money. NHA-A was unable to provide documentation of any staff or resident interviews conducted during the investigation. On 6/28/22, at 1:40 PM, Surveyor shared the concern with NHA-A that a thorough investigation had not been completed for R108's allegation of missing money. No further information was provided at this time.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not notify the resident or resident's representative in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which the resident is transferred, a statement of the resident's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman for 7 (R107, R4, R69, R43, R108, R359, and R56) of 9 residents reviewed for transfer to the hospital. *R107 was transferred to the hospital on 5/2/2022. A Bed Hold notice and Notice of Transfer form was partially completed, and indication was made on the form a verbal consent was obtained from the Power of Attorney (POA). This written form was never provided to R107's POA. *R4 was transferred to the hospital on 2/17/2022, 2/26/2022, and 6/7/2022. A Bed Hold notice and Notice of Transfer form was inaccurately completed on 2/17/2022 and indication was made on the form that a verbal consent was obtained from the Guardian. This written form was never provided to the Guardian. No Bed Hold notice and Notice of Transfer forms were provided for the transfers that occurred on 2/26/2022 or 6/7/2022 or documentation the forms were provided to the Guardian. *R69 was transferred to the hospital on 1/15/2022, 1/24/2022, 3/8/2022, 3/13/2022, 4/17/2022, 4/25/2022, and 5/26/2022. No Bed Hold notuce and Notice of Transfer forms were provided for any of the dates R69 was transferred to the hospital or documentation the forms were provided to R69's Power of Attorney. *R43 was transferred to the hospital on 2/20/2022, 3/2/2022, and 3/15/2022. Bed Hold notice and Notice of Transfer forms were inaccurately completed on 3/2/2022 and 3/15/2022 and indication was made on the forms that a verbal consent was obtained from the Guardian. These written forms were never provided to the Guardian. No Bed Hold notice and Notice of Transfer form was provided for the transfer that occurred on 2/20/2022 or documentation the form was provided to R43's Guardian. *R108 was transferred to the hospital on 3/24/2022 and 4/20/2022. No Bed Hold notice and Notice of Transfer forms were provided for any of the dates R108 was transferred to the hospital or documentation the forms were provided to R108 or R108's representative. *R359 was transferred to the hospital on 3/2/2022 and 5/29/2022. No Bed Hold notice and Notice of Transfer forms were provided for any of the dates R359 was transferred to the hospital or documentation the forms were provided to R359 or R359's representative. *R56 was transferred to the hospital on 6/3/2022 and 6/10/2022. No Bed Hold notice and Notice of Transfer forms were provided for any of the dates R56 was transferred to the hospital or documentation the forms were provided to R56 or R56's representative. Findings include: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility policy and procedure entitled: Bed-Holds and Returns, dated 3/2017, states: Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Policy Interpretation and Implementation: . 3. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: . d. The details of the transfer (per the Notice of Transfer). The facility Wisconsin Bed Hold and Notice of Transfer form consists of the reason for transfer, the bed hold policy, the appeal rights, and the bed hold request form with the bed hold daily rate per type of room. The reason for transfer has four options listed in which to choose the appropriate reason for transfer: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer; the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the health or safety of individuals in the facility is endangered; the resident and/or legal representative is requesting transfer to an alternative facility. The appeal rights are explained, and the following agencies are listed for the appeal process: the Division of Quality Assurance with address, phone number, and email address; the State of Wisconsin Board on Aging and Long-Term Care with address, phone number, and email address; the Regional Ombudsman with address, phone number, and email address; and the Wisconsin Coalition for Advocacy with address and phone number. The Ombudsman information listed is out of date with the wrong name and email address for the Regional Ombudsman. The Wisconsin Coalition for Advocacy listed is outdated and should reflect the Disabilities Rights of Wisconsin with address, phone number, and email address. There is a signature and date line for the resident or resident representative to complete indicating acknowledgement of appeal rights and a section to complete if a signature was unable to be obtained as well as how the resident or representative was notified (phone, hand delivered, or mailed). 1) R107 was admitted to the facility on [DATE]. R107 had an activated POA (Power of Attorney). On 5/2/2022, at 11:18 AM, in the progress notes, nursing charted R107 requested to go to the hospital due to excruciating pain to the gastrostomy tube site but refused to let facility staff assess the gastrostomy tube site. R107's POA called the facility at the time R107 was being prepared for transfer to the hospital and was informed of the transfer. On 6/21/2022, at 3:06 PM, Surveyor requested from Nursing Home Administrator (NHA)-A a copy of R107's transfer notice for R107's hospitalization on [DATE] that was provided to R107's POA. On 6/22/2022, R107's Bed Hold and Notice of Transfer form dated 5/2/2022 was provided to Surveyor. The form did not indicate the reason for transfer and the appeal rights information was inaccurate. The form indicated a verbal confirmation of the transfer was obtained but no documentation was found indicating the written notification was provided to R107's POA as required. 2) R4 was admitted to the facility on [DATE]. R4 had a Legal Guardian appointed. On 2/17/2022, at 7:05 AM, in the progress notes, nursing charted R4 had a change in condition with copious dark brown secretions from the tracheostomy tube, hypoxia, accessory muscle use for breathing, tachycardia, and fever. Nursing charted 911 was called and R4's Guardian was notified of the change of condition and informed of the transfer to the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	On 2/26/2022, at 8:00 AM, in the progress notes, nursing charted R4 was in respiratory distress, using accessory muscles to breathe, and had excessive secretions. R4 was transferred to the hospital. R4's Guardian was attempted to be notified of R4's transfer to the hospital but the Guardian did not answer the phone. At 10:06 AM, in the progress notes, nursing charted a second attempt was made to call R4's Guardian, but R4's Guardian did not answer the phone and the mailbox was full so no message could be left. On 6/7/2022. at 2:59 PM, in the progress notes, nursing charted R4 had an oxygen saturation at 85% with elevated heart rate at 6:20 AM. Oxygen was increased to 10 liters and the oxygen saturation increased to 90%. R4 was noted to have an emesis and R4's temperature was elevated to 101.7 degrees. R4 was sent to the hospital for evaluation. The progress note stated R4's family was notified. On 6/21/2022, at 3:06 PM, Surveyor requested from Nursing Home Administrator (NHA)-A a copy of R4's transfer notices for R4's hospitalization s on 2/17/2022, 2/26/2022, and 6/7/2022 that were provided to R4's Guardian. On 6/22/2022, R4's Bed Hold notice and Notice of Transfer form dated 2/17/2022 was provided to Surveyor. The form had an X marked on all four reasons for transfer: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer; the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the health or safety of individuals in the facility is endangered; the resident and/or legal representative is requesting transfer to an alternative facility. The appeal rights information was inaccurate. The form indicated a verbal confirmation of the transfer was obtained but no documentation was found indicating the written notification was provided to R4's Guardian as required. No Bed Hold notice and Notice of Transfer forms were provided to Surveyor for 2/26/2022 or 6/7/2022 and no documentation was found indicating the written notifications were provided to R4's Guardian as required. 3) R69 was admitted to the facility on [DATE]. R69 had an activated POA (Power of Attorney). On 1/15/2022, at 6:30 PM, in the progress notes, nursing charted R69 had a change in condition with elevated heartrate and hypoxia. R69's POA was present at the time and aware of the transfer to the hospital. On 1/24/202,2 at 12:49 AM, in the progress notes, nursing charted R69's oxygen saturation was dropping and R69 was transferred to the hospital. R69's POA was notified. On 3/8/2022, at 9:28 AM, in the progress notes, nursing charted R69 was unresponsive and Respiratory Therapy was bagging R69. R69 regained consciousness and denied wanting to go to the hospital, but R69's POA requested transfer to the hospital. On 3/13/2022, at 9:16 AM, in the progress notes, nursing charted R69 was weak and lethargic. R69's POA requested R69 go to the hospital for evaluation. R69 was transferred to the hospital. On 4/17/2022, at 6:09 PM, in the progress notes, nursing charted R69's POA was visiting and insisted R69 be sent to the hospital to be evaluated due to being more sleepy than usual. R69 was sent to the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	On 4/25/2022, at 9:50 PM, in the progress notes, nursing charted R69 complained of difficulty breathing even after a breathing treatment was administered. R69's POA was notified and requested R69 be sent to the hospital for evaluation. R69 was sent to the hospital. On 5/26/2022, at 1:55 PM, in the progress notes, nursing charted R69 was sent to the hospital due to anemia and complaints of inability to breathe. R69's POA was notified of the transfer to the hospital. On 6/21/2022, at 3:06 PM, Surveyor requested from NHA-A a copy of R69's transfer notices for R69's hospitalization s on 1/15/2022, 1/24/2022, 3/8/2022, 3/13/2022, 4/17/2022, 4/25/2022, and 5/26/2022 that were provided to R69's POA. No Bed Hold notice and Notice of Transfer forms for R69 were provided to Surveyor for 1/15/2022, 1/24/2022, 3/8/2022, 3/13/2022, 4/17/2022, 4/25/2022, and 5/26/2022 and no documentation was found indicating the written notifications were provided to R69's POA as required. 4) R43 was admitted to the facility on [DATE]. R43 had a Legal Guardian appointed. On 2/20/2022, at 4:13 AM, in the progress notes, nursing charted R43 had a large emesis with elevated pulse and labored breathing. R43 was sent to the hospital for evaluation and treatment and R43's Guardian was notified of the transfer. On 3/2/2022, at 1:36 AM, in the progress notes, nursing charted R43 was breathing against the ventilator and needed pressure control in the hospital. R43 was sent to the hospital for evaluation and treatment and R43's Guardian was notified of the transfer. On 3/15/2022, at 1:28 AM, in the progress notes, nursing charted R43 had a decline in condition with increased respirations and retractions. R43 was sent to the hospital for evaluation and treatment and R43's Guardian was notified of the transfer. On 6/21/2022 at 3:06 PM, Surveyor requested from NHA-A a copy of R43's transfer notices for R43's hospitalization s on 2/20/2022, 3/2/2022, and 3/15/2022 that were provided to R43's Guardian. On 6/22/2022, R43's Bed Hold and Notice of Transfer form dated 3/2/2022 was provided to Surveyor. The form had an X marked on all four reasons for transfer: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer; the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the health or safety of individuals in the facility is endangered; the resident and/or legal representative is requesting transfer to an alternative facility. The appeal rights information was inaccurate. The form indicated a verbal confirmation of the transfer was obtained but no documentation was found indicating the written notification was provided to R43's Guardian as required. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/22/2022, R43's Bed Hold and Notice of Transfer form dated 3/15/2022 was provided to Surveyor. The form had an X marked on the reasons for transfer: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, including hospital transfer. The appeal rights information was inaccurate. The form indicated a verbal confirmation of the transfer was obtained but no documentation was found indicating the written notification was provided to R43's Guardian as required. No Bed Hold notice and Notice of Transfer form for R43 was provided to Surveyor for 2/20/2022 and no documentation was found indicating the written notification was provided to R43's Guardian as required. In an interview on 6/23/2022 at 3:20 PM, Surveyor asked NHA-A who was responsible for written transfer notices to be sent to resident [NAME] of Attorney or Guardians when a resident was transferred to the hospital. NHA-A stated the nurses on the floor start the process by filling out the form and then the receptionist mails them out once they are completed. Surveyor asked NHA-A if this process had been done with R107, R4, R69, and R43. NHA-A stated that had not consistently been done and did not have any documentation to show that those transfer notices had been sent out. No further information was provided at that time. 38829 5) R108 was admitted to the facility on [DATE] with diagnoses of Morbid Obesity, Heart failure, Chronic Respiratory Failure with Hypoxia, Peripheral Vascular Disease, and Chronic Kidney Disease. R108 was his own person while residing at the facility. Surveyor reviewed R108's Admission (Minimum Data Set) MDS assessment, dated 3/15/22, which documents R108's Brief Interview for Mental Status to (BIMS) to be a 14, indicating R108 is cognitively intact for daily decision making. R108's MDS also documents R108 required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. Surveyor reviewed R108's Electronic Medical Record (EMR) progress notes and notes documentation indicating R108 was discharged to the hospital two different times. R108 was discharged to the hospital on 3/24/22 and admitted for pneumonia. R108 was readmitted to the facility on [DATE]. R108 was discharged to the hospital on 4/20/22 for shortness of breath and did not return to the facility. Surveyor was unable to locate a transfer notice for 3/24/22 and 4/20/22 for R108 indicating the reason for the transfer, location, effective date and appeal rights. On 6/22/22, at 10:58 AM, Surveyor shared with Administrator (NHA-A) that Surveyor could not locate the transfer notices for R108's discharges to the hospitals. On 6/22/22, at 3:38 PM, NHA-A informed Surveyor that NHA-A was unable to locate transfer notices for R108's two discharges to the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/28/22 at 1:32 PM, Surveyor shared the concern with NHA-A that R108 should have been provided transfer notices at time of discharge on 3/24/22 and 4/20/22 which would have also contained the regulatory required information containing appeal rights, name and address of state ombudsman, and name and address of agencies to contact for Residents with intellectual and developmental disabilities as well as Residents with a mental disability. No further information was provided at this time. 40533 6) R359 was admitted to the facility on [DATE] with diagnoses of Respiratory Failure, Protein Calorie Malnutrition, Vascular Dementia without Behavioral Disturbances, Type 2 Diabetes Mellitus and History of Pneumonia. Surveyor reviewed R359's Electronic Medical Record (EMR). Documented under Census was R359 was discharged to the hospital two times. R359 was discharged to the hospital on 3/2/22 and admitted with Urosepsis. R359 was readmitted to the facility on [DATE]. R359 was discharged to the hospital on 5/30/22 and admitted with Pneumonia. R359 was readmitted to the facility on [DATE]. Surveyor was unable to locate a transfer notice for 3/2/22 and 5/30/22 for R359 indicating the reason for the transfer, location, effective date, appeal rights and ombudsman notification. On 6/27/22, at 8:13 AM, Surveyor asked Nursing Home Administrator (NHA-A) for the transfer notices for R359's two hospitalization s. On 6/23/22, at 12:02 PM, NHA-A informed Surveyor that NHA-A was unable to locate transfer notices for R359's two hospitalization s. 20025 7) R56 was admitted to the facility on [DATE] with diagnoses of cognitive deficits, heart failure, type 2 diabetes and chronic respiratory failure. R56's Quarterly MDS (minimum data set) assessment, dated 5/5/22, indicates R56 has cognitive impairments. Surveyor reviewed R56 medical record and R56 was transferred to the hospital on 6/3/22 and 6/10/22. The documentation does not indicate if a transfer notice was given to R56's POA (power of attorney). On 6/23/22, at 3:00 p.m., during the daily exit meeting with the Nursing Home Administrator (NHA- A and Director of Nursing (DON)- B, Surveyor asked if facility had documentation of a transfer notice for R56's two hospitalization s on 6/3/22 and 6/10/22. On 6/27/22, at 10:30 a.m., NHA-A and DON-B explained to Surveyor they have no documentation of a transfer notice being given to R56's POA.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not notify at the time of transfer the resident or resident's representative in writing the state bed-hold policy, the duration of the bed hold, the reserve bed payment policy, and the return to the facility for 7 (R107, R4, R69, R43, R108, R359, and R56) of 9 residents reviewed for bed hold notice. *R107 was transferred to the hospital on 5/2/2022. A Bed Hold and Notice of Transfer form was partially completed, and indication was made on the form a verbal consent was obtained from the Power of Attorney (POA). This written form was never provided to the POA. *R4 was transferred to the hospital on 2/17/2022, 2/26/2022, and 6/7/2022. A Bed Hold and Notice of Transfer form was inaccurately completed on 2/17/2022 and indication was made on the form a verbal consent was obtained from the Guardian. This written form was never provided to the Guardian. No Bed Hold and Notice of Transfer forms were provided for 2/26/2022 or 6/7/2022 or documentation the forms were provided to the Guardian. *R69 was transferred to the hospital on 1/15/2022, 1/24/2022, 3/8/2022, 3/13/2022, 4/17/2022, 4/25/2022, and 5/26/2022. No Bed Hold and Notice of Transfer forms were provided for any of the dates R69 was transferred to the hospital or documentation the forms were provided to the Power of Attorney. *R43 was transferred to the hospital on 2/20/2022, 3/2/2022, and 3/15/2022. Bed Hold and Notice of Transfer forms were inaccurately completed on 3/2/2022 and 3/15/2022, and indication was made on the form a verbal consent was obtained from the Guardian. The written form was never provided to the Guardian. No Bed Hold and Notice of Transfer form was provided for 2/20/2022 or documentation the form was provided to the Guardian. *R108 was transferred to the hospital on 3/24/2022 and 4/20/2022. No Bed Hold and Notice of Transfer forms were provided for any of the dates R108 was transferred to the hospital or documentation the forms were provided to R108 or R108's representative. *R359 was transferred to the hospital on 3/2/2022 and 5/29/2022. No Bed Hold and Notice of Transfer forms were provided for any of the dates R359 was transferred to the hospital or documentation the forms were provided to the R359 or R359's representative. *R56 was transferred to the hospital on 6/3/2022 and 6/10/2022. No Bed Hold and Notice of Transfer forms were provided for any of the dates R56 was transferred to the hospital or documentation the forms were provided to the R56 or R56's representative. Findings: (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility Bed Hold Policy that is provided to residents on admission states: hospitalization must be ordered by the physician for the treatment of an acute condition that cannot be treated in the nursing facility. The facility will request a written or verbal approval/denial for a bed hold. The facility will request a written or verbal approval/denial. [sic] If the family/responsible party wishes to hold the bed he/she will be charged the facility daily rate. The bed hold rate to hold a bed is the private pay rate per day. The facility policy and procedure entitled Bed-Holds and Returns dated 3/2017 states: Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Policy Interpretation and Implementation: . 3. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); . The facility Wisconsin Bed Hold and Notice of Transfer form consists of the reason for transfer, the bed hold policy, the appeal rights, and the bed hold request form with the bed hold daily rate per type of room. The bed hold policy describes the process for Medicaid/Title 19 residents and Medicare/Private-Pay/Insurance residents. The bed hold request form has a blank to be filled out for resident name, where resident was transferred to, and the date of the transfer. The following paragraph has blanks to be filled out indicating the dates the bed hold is effective and the current daily rate. There is a signature and date line for the resident or resident representative to complete indicating acknowledgement of the bed hold confirmation. 1) R107 was admitted to the facility on [DATE]. R107 had an activated POA. On 5/2/2022, at 11:18 AM, R107's progress notes document, nursing charted [R107] requested to go to the hospital due to excruciating pain to the gastrostomy tube site but refused to let facility staff assess the gastrostomy tube site. [R107's] POA called the facility at the time [R107] was being prepared for transfer to the hospital and was informed of the transfer. On 6/21/2022 at 3:06 PM, Surveyor requested from Nursing Home Administrator (NHA)-A a copy of R107's bed hold notice for R107's hospitalization on [DATE] that was provided to R107's POA. On 6/22/2022, R107's Bed Hold and Notice of Transfer form dated 5/2/2022 was provided to Surveyor. The form did not indicate the dates the bed hold went into effect and did not state what the cost of the bed hold per day would be. The form indicated a verbal confirmation of the bed hold was obtained but no documentation was found indicating the written bed hold notice) was provided to R107's POA as required. 2) R4 was admitted to the facility on [DATE]. R4 had a Legal Guardian appointed. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	On 2/17/2022, AT 7:05 AM, R4's progress notes document, nursing charted [R4] had a change in condition with copious dark brown secretions from the tracheostomy tube, hypoxia, accessory muscle use for breathing, tachycardia, and fever. Nursing charted 911 was called and [R4's] Guardian was notified of the change of condition and informed of the transfer to the hospital. The bed hold was reviewed with [R4's] Guardian and [R4's] Guardian agreed to the bed hold. On 2/26/2022, at 8:00 AM, R4's progress notes document, nursing charted [R4]was in respiratory distress, using accessory muscles to breathe, and had excessive secretions. [R4] was transferred to the hospital. [R4's] Guardian was attempted to be notified of [R4's] transfer to the hospital but the Guardian did not answer the phone. At 10:06 AM in the progress notes, nursing charted a second attempt was made to call []R4's Guardian, but [R4's] Guardian did not answer the phone and the mailbox was full so no message could be left. On 6/7/2022, at 2:59 PM, R4's progress notes document, nursing charted [R4] had an oxygen saturation at 85% with elevated heart rate at 6:20 AM. Oxygen was increased to 10 liters and the oxygen saturation increased to 90%. [R4] was noted to have an emesis and [R4's] temperature was elevated to 101.7 degrees. [R4] was sent to the hospital for evaluation. The progress note stated bed hold papers were obtained and [R4's] family was notified. On 6/21/2022 at 3:06 PM, Surveyor requested from Nursing Home Administrator (NHA)-A a copy of R4's transfer notices for R4's hospitalization s on 2/17/2022, 2/26/2022, and 6/7/2022 that were provided to R4's Guardian. On 6/22/2022, R4's Bed Hold and Notice of Transfer form dated 2/17/2022 was provided to Surveyor. The form did not indicate the dates the bed hold was needed and did not state what the cost of the bed hold per day would be. The form indicated a verbal confirmation of the bed hold notice was obtained but no documentation was found indicating the written notification was provided to R4's Guardian as required. No Bed Hold and Notice of Transfer forms were provided to Surveyor for R4's transfer from the facility on 2/26/2022 or 6/7/2022 and no documentation was found indicating the written bed holds notices were provided to R4's Guardian as required. 3) R69 was admitted to the facility on [DATE]. R69 had an activated Power of Attorney (POA). On 1/15/2022 at 6:30 PM, R69's medical record documents, progress notes, nursing charted [R69] had a change in condition with elevated heart rate and hypoxia. [R69's] POA was present at the time and aware of the transfer to the hospital. On 1/24/2022, at 12:49 AM, R69's medical record documents, progress notes, nursing charted [R69's] oxygen saturation was dropping and [R69] was transferred to the hospital. [R69's] POA was notified. On 3/8/2022, at 9:28 AM, R69's medical record documents, progress notes, nursing charted [R69] was unresponsive and Respiratory Therapy was bagging [R69]. [R69] regained consciousness and denied wanting to go to the hospital, but [R69's] POA requested transfer to the hospital. On 3/13/2022, at 9:16 AM, R69's medical record documents, in the progress notes, nursing charted [R69] was weak and lethargic. [R69's] POA requested [R69] go to the hospital for evaluation. [R69] was transferred to the hospital. (continued on next page)

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	525108	A. Building B. Wing	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	On 4/17/202,2 at 6:09 PM, R69's medical records documents, in the progress notes, nursing charted [R69's] POA was visiting and insisted [R69] be sent to the hospital to be evaluated due to being more sleepy than usual. [R69] was sent to the hospital. On 4/25/2022, at 9:50 PM, R69's medical record documents, in the progress notes, nursing charted [R69] complained of difficulty breathing even after a breathing treatment was administered. [R69's] POA was notified and requested [R69] be sent to the hospital for evaluation. [R69] was sent to the hospital. On 5/26/2022, at 1:55 PM, R69's medical record documents in the progress notes, nursing charted [R69] was sent to the hospital due to anemia and complaints of inability to breathe. [R69's] POA was notified of the transfer to the hospital. On 6/21/2022, at 3:06 PM, Surveyor requested from Nursing Home Administrator (NHA)-A a copy of R69's bed hold notices for R69's hospitalization s on 1/15/2022, 1/24/2022, 3/8/2022, 3/13/2022, 4/17/2022, 4/25/2022, and 5/26/2022 that were provided to R69's POA. No Bed Hold and Notice of Transfer forms for R69 were provided to Surveyor for 1/15/2022, 1/24/2022, 3/8/2022, 3/13/2022, 4/17/2022, 4/25/2022, and 5/26/2022 and no documentation was found indicating the written bed holds were provided to R69's POA as required. 4) R43 was admitted to the facility on [DATE]. R43 had a Legal Guardian appointed. On 2/20/2022, at 4:13 AM, R43's medical record documents in the progress notes, nursing charted [R43] had a large emesis with elevated pulse and labored breathing. [R43] was sent to the hospital for evaluation and treatment and [R43's] Guardian was notified of the transfer. On 3/2/2022, at 1:36 AM, R43's medical record documents in the progress notes, nursing charted [R43] was breathing against the ventilator and needed pressure control in the hospital. [R43] was sent to the hospital for evaluation and treatment and [R43's] Guardian was notified of the transfer and verbally agreed to a bed hold. On 3/15/202,2 at 1:28 AM, R43's medical record documents in the progress notes, nursing charted [R43] had a decline in condition with increased respirations and retractions. [R43] was sent to the hospital for evaluation and treatment and [R43's] Guardian was notified of the transfer. On 6/21/2022, at 3:06 PM, Surveyor requested from Nursing Home Administrator (NHA)-A a copy of R43's bed hold notices for R43's hospitalization s on 2/20/2022, 3/2/2022, and 3/15/2022 that were provided to R43's Guardian. On 6/22/2022, R43's Bed Hold and Notice of Transfer form dated 3/2/2022 was provided to Surveyor. The form did not indicate the dates the bed hold was needed and did not state what the cost of the bed hold per day would be. The form indicated a verbal confirmation of the bed hold was obtained but no documentation was found indicating the written notification was provided to R43's Guardian as required. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/28/22 at 1:32 PM, Surveyor shared the concern with NHA-A that R108 should have been provided transfer notices at time of discharge which would have also contained the regulatory required information containing the duration of the state bed-hold policy, the reserve bed payment state policy, and the facility policies regarding bed-hold periods. No further information was provided at this time. 40533 R359 was admitted to the facility on [DATE] with diagnoses of Respiratory Failure, Protein Calorie Malnutrition, Vascular Dementia without Behavioral Disturbances, Type 2 Diabetes Mellitus and History of Pneumonia. Surveyor reviewed R359's Electronic Medical Record (EMR). Documented under Census: R359 was discharged to the hospital two times. R359 was discharged to the hospital on 3/2/22 and admitted with Urosepsis. R359 was readmitted to the facility on [DATE]. R359 was discharged to the hospital on 5/30/22 and admitted with Pneumonia. R359 was readmitted to the facility on [DATE]. Surveyor was unable to locate a bed hold notice for R359's transfers that occurred on 3/2/22 and 5/30/22 for R359. On 6/27/22, at 8:13 AM, Surveyor asked Nursing Home Administrator (NHA)-A for the bed-hold notices for R359's two hospitalization s, 3/2/22 and 5/30/22. On 6/23/22, at 12:02 PM, NHA-A informed Surveyor NHA-A was unable to locate bed-hold notices for R359's two hospitalization s. 20025 7) R56 was admitted to the facility on [DATE] with diagnoses of cognitive deficits, heart failure, type 2 diabetes and chronic respiratory failure. The Quarterly MDS (Minimum Data Set) assessment, dated 5/5/22, indicates R56 has cognitive impairments. Surveyor reviewed R56's medical record and R56 was sent to the hospital on 6/3/22 and 6/10/22. The documentation for 6/3/22 does not indicate if a bed hold notice was given to R56's POA (Power of Attorney). The 6/10/22 documentation indicate a bed hold notice was sent along with R56. Surveyor was unable to find a signed bed hold notice in R56 medical record. On 6/23/22, at 3:00 p.m., during the daily exit meeting with Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B, Surveyor asked if a signed bed hold notice was available to review for R56's two hospitalization s on 6/3/22 and 6/10/22. On 6/27/22, at 10:30 a.m., NHA-A and DON-B explained to Surveyor they have no documentation of a signed bed hold notice being provided for R56's hospitalization s on 6/3/22 and 6/10/22.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 03444 Based on record review, observation and interview, the facility did not ensure timely assistance for 1 of 22 residents (R21) dependent on staff for activities of daily living (ADLs). As a result of staff not answering the call light and the call light was not working properly, R21 went without assistance with ADLs, specifically toileting/incontinence care. Findings include: R21 was admitted to facility on 3/24/16. Diagnoses include cerebral infarction, muscle weakness, lack of coordination, chronic pain syndrome, and anxiety disorder. R21's Minimum Data Set (MDS) dated [DATE] indicated extensive assistance of two persons with toileting and one person for personal hygiene. R21's care plan, dated 4/17/22, confirmed extensive assistance with ADL's, provide incontinence care as needed to keep skin as clean and dry as possible and check every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. On 6/20/22 at 09:51 AM, interview with R21. R21 stated that she was all soaked and did not get changed until 8:00 AM on Sunday, 6/19/22. R21 reported that she put her call light on but staff did not answer her call light. R21 further stated, They put me to bed at 7 on Saturday, 6/18/22, night. I woke up at 8:00 on Sunday and I was all soaked. They didn't change my brief during the night and I was full of pee. There is no need for that. I left a complaint to the Nursing Home Administrator on the phone on Sunday. I have not heard anything back from her yet. On 6/21/22 at 7:13 AM, interview with R21. R21stated, I had my call light on since 6:10 this morning and now it is 7:15 and I am wet. Can you ask for a staff to come in and change me? Surveyor noticed that the call light in the room was lit but the light outside above the room was not working. On 6/21/22 at 7:25 AM, interview with LPN-MM and she reported that she told maintenance yesterday around 3:30 PM about the light above R21's room was not working. I don't know why they have not come up to fix it. I will let them know right away. Surveyor observed LPN-MM asked CNA-RR to go and assist R21. On 6/21/22 at 8:00 AM, surveyor observed Maintenance-PP changed the light bulb outside of R21's room. Surveyor shared with Administrator the concerns of R21's call light not working, staff not answering her call light timely and staff not changing her for a long period of time after being incontinent. No further information was provided.

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F 0686 Level of Harm - Minimal harm or potential for 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** 38829 Based on observation, interview, and record review the Facility did not ensure 3 (R23, R64, and R74) of 8 Residents at risk for development of pressure injuries received the necessary treatment and services to prevent pressure injuries from developing. R23, R64 and R74 were observed during the survey process to not have their heels floated/pressure off loaded to help prevent a pressure injury despite being a care planned intervention. Findings Include: Surveyor reviewed the facility's revised April 2020 Prevention of Pressure Injuries policy and procedure and noted the following applicable: Purpose The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation Review the Resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment 1. Assess the Resident on admission(within 8 hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. Mobility/Repositioning 1. Reposition all Residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team(IDT). 2. Choose a frequency for repositioning based on the Resident's risk factors and current clinical practice guidelines. 3. Teach Resident who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage Residents to change positions. Device-Related Pressure Injuries (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device. 2. Monitor regularly for comfort and signs of pressure-related injury. 3. For prevention measures associated with specific devices, consult current clinical practice guidelines. Monitoring 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. 1.) R23 was admitted to the facility on [DATE] with diagnoses of Adult Failure to Thrive, Dysphagia, Pain, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. R23 is her own person at this time. R23's Quarterly Minimum Data Set (MDS) dated [DATE] documents that R23's cognitive status was not assessed. R23's MDS also documents that R23 requires extensive assistance for bed mobility, toileting, dressing, and hygiene. The MDS identifies R23 is at risk for pressure injuries. Surveyor reviewed R23's Care Area Assessment (CAA) dated 10/14/21. R23's CAA documents that R23 is at risk for development of pressure injuries due to impaired mobility and incontinence. R23 requires assistance with bed mobility due to spinal stenosis. Surveyor reviewed R23's comprehensive care plan which documents R23 is at risk for impaired skin due to impaired mobility initiated on 10/2/21. On 10/2/21 an intervention documents to offload R23 to reduce direct pressure on bony prominences. Utilize pillows to keep heels floated as R23 will allow. Monitor offloading devices with each encounter to ensure proper positioning. Surveyor notes that R23's care card dated 6/23/22 instructs the certified nursing assistants (CNAs) to offload R23 to reduce direct pressure on bony prominences. Utilize pillows to keep heels floated as R23 will allow. Monitor offloading devices with each encounter to ensure proper positioning. Surveyor notes R23's assessment for predicting pressure ulcer risk dated 5/11/22 documents R23 is at risk. On 6/20/22 at 10:57 AM, Surveyor observed R23 in bed on R23's back with heels directly on the mattress. Surveyor notes that the sign above R23 states to reposition every 2 hours. On 6/20/22 at 12:39 PM, Surveyor observed R23 in bed on R23's back with heels directly on the mattress. Surveyor notes R23 is in the same position as 10:57 AM, on R23's back, in same position as this morning. Bed up in high position. On 6/21/22 at 8:01 AM, Surveyor observed R23 on R23's back, heels not floated off mattress, sleeping. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/21/22 at 11:04 AM, Surveyor observed R23 on R23's back, exact same position as 8:01 AM, heels not floated off of mattress. On 6/21/22 at 1:44 PM, R23 is in bed, leaning over on right side, head off of pillow, on R23's back, heels not floated, same position as the morning. On 6/22/22 at 8:05 AM, R23 is in bed, head of bed elevated, eating breakfast, heels not floated. R23 was dressed. On 6/22/22 at 12:55 PM, R23 is in bed, head of bed elevated, heels are not floated. On 6/22/22 at 1:07 PM, Surveyor spoke to Certified Nursing Assistant (CNA-G) who is familiar with R23. CNA-G stated that R23's preference is not get up and CNA-G confirmed that R23's heels should be floated at all times when in bed. On 6/23/22 at 9:36 AM, Registered Nurse Unit Manager(RN-O) confirmed that R23 does not like to get up and R23's heels should be floated by pillows whenever in bed. 2.) R64 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Hyperlipidemia, Essential Hypertension, Chronic Kidney Disease, Stage 3, and History of Falling. R64 currently has an activated Health Care Power of Attorney (HCPOA). R64's Admission MDS dated [DATE] documents that R64 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R64 requires extensive assistance for bed mobility, dressing, eating, and toileting. R64 requires total assistance for transfers and hygiene. The MDS indicates R64 is at risk for pressure injuries. Surveyor reviewed R64's Care Area Assessment (CAA) dated 5/17/22. R64's CAA documents that R64 was admitted with a deep tissue injury to left heel and coccyx. R64 is at risk for other pressure ulcer development due to impaired mobility and requires assistance with bed mobility. Proceed with care plan with interventions to reduce risks for pressure ulcer development. Surveyor reviewed R64's comprehensive care plan which documents that R64 was admitted to the facility with deep tissue injury on left heel initiated on 5/17/22. On 5/17/22 an intervention to offload heels when in bed was initiated. Surveyor notes the most recent skin note documented in R64's electronic medical record (EMR): 6/13/2022 13:00 Skin only Late Entry: Skin Evaluation: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal. Resident has current skin issues. Skin Issue: Pressure Ulcer / Injury. Skin issue location: Left Heel Pressure Ulcer / Injury Stage: Unstageable. Length: 2.3 Width: 1.8 Depth: 0.1 Wound bed: Necrotic. Wound exudate: None. Peri wound condition: Fragile. Wound odor: No. Tunneling: No. Undermining: No. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note / Notification / Education: Skin note: Weekly assessment completed by Wound Care Team. Unstageable to left heel slightly improved as edges begin to lift/peel away. Braden score is 13. Risk factors are unchanged from previous assessment. Recent weight is 196.4lbs. Intakes are adequate and blood sugars not monitored. Interventions in place and include: every 2 hour turning/repositioning (refuses often), offloading with pillows, heel boots as resident allows (kicks them off), alternating pressure mattress, pressure relieving w/c cushion, pain management, diabetic monitoring, incontinence cares, and weekly skin assessment by nursing. Resident educated on skin condition, interventions, and risks of non-adherence-nodded in understanding, but level of retention unclear. Heel boot to be on left foot at all times except for transfers & standing with therapy- resident kicks off & requires frequent reapplying. WCT (wound care team) will continue to follow. Nursing to notify WCT of any concern or change in skin condition. Surveyor notes R64's assessment for predicting pressure ulcer risk dated 5/4/22 documents R64 is at moderate risk. On 6/20/22 at 9:51 AM, Surveyor observed R64 in bed with heels directly on the mattress. On 6/20/22 at 12:35 PM, Surveyor observed R64 on back in bed and heels directly on mattress. On 6/21/22 at 7:57 AM, Surveyor observed R64 in bed on R64's back with heels directly on mattress. On 6/21/22 at 10:59 AM, Surveyor observed R64 in bed with heels on mattress, and 2 pillows in the bed but not used to offload R64's heels. On 6/21/22 at 1:39 PM, Surveyor observed R64 in bed with head of bed elevated, right heel on the mattress, pillow under R64's left heel with left leg crossed over. On 6/22/22 at 7:56 AM, Surveyor observed R64's heels directly on the mattress, no pillow between the legs. On 6/22/22 at 1:05 PM, CNA-G informed Surveyor that any Resident who can not move or reposition self, heels are supposed to be floated with heels boots or if they do not have those, pillows should be used. On 6/22/22 at 1:18 PM, Surveyor observed R64 up in highback chair with a heel boot on left foot. On 6/23/22 at 9:36 AM, Surveyor spoke to RN-O who confirmed that R64 should have both heels floated whenever in bed. 3.) R74 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Dysphagia, Chronic Viral Hepatitis C, Hemiplegia Affecting Left Dominant Side, Ataxia, and Dementia. R74 currently has a legal guardian. R74's Quarterly Minimum Data Set (MDS) dated [DATE] documents R74's Brief Interview for Mental Status (BIMS) score to be a 9, indicating R74 demonstrates moderately impaired skills for daily decision making. R74's MDS also documents that R74 requires extensive assistance for bed mobility, dressing, toileting, and hygiene. The MDS identifies the resident is at risk for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R74's Care Area Assessment (CAA) dated 5/11/22. R74's CAA documents that R74 is at risk for development of pressure ulcers due to impaired mobility, incontinence. Pressure relieving device to bed and chair. Will proceed to care plan with interventions to reduce risks for development of pressure ulcers. Surveyor reviewed R74's comprehensive care plan which documents that R74 is at risk for further impaired skin integrity due to impaired mobility, dementia, pain, and incontinence initiated on 11/20/21. On 11/22/21, an intervention documents to offload R74 to reduce direct pressure on bony prominences. Utilize pillows to keep heels floated as R74 will allow. Monitor offloading devices with each encounter to ensure proper positioning Surveyor notes that R74's care card dated 6/23/22 instructs the certified nursing assistants (CNAs) to offload R74 to reduce direct pressure on bony prominences. Utilize pillows to keep heels floated as R74 will allow. Monitor offloading devices with each encounter to ensure proper positioning. Surveyor notes R74's assessment for predicting pressure ulcer risk dated 5/11/22 documents R74 is at moderate risk. On 6/20/22 at 11:14 AM, Surveyor observed R74 on R74's back in bed with both heels directly on the mattress. Surveyor observed 2 blue boots in R74's closet. On 6/21/22 at 8:11 AM, Surveyor observed R74 on R74's back in bed with both heels not floated, bed is flat. On 6/22/22 at 8:16 AM, Surveyor observed R74 in bed with head of bed elevated. Right heels is directly on mattress and R74 is on R74's back. On 6/22/22 at 12:58 PM, Surveyor spoke to CNA-G in regards to R74. CNA-G stated that R74 refuses the head of the bed to be elevated at times, CNA-G stated that R74 is supposed to have the blue boots on whenever in bed and also has a blue wedge for under the the right leg. CNA-G and Surveyor both observed at this time that R74 does not have either blue boots on or a blue wedge under the right leg. CNA-G and Surveyor observed both the heels boots and blue wedge up in the closet. On 6/23/22 at 9:34 AM, RN-O informed Surveyor that RN-O is not sure what staff should be using to offload R74's heels. RN-O informed Surveyor that RN-O will need to look into that. RN-O stated that if R74 is refusing the intervention, there should be documentation that R74 is being encouraged and/or refusing the intervention. RN-O confirmed that if R74 is not getting out of bed that R74 should have R74's heels floated at all times. On 6/28/22 at 1:42 PM, Surveyor shared the concern with Administrator(NHA-A) that R23, R64, and R74 who are risk for developing a pressure injury were observed during the survey process to not have their heels floated while in bed. No further information was provided at this time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40533 Based on interview, observation and record review, the facility did not ensure that 5 (R356, R50, R64, R23, and R45) of 10 sampled residents for falls, 1 (R74) of 1 sampled resident for transfers and 4 (R58, R29, R44 and R71) of 4 sampled residents reviewed for smoking were free from accident hazards and provided supervision and assistive devices to prevent avoidable accidents. R356 was admitted to the facility and assessed as a high fall risk. The resident had 11 falls at the facility. The facility did not assess the resident implementing immediate interventions, plan of care interventions or a root cause analysis identifying why the falls were occurring. Some falls were not investigated and there were no fall reports or documentation of the fall. R50 and R64 had no staff statements for unwitnessed falls for the investigations of falls at the facility. The facility did not ensure the call lights were accessible to R23, R50, R64, and R45 despite being a care planned intervention to prevent falls. R74 was observed being transferred by staff without a lift per plan of care and R74's call light was not accessible despite being an intervention to prevent falls. R58, R29, R44 and R71 had no smoking assessments completed and they smoked outside of the facility without supervision. Findings include: Surveyor reviewed facility's Falls - Clinical Protocol policy with a revision date of March 2018. Documented was: Assessment and Recognition 1. The physician will help identify individuals with a history of falls and risk factors for falling. a. Staff will ask the resident and the caregiver or family about a history of falling. b. The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days). c. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause. 2. In addition, the nurse shall assess and document/report the following: a. Vital signs; b. Recent injury, especially fracture or head injury; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in cognition or level of consciousness; e. Neurological status; f. Pain; g. Frequency and number of falls since last physician visit; h. Precipitating factors, details on how fall occurred; i. All current medications, especially those associated with dizziness or lethargy; and j. All active diagnoses. 3. The staff and practitioner will review each resident's risk factors for falling and document in the medical record. a. Examples of risk factors for falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, hypotension, and medical conditions affecting the central nervous system. b. After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur. 4. The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications that cause dizziness or hypotension) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant). a. Falls often have medical causes; they are not just a nursing issue. 5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. 6. Falls should be categorized as: a. Those that occur while trying to rise from a sitting or lying to an upright position; b. Those that occur while upright and attempting to ambulate; and c. Other circumstances such as sliding out of a chair or rolling from a low bed to the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Falls should also be identified as witnessed or unwitnessed events Cause Identification 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. a. Often, multiple factors contribute to a falling problem. 2. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. a. After a fall, the physician should review the resident's gait, balance, and current medications that maybe associated with dizziness or falling. b. Many categories of medications, and especially combinations of medications in several of those categories, increase the risk of falling. 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). Monitoring and Follow-Up 1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. 2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented. 3. If interventions have been successful in fall prevention. the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause. 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. 5. As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes. Surveyor reviewed facility's Falls and Fall Risk, Managing policy with a revision date of March 2018. Documented was: Policy Statement Based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Policy Interpretation and Implementation Definition According to the [Minimum Data Set (MDS)], a fall is defined as: Unintentionally coming to rest on ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost her/his balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred . Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. wet floors; b. poor lighting; c. incorrect bed height or width; d. obstacles in the footpath; e. improperly fitted or maintained wheelchairs; and f. footwear that is unsafe or absent. 2. Resident conditions that may contribute to the risk of falls include: a. fever; b. infection; c. delirium and other cognitive impairment; d. pain; e. lower extremity weakness; f. poor grip strength; g. medication side effects; h. orthostatic hypotension; i. functional impairments; j. visual deficits; and k. incontinence. 3. Medical factors that contribute to the risk of falls include: a. arthritis; b. heart failure; c. anemia; d. neurological disorders; and e. balance and gait disorders; etc. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident-Centered Approaches to Managing Falls and Fall Risks 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. 8. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. 1.) R356 was admitted to the facility 3/17/22 with diagnoses that included Chronic Respiratory with Hypoxia, Muscle Weakness, Abnormalities of Gait and Mobility, Unspecific Lack of Coordination, Cognitive Communication Deficit, Low Back Pain, Diabetes Mellitus 2 (DM II), Tracheostomy Status, Dependence on Supplemental Oxygen, Major Depressive Disorder, Encephalopathy, Spinal Stenosis and Anxiety Disorder. Surveyor reviewed R356's Comprehensive Care Plan with an initiation date of 3/18/20. Documented was: Focus: [R356] is at high risk for falls [related to (r/t)] confusion, gait/balance problems, incontinence, weakness, and history of falls. Goal: [R356] will not sustain serious injury from a fall through the review date. Interventions: o 3/18/22--fall mat to right side of bed. o Anticipate and meet [R356's] needs. o Follow therapy recommendations for transfers and mobility. o Review information on past falls and attempt to determine cause of falls. o Be sure [R356's] call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. o Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. o Follow facility fall protocol. o [R356] needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light; the bed in low position; side rails as ordered; personal items within reach. o [Physical Therapy/Occupational Therapy (PT/OT)] evaluate and treat as ordered or PRN (as needed). o Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/[interdisciplinary team (IDT)] as to causes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R356's Comprehensive Care Plan with revision dates of 3/31/22, 4/15/22, 4/16/22, 6/16/22 and 6/21/22. Documented was: .Interventions: o 4/16/22--keep bed in lowest position. Date Initiated: 04/16/2022 o 4/16/22--mattress placed to right side of bed; Fall mat discontinued; Resident with room move 6/17/22 mattress now on left side of bed, right side of bed against wall Date Initiated: 04/16/2022 o 6/16/22 - therapy evaluation for positioning. Date Initiated: 06/16/2022 o RESOLVED: Foam wedges provided for positioning. Date Initiated: 03/31/2022 Resolved Date: 06/21/2022 o Resident chooses to place self on mattress next to bed and stay there to rest, sleep and at time eat meals Date Initiated: 06/21/2022 o Room management--room rearranged to reduce stimulation. Date Initiated: 04/15/2022 o Scoop mattress and foam wedges provided to help with positioning in center of bed due to poor trunk control. (Resolved and resident upgraded to air mattress with bolsters 3/31/22) Date Initiated: 04/15/2022 Revision on: 06/21/2022 o Scoop mattress in place to help keep resident in center of bed. (Resolved and resident upgraded to air mattress with bolsters 3/31/22) Date Initiated: 04/15/2022 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revision on: 06/21/2022 Surveyor reviewed R356's admission MDS (Minimum Data Set) with an assessment reference date of 3/23/22. Documented under Cognition was a BIMS (brief interview mental status) score of 12 which indicated moderately impaired. Documented under Functional Status for Bed Mobility was 3/2 which indicated Extensive assistance - resident involved in activity, staff provided weight-bearing support; One person physical assist. Documented under Transfer Status 7/3 which indicated Activity occurred only once or twice - activity did occur only once or twice; Two+ (two plus) persons physical assist. Documented under Walk in Room and Walk in Corridor was 8/8 which indicated Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period; ADL (activity of daily living) activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period. Surveyor reviewed R356's Care Area Assessment (CAA) for falls with an assessment reference date of 3/23/22. Documented under Nature of the Problem/Condition was At risk for falls due to weakness and dementia. He is unable to comprehend safety issues at times due to cognitive loss. Unable to ambulate. He is currently Hoyer lift (sic). He has history of falls prior to hospitalization and had one fall since admission with laceration to face. Staff to monitor resident frequently and assist resident as needed with personal items, ADLs. He is receiving therapy for strengthening and rehabilitation. Will proceed to care plan . Surveyor reviewed R356's Progress Notes. Documented on 3/18/22 at 12:54 AM was Patient is new admit day 2, patient is with increased confusion, stating that he needs to go to the hospital and requesting staff to call the police because he states he left the bar a few hours ago and while he was there someone spiked his drink. Called to the patients room by [Respiratory Therapist (RT)], patient on the floor laying aside the bed, bed in low position, call light attached to patients gown, patient states he fell out of the bed to get someone's attention, patient complaint of hitting his head at time of fall, states his neck hurts, there is a laceration to the right head and left lower leg, [NP] updated and to send patient to (name of hospital) for eval and treat, left message for patients wife to call for an update, (name of) ambulance was called and on their way for pick up. Surveyor reviewed Unwitnessed Fall Report for fall on 3/18/22. R356 had a fall in his room. Documented under Incident Description was Nursing Description: Patient with increased confusion, stating he needs to go to the hospital and that when he was at the bar a few hours ago someone spiked his drink, patient states I fell on the floor because I was trying to get someone's attention, patient states he hit his head on the floor and that his neck hurts He has a laceration near right eyebrow and a cut on left lower leg. Immediate Action Taken: Patient on the floor, [NP] on call, called and updated, to send to (name of hospital) for eval and treat in ER, left message for wife to call for update, ambulance has been notified for pick up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed Progress Notes for R356. Documented on 3/31/22 at 12:41 PM was IDT unwitnessed fall- Resident found lying on floor next to bed. Resident states he threw self out of bed to get someone's attention. Bed in lowest position, call light attached to gown. Resident states he hit his head with complaints of pain. Laceration to right forehead noted and to left lower leg. NP updated. Attempted to update POA (Power of attorney) wife, did not answer phone. [vital signs stable], neuro check negative. New order received to send resident out to [hospital] for evaluation. Resident returned and all scans were negative. Resident with history of resp (respiratory) failure with hypoxia, copd (chronic obstuctive pulmonary disease), muscle weakness, abnormality of gait and mobility, lack of coordination, cognitive communication deficit, diabetic, chronic pain syndrome, spondylosis, anti-coagulant use, MDD (major depressive disorder), anxiety, encephalopathy, dysarthria, restless leg syndrome, a fib (atrial fibrilation). Resident on oxybutynin, diltiazem, gabapentin, atorvastatin, apixaban, oxycodone, donepezil, metformin, lorazepam, lidocaine patch. Resident with little to no safety awareness. Resident with extensive behaviors. Intervention to include fall matt (sic) on right side of resident bed. IDT did not identify the cause of the fall and the meeting was not completed timely. There was no Root Cause Analysis completed for the fall on 3/18/22. Surveyor reviewed Unwitnessed Fall Report for fall on 3/26/22 at 12:38 AM. R356 had a fall in his room. Documented under Incident Description was Nursing Description: Called into patients' room by [Certified Nursing Assistant], patient found on floor on side of bed face first. Resident Description: Patient states he was trying to get everyone's attention so he put himself on the floor, call light was on, staff were in the room minutes prior changing him and upon fall he was dry. Immediate Action Taken: Assessed patient for injury, no injury seen, VSS (vital signs stable), denies pain or discomfort. Patient was removed from the floor via the Hoyer and two other staff members, NP updated and attempted to notify the patients wife but no answer. Surveyor reviewed Progress Notes for R356. Documented on 3/26/22 at 2:49 PM was [Registered Nurse (RN)] stated she found resident partially out of bed with right shoulder on the ground. Resident c/o of shoulder pain from fall [on night shift (NOC)], and is demanding to go to the emergency room . Writer spoke with on call NP, NP agrees to send resident the ER. In addition, resident stated he does not want to live anymore and has been refusing to eat, refusing RT (respiratory therapy) treatment, and refusing to take his medication. Writer requested a psych evaluation while resident is in hospital if possible. Wife was notified and is agreeable. (Name of Ambulance) arrived to take resident, resident left with no resistance. There was no fall investigation or report for this fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed Progress Notes for R356. Documented on 4/12/22 at 8:42 AM for R356 was IDT unwitnessed fall x 2 on 3/26/22 - First fall at 0032, resident found lying on floor on stomach. Resident states he was trying to get everyone's attention and threw self on floor. Staff had completed cares on resident minutes prior. Resident's call light was on. Neuro checks negative, VSS. NP updated. No new orders. Attempted to update POA, who did not answer. No injury noted. Resident states he did not hit head. Second fall at 0250, resident found partially out of bed with right shoulder on ground. Resident reported shoulder pain and was demanding to go to ED. NP notified, and orders received to send to ED. POA, (name of) notified and in agreement with plan. Resident stating he did not want to live anymore, refusing to eat, refusing RT treatments, and medications. Resident transported to [hospital]. Resident with significant medical history of chronic respiratory failure, COPD, muscle weakness, abnormalities of gait and mobility, lack of coordination, vascular Dementia, anxiety disorder, insomnia, depression, and encephalopathy. Medications in use that may effect fall risk include: Seroquel, Lorazepam, Apixaban, Gabapentin, and Diltiazem. Root cause determined to be resident with no safety awareness, decreased mobility. Resident sent out for evaluation with request for psych. evaluation r/t behaviors. IDT did not identify the cause of the fall and the meeting was not completed timely. There was no immediate action put in place for first fall on 3/26/22 to prevent further falls. There was no Root Cause Analysis completed for either fall on 3/26/22. Surveyor reviewed Progress Notes for R356. Documented on 3/31/22 7:35 PM was writer called to room- resident laying on floor mat next to bed, fully dressed with gripper socks. bed in low position. resident yelling send me to hospital . I threw myself out of bed and hurt my right arm and shoulder. resident thrashing up and down from ground. CNA (certified nursing assistant) monitoring resident until EMS (emergency medical services) arrives. VSS, [NP] and [wife] updated . Surveyor reviewed Unwitnessed Fall Report for fall on 3/31/22. R356 had a fall in his room. Documented under Incident Description was Nursing Description: Resident found at side of bed on fall mat, fully dressed with gripper socks in place. Bed in low position. Resident Description: Resident reporting that he threw himself out of bed and was having pain to his right shoulder and arm. Immediate Action Taken: Resident assessed. NP and POA notified. Resident sent out for evaluation. Surveyor reviewed Progress Notes for R356. Documented on 4/12/22 at 9:19 AM for R356 was IDT (interdisciplinary team) unwitnessed fall on 3/31/22 at 1935. Resident found laying on floor mat next to bed. Fully dressed with gripper socks. Bed in low position. Resident states he threw self on floor and was having 10/10 pain to right shoulder and arm. Neuro checks negative, VSS. NP updated. Order received to send resident to hospital for evaluation. POA updated and in agreement with plan. No obvious injury noted. Resident with significant medical history of chronic respiratory failure, COPD, muscle weakness, abnormalities of gait and mobility, lack of coordination, vascular Dementia, anxiety disorder, insomnia, depression, and encephalopathy. Medications in use that may effect fall risk include: Seroquel, Lorazepam, Apixaban, Gabapentin, and Diltiazem. Root cause determined to be resident with no safety awareness, decreased mobility, and behaviors r/t vascular Dementia. Interventions in place remain appropriate for protecting resident from serious injury. IDT did not identify the cause of the fall and the meeting was not completed timely. There was no immediate action put in place for the fall on 3/31/22 to prevent further falls. There was no update to the care plan with added interventions to prevent further falls for either fall. There was no Root Cause Analysis completed for the fall on 3/31/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed Progress Notes for R356. Documented on 4/1/22 at 7:05 AM for R356 was Writer called to the room by the aides because [R356] was on the floor. Writer assessed [R356] and he complained of left hip pain and left thigh pain and stated, send me to the emergency room . Writer contacted (name of ambulance) for transport . There was no fall report or investigation for the fall on 4/1/22. There was no other documentation of this fall. IDT did not identify the cause of the fall and the meeting was not completed timely. There was no immediate action put in place for the fall on 4/1/22 to prevent further falls. There was no update to the care plan with added interventions to prevent further falls. There was no Root Cause Analysis completed for the fall on 4/1/22. Surveyor reviewed Progress Notes for R356. Documented on 4/16/22 at 1:29 PM was pt (patient) sent to hospital for unwitnessed fall. Pt was found on floor denied hitting head but said had shoulder and neck pain. Pt vitals were taken B/P165/116 pulse 59 oxygen 95 resp 20. Surveyor reviewed Unwitnessed Fall Report for fall on 4/16/22. R356 had a fall in his room. Documented under Incident Description was Nursing Description: Patient found laying on the floor next to bed with no clothes or gown on. Patient agitated and yelling out all morning, even after all needs met by staff. Resident Description: trying to go home by my wife. Immediate Action Taken: [blank]. Surveyor reviewed Progress Notes for R356. Documented on 4/19/22 at 11:22 AM was IDT unwitnessed fall 4/16/22- Resident screaming out and yelling throughout morning shift. Resident with all cares provided by staff multiple times throughout shift with frequent rounds conducted. Redirection provided and unsuccessful. Found laying next to bed on mat on floor. No injury noted, but resident stating he hurt his neck and wants to be sent out to the hospital. Multiple interventions in place including low bed, mat next to bed, room management, scoop mattress, foam wedges. VSS. Resident stating he is trying to go home to tell his wife where he is. Resident sent to [hospital] for evaluation and psych review. Returned with all scans negative, no psych review and no new orders. [NP] updated, voicemail left for wife, but wife does not often answer phone or call facility back. Resident with a history of resp failure, COPD, muscle weakness, abnormal gait, lack of coordination, DM II, encephalopathy, depression, anxiety, spinal stenosis, RLS (restless leg syndrome). Resident on valproic acid, gabapentin, donepezil, oxy, apixaban, diltiazem, metformin, Namenda. Resident with excessive behaviors, no safety awareness and extreme impulsiveness. Intervention to include low bed for patient safety. Discussion all held with wife regarding dementia unit that is appropriate for resident needs. IDT did not identify the cause of the fall. There was no immediate action put in place for the fall on 4/16/22 to prevent further falls. There was no Root Cause Analysis completed for the fall on 4/16/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed Progress Notes for R356. R356 had a second fall on 4/16/22. Documented on 4/16/22 at 6:29 PM was Called to patients room by his nurse, patient on the floor, patient states that he put himself on the floor because he was trying to get some attention, VSS, patients wife updated and message left for case worker, call out to oak medical to update them, no injury noted, patient has been hoyered back to bed, reminders to use call light for assistance, bed in low position and mat at side of bed. Documented on 4/16/22 was 6:33 PM was Writer called to resident room regarding resident being on floor in room. Per CNA report, resident had legs flung out of bed and resident was yelling out demanding to go to the hospital. 2 CNAs went to resident room to put resident legs back in bed. Resident continent at time of fall with bed against wall and mat next to bed. Once placed in bed resident states to CNAs I'm just gonna keep throwing myself on the floor for attention. I want to get out of here. Where is my wife. Resident assessed by RN supervisor. Resident placed back in bed with the assist of 5 staff members. Writer to leave message for wife, the POA who does not answer her phone or call facility back. Message left for RN case manager as well. NP updated and no new orders. Vitals stable, no injury noted, neuro checks negative. Resident continues with consistent psych behaviors, throwing self out of bed, making comments about going to the bar or being in a fight after leaving the bar, etc. Surveyor reviewed Unwitnessed Fall Report for second fall on 4/16/22. R356 had a fall in his room. Documented under Incident Description was Nursing Description: Patient found on floor by patients nurse in his room. This occurred at 1800. Resident Description: Patient states I threw myself on the floor because I was trying to get someone's attention. Immediate Action Taken: Patient was assessed, no injuries noted, denies pain or discomfort. VSS, Hoyer used to put patient back into bed. Surveyor reviewed Progress Notes for R356. Documented on 4/19/22 was 11:48 AM was IDT unwitnessed fall 4/16/22 1710pm- Resident last seen two minutes prior to fall as resident had flung legs over bed and two CNAs on first floor went to resident room to reposition patient and place legs back in bed. Writer was present at time of resident behaviors and incident. Both CNAs then proceeded to walk down to the nurses station to go back to their assignments and resident threw himself out of bed onto floor. Resident states I threw myself out of bed to get someone's attention. Residents bed was in lowest position, continent at time of fall, mat next to bed, bed placed against wall, all belongings within reach, no injury noted, no reports of pain from patient. Resident hoyered back to bed with six staff members and a mattress replaced the mat next to the bed. Bed was left in lowest position, mattress next to bed and left without gown on per patient request. NP updated and wife called regarding resident fall and behaviors. Resident with a history of resp failure, COPD, muscle weakness, abnormal gait, lack of coordination, DM II, encephalopathy, depression, anxiety, spinal stenosis, RLS. Resident on valproic acid, gabapentin, donepe[TRUNCAT

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on interview and record review, the facility did not provide appropriate treatment and services to allow a resident to attain or maintain his or her highest practicable physical, mental and psychosocial well-being for 1 (R356) of 1 resident reviewed who has a diagnosis of dementia. The facility did not put effective interventions in place for the suspected root cause of R356's increased behaviors. When R356 had increased anxiety and delirium resulting in multiple falls, including one with physical injury on admission, the resident was not assessed, provided appropriate interventions and only sent to the hospital. Staff were unaware of interventions to help address R356's increased behaviors. The resident was not assessed by Psychiatric Services in an appropriate manner and resident specific interventions were not put in place. Staff were unaware of how to address R356's behaviors. MDS assessments were not completed to reflect behaviors or dementia with behaviors. Psych medications were not put in place appropriately and were not discontinued when ordered to. After supposedly being discontinued, these medications were used and deemed effective but no assessment of the resident or medication usage was completed. Resident continued to have increased behaviors on an almost daily basis that were not addressed resulting in psychosocial harm. The resident made comments of self-harm that were not addressed by the facility and not monitored or reported to psych services. Findings include: Facility policy and procedure entitled: Behavioral Health Services, with a revision date of February 2019, documents: Policy Statement The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Policy Interpretation and Implementation 1. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care. 2. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care. 3. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder(s) will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	4. Staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress. 5. Staff training regarding behavioral health services includes, but is not limited to: a. Recognizing changes in behavior that indicate psychological distress; b. Implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs; c. Monitoring care plan interventions and reporting changes in condition; and d. Protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma and post-traumatic stress disorder. 6. Behavioral health services are provided by staff who are qualified and competent in behavioral health and trauma-informed care. 7. Staff are scheduled in sufficient numbers to manage resident needs throughout the day, evening and night. Facility policy entitled: Behavior Assessment and Management, with an effective date of 6/25/17, documents: It is important to understand causes of behavior problems in our residents. Examples of behavior problems can include a depressed resident withdrawing from other people, an agitated resident shouting repeatedly, and agitated resident hitting someone, or a confused resident wandering from his or her unit. Behavioral health encompasses a residents whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance abuse. Causes of these behaviors can be internal or external factors that combine to make a behavior happen or keep happening. Some internal factors could be emotion (despair, anxiety, fear), mediation, illness, confusion and pain. Some external factors could be lack of meaningful activity, unpleasant events, unpleasant actions of others, demands of others, light too bright or too dim, too much noise and being misunderstood by others. REMEMBER every problem behavior is likely to have both internal and external causes. Alzheimer's disease and related dementia's as well as mental illness diagnosis can cause a person to act in different and unpredictable ways. Some become anxious or aggressive. Others repeat certain questions or gestures. Many misinterpret what they hear. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and lives of those with whom the resident interacts. Once behaviors have been assessed, the next step is to develop a resident-specific care plan based directly on the conclusion/underlying cause. If behaviors place the resident or others at risk for harm, immediate action is required to prevent any harm. The focus of the care plan should be to address the underlying cause or causes, reversing the daily display of troubling behaviors, and preventing any harm from occurring. How do I handle different behaviors? Working in a long term care facility with many different personalities, disease processes and age differential can be challenging. There is a myriad of responses staff members can take when dealing with a resident exhibiting behaviors. What works one time may not work the next time. The goal is to identify what is causing behaviors and address that cause. Aggressive behavior: This can be verbal (shouting, name calling), or physical (hitting, kicking). May occur suddenly with no apparent reason or can result from a frustrating situation. How to respond: - Identify the immediate cause-what happened right before the event that may have triggered this behavior - Rule out pain - Focus on feelings-look for feelings behind the words or actions other than just details of event - Don't get upset - Try a relaxing activity or shift the focus to another activity- music, massage or activity may have unintentionally cause the event. If so try something different. Anxiety/Agitation A resident may become restless and need to move around or pace. Or, the resident may become upset in certain places and focused on specific details. How to respond: - Listen to the frustration - Provide reassurance-use calming phrases. Maintain your composure. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	- Involve the person in activities-art, music or whatever their specific interests are. - Modify the environment-decrease noise/distractions, or relocate to different area. - Find outlets for energy-resident may be looking for something to do. Go for a walk. Confusion Resident may not recognize familiar people, places or things. May call family members by other names or confused about where home is. Common items such as a pen or fork may also be forgotten. How to respond: - Stay calm- Not being recognized may be painful or frustrating. Try not to make this apparent. - Respond with brief explanation-Lengthy statements can overwhelm the resident. - Show photos and other reminders - Don't contradict the resident-avoid explanations that sound like scolding. Try I thought that was a fork vs. You know that is a fork and you use it to eat. - Try not to take it personally Repetition A resident may say or do something over and over again. (repeating words, say same phrase, ask same question) May pace or undo what was just done. These actions are rarely harmful to resident but rather stressful for the caregiver. How to respond: - Look for reason behind the repetition - Focus on emotion, not the behavior-do not react to what the resident is doing, respond to how their feeling - Turn action or behavior into an activity-if resident is rubbing his or her hand across a table, provide a cloth and ask for help dusting. - Stay calm and be patient - Provide an answer-give the resident an answer even if you have to repeat it several times. - Use memory aids-like notes, clocks, calendars or photographs - Accept the behavior and work with it-if it isn't harmful, don't worry about it. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Suspicion Residents may become suspicious of those around them, accusing others of theft, infidelity or other improper behavior. Misinterpretation of what he or she sees and hears may occur. How to respond: -Don't take offense - Don't argue or try to convince-acknowledge residents opinion - Offer a simple answer-don't overwhelm with lengthy explanation - Switch the focus to another activity-ask for help with a chore, ask what resident did for a living, etc. - Duplicate any lost items-if resident searches for a specific item, have several available. For example, if the resident is always looking for wallet, purchase a few of the same kind. 10 Quick Tips for Responding to Behaviors 1. Remain flexible, patient and calm 2. Explore pain as a trigger 3. Respond to the emotion, not the behavior 4. Don't argue or try to convince 5. Try to identify the unmet need. 6. Acknowledge requests, and respond to them 7. Look for reasons behind each behavior 8. Consult a physician to identify any causes related to medications or illness 9. Don't take the behavior personally 10. Share your experiences with others. R356 was admitted to the facility with diagnoses that included Chronic Respiratory Failure with Hypoxia, Diabetes Mellitus 2, Tracheostomy Status, Dependence on Supplemental Oxygen, Major Depressive Disorder, Encephalopathy, and Anxiety Disorder. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R356's Progress Notes. Documented on 3/17/22, at 7:30 PM, was Resident admitted from [hospital name]. Upon arrival, [spouse/wife/Power of Attorney (POA)], present with resident. Resident pleasant and cooperative. Approximately 10 minutes after spouse left facility, resident became agitated, and began to complain of 15/10 pain. Resident demanding to be sent to the hospital, refusing to accept pain medication offered by staff. Resident has diagnosis of vascular dementia, and was unable to recall being in the hospital, transferring to facility, etc. Resident began to perseverate that his wife was cheating on him with a younger man. Writer called [POA] who wanted resident to remain at the facility. [POA] tried to talk to resident on the phone about staying, but resident continued to talk about relationship issues. Writer updated [Nurse Practitioner (NP)] to confirm admission orders and notified on call NP of resident's current mental state. Writer and [Registered Dietician (RD)] remained in room with resident and talked with resident, offering reassurance and building report (sic). Resident became much calmer, but remained very confused. Writer was able to get resident to openly accept and take Tylenol for pain, which resident had not mentioned again since initial conversation. [Executive Director (NHA)-A], updated on resident situation, and also came to talk with resident. Resident agreeable at this time to staying the night at the facility, but will require frequent monitoring and reassurance/redirection due to confusion. Bed in low position with wheels locked. Door open for staff to visualize resident. Personal items, water, call light, urinal, and remote within reach. Resident clean, dry, and appears comfortable with alternating pressure/[low air loss (LAL)] mattress in place and functioning appropriately. Writer assisted resident with using urinal prior to leaving room. Surveyor noted that staff identified spouse leaving as a trigger for anxiety and increased behaviors. Documented on 3/18/22, at 12:54 AM, was Patient is new admit day 2, patient is with increased confusion, stating that he needs to go to the hospital and requesting staff to call the police because he states he left the bar a few hours ago and while he was there someone spiked his drink. Called to the patients room by [Respiratory Therapist (RT)], patient on the floor laying aside the bed, bed in low position, call light attached to patients gown, patient states he fell out of the bed to get someone's attention, patient complaint of hitting his head at time of fall, states his neck hurts, there is a laceration to the right head and left lower leg, [NP] updated and to send patient to [name of hospital] for eval and treat, left message for patients wife to call for an update, [name of ambulance company] ambulance was called and on their way for pick up. The resident was sent to the hospital and returned. R356 suffered a head and leg laceration. R356's medical record documented on 3/18/22, at 1:13 PM, was Writer spoke with [POA] this morning to obtain a verbal consent for resident to be seen by [psych services] - [POA] gave verbal consent to writer over the phone. Surveyor reviewed R356's Referral for Psychiatric Services form. Documented under Reason for Referral was Depression. Surveyor reviewed R356's Comprehensive Care Plan with an initiation date of 3/18/20. Documented was: Focus: [R356] has a behavior problem (agitation, impulsiveness, paranoia) related to (r/t) vascular dementia. Refuses to take medications, respiratory treatments and to eat at times. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Goal: [R356] will have fewer episodes of behaviors by review date. Interventions: - Administer medications as ordered. Monitor/document for side effects and effectiveness. - Anticipate and meet [R356's] needs. - Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him when passing by. - Explain all procedures to the resident before starting and allow the resident time to adjust to changes. - Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention such as talking about family . (daughters) or work history. - Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. - Provide a program of activities that is of interest and accommodates resident's status . Focus: [R356] has impaired cognitive function and impaired thought processes r/t vascular dementia. Goal: - [R356] will maintain current level of cognitive function through the review date. Interventions: - Administer medications as ordered. Monitor/document for side effects and effectiveness. - Allow/encourage resident to verbalize feelings and fears. - Approach resident in a calm, friendly, non-rushed manner. - Assist resident per ADL (Activities of Daily Living) care plan. - Communicate with the resident/family/caregivers regarding residents capabilities and needs. - Cue, reorient, and supervise as needed. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	- Focus on resident's strengths. - Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. - Let resident make as many daily decisions as possible. - Monitor with routine MDS interviews and [as needed (PRN)]. - Prefers to be called: [R356's name] - Provide a program of activities that accommodates the resident's abilities. - Psych. referral as needed. Surveyor noted spouse not present was not documented as a trigger for anxiety and increased behaviors in R356's care plan. The care plan was not updated to address the potential behavior trigger or to provide interventions to address resident specific behaviors during R356's stay at the facility. R356's medical record documented on 3/18/22, at 2:56 PM,: 0715 (7:15 AM): Writer received call from wife, wife wanted writer to take away resident's cell phone and room phone so he is unable to call her. Wife state he was constantly calling her throughout the night and she would like some rest. Writer warned wife, we are unable to comply with request at this time. Wife verbalized understanding. R356's medical record documented on 3/18/22, at 0820 (8:20 AM): Resident began whistling and yelling for help. Writer entered residence room to address concern. Resident wanted urinal to void. Writer handed resident urinal and reminded him to use call light instead of yelling and whistling for staff. Resident agreed. R356's medical record documented on 3/18/22, at 0900 (9:00 AM): Resident refused morning medication and stated writer was holding him against his will. R356's medical record documented on 3/18/22, at 1245 (12:45 PM): Resident began whistling and yelling for help once more demanding for staff to call wife, he refused his noon medication once again accusing writer of holding him against his will. Writer attempted to call wife however, call went straight to voicemail. Resident proceeded to ask writer to call daughter. Daughter answered phone and writer witness resident demanding daughter to call the District Attorney . R356's medical record documented on 3/18/22, at 3:27 PM, Writer visited resident this afternoon to complete assessment- resident appeared very flustered, he kept referring to his wife with all questions writer asked- resident had writer call his wife but the phone went straight to voicemail, resident proceeded to leave a message for about 5 minutes, when writer asked if he wanted the phone hung up, resident stated no and continued talking into the phone accusing his wife of abandoning him-[Former Psych (NP)-SS] is visiting resident now. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed Psych NP-SS visit note from 3/18/22. Documented was .Pt (Patient) is seen today because of increased agitation, repeat phone calls to wife, paranoia about wife cheating on him, accusatory of staff. Staff reports that he has been inconsolable, he has refused cares from staff despite soiled clothing. He has refused medications, some of which are analgesics. Agitation may be associated with pain as well. The pt state he has never had mania, never had mental health hospitalization . He states he used to work with [name of company] as a distribution manager and traveled widely, that could have all the beer he wanted, He states his brother is a doctor and accurately states where the clinic was, who set it up, and who the partner is. He states he did not disagree to take pills, and states he will take his pills right now. Nurse was able to administer medications to him. As pt is highly agitated and unable to achieve good rest, with ramping up of anxiety, we will trial lorazepam 0.5mg three times daily (tid) x (for) 4 days scheduled. Next week we will have it as as needed (PRN) every (q) 8 hours, and at the same time, help to acclimatize him to new environment. Surveyor noted there were no non-pharmacological interventions added to R356's care plan at this time. R356's medical record documented on 3/20/22, at 12:59 PM, Writer called in to the room by primary nurse stating the resident is highly anxious requesting to leave against medical advice (AMA) due to his wife cheating on him and taking all his money. On arrival to resident's room resident is A/O x4 (alert and orientated to person, place, time and event). Requesting to be transferred to [name of hospital] hospital because he don't feel good. Resident state his arm is not well and want to go to the hospital. Resident noted to be moving right arm during conversation, but lacks fine motor skills. Per wife since his fall 3 months ago and has requires feeding since the fall 3 months ago. Wife has been feeding resident d/t (due to) inability to coordinate . Surveyor reviewed R356's admission MDS (Minimum Data Set) with an assessment reference date of 3/23/22, which documents: a BIMS (brief interview mental status) score of 12, indicating moderate cognitive impairment. Documented under Delirium, Acute onset mental status change: Is there evidence of an acute change in mental status from the resident's baseline? No. Inattention - Did the resident have difficulty focusing attention, for example, being easily distractable or having difficulty keeping track of what was being said? Behavior present, fluctuates (comes and goes, changes in severity). Documented under Behavior was Potential Indicators of Psychosis: None of the Above . Overall Presence of Behavioral Symptoms: No . Behaviors not exhibited . Surveyor reviewed R356's Care Area Assessments (CAA) with an assessment reference date of 3/23/22. There was no assessment for Delirium, Mood State or Behavioral Symptoms documented. R356's medical record documents on 3/23/22, at 11:14 AM, Resident currently being monitored for behaviors. Resident having some difficulty adjusting to facility. Resident continues to yell out asking help from staff. Needs are met by staff. Resident continue to express want to go home to be with family. Resident redirected several times throughout the day explaining the reason for stay. Surveyor reviewed Psych NP-SS visit note from 3/25/22. Documented was Psych NP f/u (follow up) CC: Paranoia, anxiety, disruptive behaviors (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Patient seen in room laying down in bed. Patient states his mood is pretty good. Patient denies feeling down, depressed or hopeless. Patient denies feeling anxious but reports he is wondering when he can go home. Patient states he is sleeping and eating well. Staff reports hypersexual verbal comments. Patient states he doesn't remember making any sexual comments but that he may have said it in his sleep. Spoke at length with [wife], pt started showing signs of forgetfulness about 2 years ago, but more evident of late now accusing her of extramarital affairs, now being more paranoid. Pt is in room, as well, he is eating a home cooked meal. He needs to be fed as he has pain to his extremities associated with C-spine O/A (open area), and stenosis. [Wife] stated that it seems lorazepam 0.5mg TID prn has calmed him down so he does not call her constantly or feeling increased paranoia about her . Surveyor noted no non-pharmacological interventions were added to R356's care plan and the behavior of making hypersexual verbal comments was not added to the care plan or addressed by the facility. Surveyor reviewed facility Unwitnessed Fall Report, dated 3/26/22 at 12:38 AM, which documents: [R356] had a fall in his room. Documented under Incident Description was Nursing Description: Called into patients' room by [Certified Nursing Assistant's name], patient found on floor on side of bed face first. Resident Description: Patient states he was trying to get everyone's attention so he put himself on the floor, call light was on, staff were in the room minutes prior changing him and upon fall he was dry. Immediate Action Taken: Assessed patient for injury, no injury seen, VSS (Vital Signs Stable), denies pain or discomfort. Patient was removed from the floor via the Hoyer and two other staff members, NP updated and attempted to notify the patients wife but no answer. R356's medical record documented on 3/26/22, 2:47 PM, Pt (Patient) stated wanted to die pt was transported to hospital reported shoulder was in pain. R356's medical record documented on 3/26/22, at 2:49 PM, RN (Registered Nurse) stated she found resident partially out of bed with right shoulder on the ground. Resident c/o (complained of) shoulder pain from fall on NOC (night shift) and is demanding to go to the emergency room . Writer spoke with on call NP, NP agrees to send resident the ER (emergency room). In addition, resident stated he does not want to live anymore and has been refusing to eat, refusing RT (Respiratory Therapy) treatment, and refusing to take his medication. Writer requested a psych evaluation while resident is in hospital if possible. Wife was notified and is agreeable. [Name of ambulance company] ambulance arrive to take resident, resident left with no resistance. [R356' a name] was transported to the hospital on 3/26/22 around 3:00 PM. Surveyor reviewed Hospital Paperwork from 3/26/22 ER visit. There was no documentation of a psych evaluation occurring in the hospital. There was no documentation R356 was assessed for suicidal thoughts. Paperwork documented resident was sent to ER for Fall (uncertain cause), contusion (upper extremity) and back contusion. R356's medical record documented on 3/26/22, at 11:01 PM, Resident returned from [ER] for evaluation for fall, nno (no new orders) remains alert responsive no injury noted rom (range of motion) wnl (within normal limits) denies pain at this time. Will continue to monitor. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted upon R356's return to the facility from the ER, there was no monitoring, assessments or interventions put in place to address R356 stating he does not want to live anymore. Surveyor reviewed Electronic Medical Record (EMR). There was no monitoring, documentation or assessments of R356's mood and behavior upon readmission. The next documentation in the EMR was completed 3/27/22, at 6:05 PM, by the Activities Director (AD)-ZZ which documented Resident was visited and appeared to be less anxious prior to his going to the hospital. Resident stated he did not need anything at this time and was watching TV. Staff will continue to visit for socialization. R356's medical record documents on 3/29/22, at 7:00 PM, resident refused dinner. yelling at CNA stating I'm having chest pain send me out nurse assessed resident, VSS and writer made aware of situation. lungs coarse, RR (Respiratory Rate) WNL, resident on trach collar 6 liters, 02 (oxygen level) in 90s. NP to be called. Resident was sent to the hospital and admitted [DATE] through 3/31/22. R356's medical record documented on 3/31/22, at 6:15 PM, EMS (Emergency Medical Services) returned to facility to drop off hospital paperwork. Resident was discharged from hospital due to noncompliance per DC (Discharge) summary. NP aware. Surveyor noted R356's care plan was not updated to reflect the noncompliance nor new interventions put into place to address R356's noncompliance. R356's medical record documented on 3/31/22, at 7:35 PM, writer called to room-resident laying on floor mat next to bed, fully dressed with gripper socks. bed in low position. resident yelling send me to hospital . I threw myself out of bed and hurt my right arm and shoulder. resident thrashing up and down from ground. CNA monitoring resident until EMS arrives. VSS, NP and wife updated . R356's medical record documented on 4/1/22, at 3:29 PM, Patient returned back to facility via ambulance on a stretcher at 0247 (2:47 AM) to room [room number], pt has been oriented to his room, bed and call light controls, pt went out because of right shoulder and arm pain and returned with negative x-ray results no fx (fracture). Patient is alert x 1-2, he knows that he is in a medical setting but then said not sure where, when asked where he is coming from he said I was at the bar having a drink with my guy . Surveyor noted there were no interventions added to R356's care plan to address his delusions and no behavior monitoring put into place assess R356's delusional behaviors. R356's medical record documented on 4/1/22, at 7:05 AM, Writer called to the room by the aides because [name of resident] was on the floor. Writer assessed [name of resident] and he complained of left hip pain and left thigh pain and stated, send me to the emergency room . Writer contacted [name of transport company] for transport . At 8:46 AM a Physician Progress Note was written stating Staff reports pt, has delusions he could walk, when he attempts he falls; he also has deliberately thrown himself on the ground. For the pt's safety, we will trial Seroquel 25mg bid (twice a day) for a brief trial. Surveyor noted R356 was sent to the hospital and admitted from 4/1/22 through 4/15/22. The Seroquel was not started and R356 was discharged back to the facility with orders for Depakote Sprinkles. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed MD orders starting 4/15/22 from the hospital that documented Depakote Sprinkles, Take 1 capsule (125 mg) by mouth every 6 hours as needed for agitation. Aricept, Take 0.5 tablets (5 mg total) by mouth nightly for dementia. Namenda, Take 1 tablet (5 mg total) by mouth nightly for dementia. Surveyor reviewed April 2022 Medication Administration Record (MAR) and noted only 2 doses of Aricept and 2 doses of Namenda were given between 4/15/22 and 4/30/22. Only 1 dose of Depakote as needed was given for agitation on 4/18/22 and the effectiveness was documented as unknown. R356's medial record documented on 4/16/22, 1:10 AM, F/u readmit. Resident alert to name with confusion at time. Calling out for help me. wanting to get up to go home, wanting police to be call so they can take him to the hospital . R356's medical record documented on 4/16/22, at 12:23 PM, Resident noted to be screaming out psychotically all morning, all needs met by staff, denies pain. Redirection and other interventions offered and unsuccessful. Frequent checks completed on patient as patient is very impulsive and has decreased safety awareness. Patient noted to be found laying on the floor next to his bed, stating that he is trying to go home to tell my wife where I am. Patient awake and alert, denies hitting head but states that he hurt his neck and shoulder. VSS. Trach in place and sating at 95% on RA (Room Air). Patient requesting to go to the hospital to be evaluated . Resident to be transferred to hospital . Surveyor noted R356 returned the facility on 4/16/22 with no monitoring or new interventions in place related to the documented psychotic behaviors. R356's medical record documents on 4/16/22, at 6:29 PM, Called to patients room by his nurse, patient on the floor, patient states that he put himself on the floor because he was trying to get some attention, VSS, patients wife updated and message left for case worker, call out to [name of medical group] to update them, no injury noted, patient has been hoyered back to bed, reminders to use call light for assistance, bed in low position and mat at side of bed. At 6:[TRUNCATED]

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35928 Based on observation, interview and record review, the facility did not always serve food to 3 out of 3 (R85, R21, and R97) residents that was palatable and served at the right temperature. R85, R21, and R97 all had food complaints that the food was not palatable. Surveyor received a tested tray; the food temperature was found to be cold. Findings include: 1.) R97 is alert and oriented and identified by the facility as cognitively intact. On 6/20/22, at 10:55 AM, Surveyor interviewed R97 who notes that the temperature of the food is cold and there is not much of a selection, the taste of the food is so-so that I usually just leave it. On 6/21/22, at 12:08 pm, Surveyor was observing the lunch meal on the second floor. Surveyor observed that the food was delivered to the second floor on a meal cart. At 12:10 pm, the food cart was opened, Surveyor observed some of the plates in the cart that were being served to the residents were in disposable Styrofoam containers for any resident that may have been in isolation. Surveyor waited until the second to last tray was left in the cart and obtained a food test tray. The food tray contained a salad but no salad dressing, the tray ticket identified the tray should have had French dressing, in a Styrofoam container. The plate contained a dinner roll, parmesan noodles, sauteed green beans, and a marinated chicken thigh. Surveyor requested a glass of ice water and tested the food thermometer that showed 31.3 degrees in the ice water. At 12:23 the dietary manager (DM-AAA) came into the conference room where Surveyor was conducting the test tray. Surveyor asked DM-AAA to leave the test tray until after the test has been completed. At 12:26 PM, Surveyor identified the last tray in the open cart is for a resident that needs to be assisted with their meal. At 12:46 PM, Surveyor observed the last tray was passed and the test tray was opened to complete the food temperature test. Surveyor observed that the parmesan noodles temperature was at 104 degrees Fahrenheit (F). The noodles tasted cold, bland without flavor and very overcooked and mushy. The marinated chicken thigh temperature was 102.1 F and was very lightly seasoned and lacking flavor. The sauteed green beans temperature was tested at 100.8 F, and tasted cold and lacked any flavor, the green beans tasted like canned green beans not sauteed green beans. Surveyor again observed the salad looked fresh but was without salad dressing. 03444 2.) R21 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus, anxiety disorder, heart failure, and hypocalcemia. R21's Minimum Data Set (MDS - standardized assessment tool) dated 4/7/22 recorded a Brief Interview for Mental Status (BIMS) score of 13 which indicates R21 is cognitively intact. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/21/22 at 07:13 AM, Surveyor interviewed R21in her room about her food. R21 stated, The food is cold by the time it gets to my room. Yesterday the scrambled eggs and coffee were ice cold. I told staff, but nothing changes. R21 said she has not asked to have her meals reheated by staff. 3.) R85 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, depressive disorder, neuromuscular dysfunction of bladder, and diseases of spinal cord. R85's MDS dated [DATE] recorded a BIMS score of 11 which indicates R85 is moderately impaired. On 6/20/22 at 10:34 AM, Surveyor spoke to R85. Surveyor asked R85 how his breakfast was today? R85 said It is cold and the food is garbage. I told them about the cold food and how bad it taste. They do nothing about it.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03444 Based on observation and interview, the facility did not provide a working call light system for 1 of 22 (R21) sampled residents. Findings include: R21 was admitted to the facility on [DATE] with diagnoses that included hypocalcemia, diabetes mellitus, chronic obstructive pulmonary disease and anxiety disorder. R21's most recent Minimum Data Set, dated dated dated [DATE] indicated R21 had a score of 13 on her brief interview for mental status assessment (indicating cognitively intact) and required substantial assist with toileting hygiene. On 6/21/22 at 7:15 AM R21 was observed laying in her room. Surveyor knocked on the door and R21 asked the Surveyor to come in. R21 indicated she needed assistance due to bladder incontinence and no one had come to help change her. R21 indicated she had turned on the call light since 6:10 AM. R21's call light was lit up in her room but the light outside of door and in the hallway were not on. On 6/21/22 at 11:52 AM Certified Nursing Assistant (CNA)-G and Licensed Practical Nurse (LPN)-MM indicated they would get maintenance to fix it. On 6/22/22 R21's current care plan for falls dated 4/17/22 was reviewed and read: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 06/22/22 07:19 AM Surveyor observed the call light above the Room number for R21 was lit but the light in the hallway was not on. Maintenance Assistant-PP stated, I thought it was just the light above the door. I didn't know the light in the hallway was burnt out too. If anyone had told me specifically where it was located, I would have rectify the problem.