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	12/12/2022

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interviews, the facility did not always ensure they notified the attending physician when there was changes in the Resident's condition for 1 of 2 Residents reviewed (R25). R25's physician was not notified/consulted with when R25's hypertensive medication was held on 12/9, 12/10, and 12/12/22 related to blood pressures being outside of parameters. Further, there is no documentation that R25's physician was notified of R25's falls on 11/18/22 and 11/28/22. Findings include: Surveyor reviewed the facility's Guidelines for Notifying Physicians of Clinical Problems revised 9/17 and notes the following: .Immediate Notification(Acute) Problems Immediate implies that the physician should be notified as soon as possible, either by phone, pager, text messaging, or other means. 1. Sudden in onset or a marched change compared to usual status 2. Change in vital signs 3. Fall with an identified or suspected injury 4. Laboratory results 5. Significant medication error Non-Immediate Notification Situations (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following are examples of issues that should be reported to the physician, but not immediately. Non-immediate implies that the physician should be informed of the problem or event at the time of the next routine communication or the next time he/she is making rounds(which is sooner. However, do not wait if there is concern or reason to believe that the situation requires more urgent discussion. 1. The following symptoms: In general: Any persistent or recurrent symptoms that are not life-threatening or causing severe distress and that cannot be addressed(or are not resolving) satisfactorily with existing information, interventions, or physician orders. 2. Any substantial change in physical condition or functional status that is causing no more that minimal distress 3. Consultant reports not involving a life-threatening or unstable medical or psychiatric situation. Nursing observations that might require physician action.(Minor symptoms that are only partially responsive to recently prescribed treatment) R25 was admitted to the facility on [DATE] with diagnoses of Unspecified Abnormalities of Gait and Mobility, Unspecified Lack of Coordination, Diabetes Mellitus, End Stage Renal Disease, Alzheimer's Disease, and Major Depressive Disorder. R25 is currently her own person but has a designated emergency contact documented in R25's medical record. Surveyor reviewed R25's Admission Minimum Data Set(MD'S) which documents R25's Brief Interview For Mental Status(BINS) score of 11, meaning R25 demonstrates moderately impaired skills for daily decision making. R25's MDS also documents that R25 requires limited assistance for bed mobility and extensive assistance for transfers, dressing, toileting, and hygiene. Falls: Surveyor reviewed R25's Falls and noted that the following dated falls had no physician notification: Fall on 11/18/22 at 8:55 PM Surveyor reviewed R25's Falls Management-Post Fall Assessment Tool and nursing progress notes located in R25's electronic medical record (EMR) and notes there is no documentation of notification to the physician of R25's fall. The Post Fall Assessment Tool documents that R25 had slipped in water in the shower and fell backwards onto R25's buttocks. R25 denied any injury at time of fall. Fall on 11/28/22 at 10:15 AM Surveyor reviewed R25's Falls Management-Post Fall Assessment Tool and nursing progress notes located in R25's electronic medical record (EMR) and notes there is no documentation of physician notification of R25's fall on 11/28/22 - the date of the fall. The Post Fall Assessment Tool documents that R25 slid out of the wheelchair to the floor. R25 denied any injury at time of fall. However, in review of R25's EMR, R25 expressed pain and it is only at that point (11/29/22) that the facility notified the nurse practitioner as documented: 11/29/2022 2:52 PM Nurses Note: Res being sent to St. Luke's to get X-ray for possible L hip fracture d/t fall from the other day per NP. Res transported by ambulance that arrived at facility 2:40 PM. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/30/2022 2:42 AM Nurses Note: Resident returns from ER transported via ambulance on stretcher. Resident alert and able to make needs known resident does offer c/o (complaint of) pain to left hip 8/10. ROM to left hip/leg limited due to pain. Resident returned with NNO (no new orders) or restrictions r/t (related to) left hip. Resident discharge diagnosis is left hip contusion and hematoma. some swelling noted however no bruising seen at this time. PRN (as needed) analgesic given for pain level 8/10. On 12/8/22 at 12:33 PM, Surveyor shared the concern with Administrator (NHA-A), Director of Nursing (DON-B), Corporate Consultant (CC-I), Corporate Consultant (CC-H), and Administrator Assistant (AA-F) that R25's physician had not been notified of R25's fall on 11/18/22 and 11/28/22. DON-B confirmed that the physician should have been notified of R25's falls. No further information was provided by the facility at this time. 20483 Medication: R25 was admitted to the facility on [DATE] with diagnosis which includes Hypertension. Surveyor reviewed R25's physician orders and noted the following medications: Metoprolol Succinate ER (extended release) Tablet Extended release 24 hour 25 mg with directions to give 1 tablet by mouth one time a day for HTN. Hold for SBP<100 or HR < 60 with an order date of 11/18/22. Clonidine HCL (hydrochloride) Tablet 0.1 mg with directions to give 1 tablet by mouth every 12 hours for HTN. Hold for SBP < 100 with an order date of 11/16/22. Surveyor reviewed R25's December MAR (medication administration record) and noted the following: For Metoprolol Succinate ER 25 mg tablet at 0700 (7:00 a.m.) on 12/9/22 R25's blood pressure is 97/61, on 12/10/22 R25's blood pressure is 93/58, & on 12/12/22 R25's blood pressure is 89/54. Surveyor noted there is a code of 11 which indicates vitals/labs outside of parameters. For Clonidine HCL 0.1 mg tablet at 0800 (8:00 a.m.) on 12/9/22 R25's blood pressure is 97/61, on 12/10/22 R25's blood pressure is 93/58, & on 12/12/22 R25's blood pressure is 89/54. Surveyor noted there is a code of 11 which indicates vitals/labs outside of parameters. Surveyor reviewed R25's progress notes and noted the following: 12/9/2022 at 7:46 a.m. Default PN (progress note) Type for eMAR (electronic medication administration record) Note Text: Clonidine HCl Tablet 0.1 MG Give 1 tablet by mouth every 12 hours for HTN Hold for SBP < 100. 12/9/2022 at 7:48 a.m. 07:48 Default PN Type for eMAR Note Text: Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN Hold for SBP < 100 or HR < 60. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/10/2022 at 8:52 a.m. Default PN Type for eMAR Note Text: Clonidine HCl Tablet 0.1 MG Give 1 tablet by mouth every 12 hours for HTN Hold for SBP < 100. 12/10/2022 at 8:53 a.m. Default PN Type for eMAR Note Text: Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN Hold for SBP < 100 or HR < 60. 12/12/2022 at 7:44 a.m. Default PN Type for eMAR Note Text: Clonidine HCl Tablet 0.1 MG Give 1 tablet by mouth every 12 hours for HTN Hold for SBP < 100. 12/12/2022 at 7:47 a.m. Default PN Type for eMAR Note Text: Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN Hold for SBP < 100 or HR < 60. Surveyor was unable to locate R25's physician/nurse practitioner was notified of her morning dose of Metoprolol Succinate ER 25 mg & Clonidine HCL 0.1 mg not being administered on 12/9/22, 12/10/22, & 12/12/22 due to R25's systolic blood pressure being under 100. On 12/12/22 at 12:37 p.m. Surveyor asked RN (Registered Nurse) Unit Manager-C if the physician or nurse practitioner should be notified when a medication is not administered due to a Resident's vital signs not being within the parameters to receive a medication. RN Unit Manager-C informed Surveyor they are suppose to notify the MD (medical doctor) or NP (nurse practitioner) of the medication not being given and they have to document this. RN Unit Manager-C indicated some nurses will put a note in where there is a pop up section on the emar (electronic medication administration record). Surveyor informed RN Unit Manager-C the nurse held R25's morning dose of Metoprolol Succinate ER 25 mg & Clonidine HCL 0.1 mg on 12/9/22, 12/10/22, & 12/12/22 due to her systolic blood pressure being less than 100 and Surveyor could not locate evidence R25's medical provider was notified of the medication not being administered. RN Unit Manager-C reviewed R25's medical record and informed Surveyor I don't see the nurses updated anyone. On 12/12/22 at 1:47 p.m. Surveyor informed Administrator-A and DON (Director of Nursing)-B of the above.

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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** 03357 Based on observation and interview, the facility did not provide for a clean, comfortable, and homelike environment for 1 of 5 residents (R41) who attended the resident council meeting with Surveyors and for residents residing on the first and second floors who potentially may be affected by their environment primarily with the wall scrapings. * Surveyor observed scrapped and stained walls along the corridors walls. Findings include: On 12/7/22 1:41 pm, Surveyors met with the Resident Council group in the second floor dining room where 1 of 5 residents were in attendance. R41 was in attendance. R41 informed Surveyors that the facility windows were dirty and the facility should hire a window washer to go room to room. R41 stated the window washing the facility did looks [NAME]. R41 stated he was also concerned about the second floor dining room ceiling tiles which he said were water logged stained brown, leaking and will fall and hit someone in the head pointing to 2 tiles in the dining room. R41 said those should be replaced, they've been that way since August 24th. I have seen from experience they fell down. R41 then pointed out additional 10 warped ceiling tiles. R41 went on to say the place needs a paint job to make it look more of a home like environment. On 12/8/22 11:05 am Surveyor observed the first floor and noted the following: Paint peeling on corridor wall by room [ROOM NUMBER] near thermostat and above the hand rail. Wall scraping on corridor wall near room [ROOM NUMBER]. Wall scraping on corridor wall near Service door. Paint scraping on corridor wall between rooms 116-118 (upper and lower wall) also between rooms 120-122 and between the admission office and room [ROOM NUMBER]. Paint scrapping on corridor wall (upper and lower portions) near room [ROOM NUMBER]-134 Paint scrapping on corridor wall by name plate for room [ROOM NUMBER] Unpainted plaster on corridor wall between room [ROOM NUMBER] and shower room Wall scrapping on corridor wall between room [ROOM NUMBER]-140 Wall scrapping on corridor wall between room [ROOM NUMBER]-145 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wall scrapping on corridor wall between room [ROOM NUMBER]-144 (upper and lower portions) Paint scraping on corridor wall between room [ROOM NUMBER] to end of hallway by light switch upper portion. Some dust build up vent door with air coming out on first floor near room [ROOM NUMBER] Inside the elevator the car had paint scrapings Second floor elevator frame heavily scraped. Corner ceiling tile near elevator has a brown stain on it. Brown ceiling tile outside of room [ROOM NUMBER] Scrapping on corridor wall between rooms 232-234 lower 1/2 hallway Corridor wall between rooms 241-243 wall drip stains and pain scrap under the gel out dispenser Black wall scrapping lower wall between rooms 243-245. Drip stains on wall below gel dispenser near room [ROOM NUMBER] Bubbler does not work on second floor is unplugged across from room [ROOM NUMBER] On 12/12/22 at 10:00 am, Surveyor finished observing the second floor corridor. Surveyor observed the following: Black wall scrapings on lower corridor wall near room [ROOM NUMBER]. White and brown drip stains on the wall near room [ROOM NUMBER] Black marks on the wall near thermostat and room [ROOM NUMBER] Drip stains below the gel dispenser on the corridor wall between rooms [ROOM NUMBERS]. Black wall scrapping on lower wall between rooms 216 and room [ROOM NUMBER], Sitting common area at end of hallway: Some black wall discoloration noted in the sitting common area, near air conditioning units. 1 gel dispenser by phone near common dining room area, gel dispenser is just the frame on the wall. Some black wall discoloration between the fire extinguisher and shower room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/8/22, Surveyor share the environmental concerns with Administrator A, Director of Nursing B, and Corporate Consultants H and I. Surveyor was informed the facility hired painters. On 12/12/22 at 09:40 AM Surveyor met with Maintenance Director GG who stated the facility has been interviewing and taking names for painters as of last week waiting to hear back regarding a final decision. Maintenance Director GG stated Administrator A would be a good person to ask regarding the window washing because they are looking at a company to come out and do them. Maintenance Director GG reported checking the ceiling tiles and the ones with stains are hard and firm and not threatening to fall, we replace the ceiling tiles as we get to them. The Dining room ceiling tiles upstairs are scheduled to be replaced today. The warped ones are being replaced as well. The ceiling tiles that are curved are not wet and do not pose a threat.

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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** 42037 Based on observation, record review and resident and staff interviews, 2 (R73, R78) of 3 residents reviewed did not receive required assistance with Activities of Daily Living. * R73 did not receive assistance with bathing in accordance with facility protocol. *R78 did not receive assistance with nail care in accordance with facility protocol. Findings include: 1. R73 was admitted to the facility on [DATE] with diagnoses of weakness, malnutrition and cognitive communication deficit. R73's Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicates that R73 requires total assistance of 1 staff with showers/bathing. R73's Admission MDS dated [DATE] indicates that R73 has preferences for choosing between sponge bathing and showers. Per R73's medical record, R73 is to receive showers every Sunday evening. On 12/06/22 at 10:54 AM, Surveyor made observations of R73. R73 was noted to be laying in bed, in a hospital gown. R73's hair appeared disheveled and greasy at this time. On 12/07/22 at 10:58 AM, Surveyor made observations of R73. R73 was noted to be laying in bed, in a hospital gown. R73's hair appeared disheveled and greasy at this time. On 12/12/22 at 7:35 AM, Surveyor reviewed R73's shower documentation for the previous 30 days. The Facility's documentation indicated that R73 received Bed baths on 11/27/22 and 12/4/22. R72 received a shower on 12/11/22. On 12/22/22 at 2:45 PM, Surveyor conducted interview with NHA (Nursing Home Administrator)-A on how often residents should receive a bath or shower. ADON-H responded that residents should receive baths or showers at least once a week. Surveyor shared concerns related to R73's disheveled appearance on 12/6/22 and 12/7/22 and lack of supporting evidence that R73 is receiving weekly showers. No additional information was supplied by facility at this time. 46214 2.) R78 was admitted to the facility on [DATE] and has diagnoses that include acute respiratory failure with hypoxia, dysphagia and hypotension. R78's Quarterly Minimum Data Set (MDS) assessment, dated 10/19/22 documents a Brief Interview for Mental Status (BIMS) was scored at 0 indicating severe mental impairment. Section G: Personal Hygiene documents R78 requires total dependence for maintaining personal hygiene and 2+person's physical assist. Upper extremity documents impairment on both sides. On 12/07/22, at 10:21 AM, R78 was observed in bed awake. His nails on each finger were very long on both hands. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/22, at 11:00 AM, R78 was observed in bed awake. His nails on each finger were very long on both hands. On 12/07/22 Surveyor reviewed the Care Plan dated 7/13/22. Surveyor notes there is no documentation about nail care present in care plan. On 12/07/22, at 2:14 PM, Surveyor reviewed Kardex dated 12/7/22 for R78. Surveyor notes there is no documentation about nail care present in Kardex. On 12/07/22, at 3:28 PM, at the end of day meeting with Nursing Home Administrator (NHA-A) and Director of Nursing (DON-B), Surveyor requested any nail care documentation for R78 over the past 30 days. On 12/08/22, at 8:08 AM, Surveyor interviewed Certified Nursing Assistant-T (CNA-T). CNA-T informed Surveyor that resident nails are to be trimmed by the CNA unless the resident has diabetes, then the nurse would have to trim the nails. Surveyor asked CNA-T who is responsible to trim R78 nails. CNA-T informed Surveyor that she thought nursing trimmed his nails but was not sure. On 12/08/22, at 8:32 AM, Surveyor interviewed Registered Nurse Manager-V (RN Manager). Surveyor asked her what the expectation was for resident nail care. RN Manager-V informed Surveyor that the CNA's are to trim resident nails during shower days. If the resident is diabetic, then the nurse is responsible to trim the nails. Surveyor asked RN Manager-V if she was aware of R78 long fingernails. RN Manager-V stated she was not aware. On 12/12/22, Surveyor Interview the Director of Nursing-B (DON) regarding resident nail care. DON-B informed Surveyor that the CNA should be checking nails during showers each week and trimmed as needed during am and pm cares. Surveyor asked if she was aware of R78 refusing nail care and she stated that she was not aware of that however he at times can be resistive to personal cares. The above concerns were presented to the Nursing Home Administrator (NHA-A) and DON-B at the end of the day meeting on 12/8/22 and a copy of nail care policy was requested. Facility did not provide any additional information or documentation of nail care for R78.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03357 Based on observation, record review and interview, the facility did not ensure all treatment and care was provided to facility residents in accordance with assessment, professional standards of practice, the comprehensive care plan and resident choices in 4 of 4 residents (R55, R3, R17 and R25) reviewed. * On [DATE], R55 had a change in condition. On [DATE] at 6:00 am, R55 had STAT (immediate) orders for a CBC (Complete blood count) and a BMP (Basic Metabolic Panel). There was no evidence that the facility received the results of the STAT lab orders and no evidence that they followed up with the ordering nurse practitioner or the physician. R55 continued to experience a significant decline in condition and was hospitalized on [DATE] with severe sepsis due to a urinary tract infection. R55 expired while at the facility on [DATE] with cause of death as urinary tract infection. * On [DATE] R3 was noted to have Leukocytosis (a high level of white blood cells, indicating possible infection) with a Nurse Practitioner's note stating a UA (urinary analysis) will be sent. Surveyor did not locate any urinalysis results for R3 for [DATE]. Nurse Practitioner X responded she would expect about a 24-hour turnaround time. There was a delay in obtaining R3's urinalysis and was not obtained until [DATE]. * R17 had an unwitnessed fall on [DATE] and neurological checks were not fully completed. * R25 had 2 unwitnessed falls on [DATE] and [DATE]. Neurochecks were not competed. Director of Nursing (DON) B confirmed that neurochecks should been done. * R25's morning blood pressure on [DATE] was ,d+[DATE] and R25 received her morning dose of Amlodipine Besylate 2.5 mg, Metoprolol Succinate ER 25 mg & Clonidine HCL 0.1 mg. R25's physician orders document to hold these medications of R25's systolic blood pressure is less than 100. Surveyor asked RN Unit Manager-C if these medications should have been held on [DATE]. RN Unit Manager-C replied they should have been. Findings include: Surveyor reviewed the facility's Lab and Diagnostic Test Results-Clinical Protocol, Revised [DATE]; 2005, Med-Pass, Inc. Under Assessment and Recognition, the policy states, - The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. - The staff will process test requisitions and arrange for tests. - The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted this clinical protocol does not address STAT orders for lab testing, does not address STAT turnaround time, does not address staff follow-up when the results are not received and in such cases a time frame for physician notification. According to Laboratory Medicine Curriculum, Clinical Laboratory-Fundamentals, a STAT test is defined as a quick turnaround time, generally an hour or less from specimen receipt until test result reporting. Such STAT tests are usually ordered when the result is needed quickly for a decision regarding patient management. Such tests must be performed ahead of others in the queue . https://webpath.med.utah/EXAM/LabMedCurric/LabMed01_5.htm# 1.) On ,d+[DATE] and [DATE], Surveyor reviewed R55's medical record which documents in part: R55 was admitted into the facility on [DATE]. R55's diagnosis included in part: Chronic Obstructive Pulmonary Disease (COPD), Heat failure, Type 3 Diabetes Mellitus w/o complications, Essential Hypertension, Chronic Kidney disease stage 3A, Hyperlipidemia, Hypo-osmolality, and hyponatremia, etc. R55 is noted to have a legal guardian. R55's advanced directive indicates R55 is full code. R55's quarterly Minimum Data Set (MDS) dated [DATE] reflects R55 has adequate hearing, clear speech, is understood, understands, has impaired vision seeing large print. The MDS indicates R55 scored a 10 on the Brief Interview for Mental Status which indicates R55 is moderately impaired for daily decision-making skills. R55 requires supervision oversight encourage or cueing, set up help only for eating. The MDS also indicates R55 requires oxygen. R55's care plan includes in part: - R(55) has impaired cognitive function/impaired thought process related to impaired decision making, deemed incompetent by courts, long term (LT) and short-term (ST) memory impairment. Initiated [DATE] with revision on [DATE]. Interventions include: - Monitor/document/report PRN (as needed) any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. [DATE] - Has COPD and CHF (congestive heart failure) with altered respiratory status [DATE] Interventions include in-part: Give aerosol or bronchodilators as ordered, monitor/document/report PRN any signs and symptoms of respiratory infection; fever, chills, increased difficulty breathing XXX[DATE] - Has oxygen therapy related to respiratory illness [DATE] with interventions in-part to include Oxygen per MD orders, change resident position every 2 hours to facilitate lung secretion [DATE]. R's 55's medical record review includes the following progress notes: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] Rapid Swab for Covid-19 performed today resident was negative. [DATE] Resident tested via Rapid Covid test due to Covid outbreak. Results negative. Vital signs obtained on [DATE] at 7:23 a.m. are Blood Pressure: ,d+[DATE] Temperature: 97.9 forehead Pulse: 77 Respiration: 16 [DATE] 03:30 psych follow-up Chart reviewed. Case staffed with treatment team and writer met with patient. Patient seen getting ready for breakfast. She states her mood is OK. She is unable to engage in meaningful conversation today. She is unable to or choosing not to answer further assessment questions. She appears disoriented. Nurse present and states the same. Patient recently tested negative for COVID. Nurse states she will monitor. [DATE]: PHQ9 (mood score): 10 (moderate depression); BIMS: 10 (Moderately Cognitively Impaired). General appearance and behavior: Pleasant, cooperative; Speech: low and slow in rate volume tone, Mood Ok Affect- Constricted, disoriented, Thought Process- Logical, longer time to process and respond, Cognition- Alert Ox,d+[DATE], Judgement/insight-fair. Assessment and Plan: Generalized anxiety disorder. Appears Stable. Does not present anxious .mild cognitive impairment, so stated: Appears more disoriented today and is unable to engage in conversations. Patient still takes time to process and respond to queries. Monitor for worsening behaviors. Nurse aware of symptoms and current medication. Continue to provide reassurance and supportive cares. Monitor closely. Patient is a [AGE] year-old woman with anxiety disorder being seen for a follow up visit. She appears very disoriented today. Nurse states she tested negative for COVID but will monitor. Psychiatric/Mental Health AA. On [DATE], R55 had a psych follow up. Surveyor noted this progress note references R55 as being very disoriented today and to monitor closely. Vital signs obtained on [DATE] at 6:45 p.m. are Blood Pressure: ,d+[DATE] Lying Right arm. Temperature: 98.0 Pulse: 77 Respiration: 18 On ,d+[DATE]/ 22, at 5:22 am, R55 has a temperature of 102.3 orally. R55's Medication Administration Record indicates on [DATE] at 0522 (5:22 am) R55 received Acetaminophen (Tylenol) Tablet 325 mg 2 tablet by mouth every 4 hours as needed for Fever-650 mg tablet. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The [DATE] 5:55 (am) Nurses note indicates Writer in to see res d/t (due to) Certified Nursing Assistant (CNA) reports feels warm, res alert in bed responds appropriately, lungs with diminishes sounds, bilateral fields, no coughing noted, 02@3LPM (oxygen at 3 liters per minute) via NC, res given Tylenol 650mg and cooling measures in place. Call placed to on-call no answer informed by receptionist will call when available will notify supervisor and am nurse. Licensed Practical Nurse (LPN) N. There is no evidence of an RN assessment at this time. [DATE] 06:00 (am) Nurses note: (name) NP (X) returned call and updated, new orders STAT CXR (Chest X-Ray), CBC (Complete blood count), BMP (Basic Metabolic Panel), res and guardian (name) message left. On [DATE] Director of Nursing (DON) B provided Surveyor with a screen shot of documentation showing on [DATE] at 6:27 am an online order placed in the lab portal for the STAT CXR, CBC, and BMP that was ordered by NP X. R55's medical record continues: [DATE] 6:02 (am) Nurse note: Rapid Covid neg: LPN N. [DATE] 8:15 (am)-SNF Progress Note NP X acute: Chief complaint: fever, tachycardia, AMS (altered mental status). Patient is seen lying in bed. She has her eyes closed; she is slow to respond. Patient noted to have fever with tachycardia last evening rapid COVID test was negative labs and chest X-ray were ordered. No results as of yet. Oxygen saturation 89% on 3 L. Oxygen was increased to 6 L. Will have IV placed to start IV fluids. Await X -ray and lab results. Vital signs reviewed, stable, occasional soft BP, General No acute distress, comfortable, Cardiac regular rate and rhythm, respiratory clear, no wheeze, no edema, alert interactive . Assessment and Plan: Chronic obstructive lung disease: Oxygen saturation 89% on 3 L, will increase to 8L currently. AMS noted. Awaiting Chest X-ray and lab results. Maintain oxygen saturation greater than 90%. Continue DuoNeb treatments as needed and prescribed inhalers. Monitor closely Fever unspecified: Fever 102.3 last evening, currently afebrile, but feels warm. Tachycardia unspecified: rates is ,d+[DATE]s. Appears regular. Surveyor noted the lab order had been placed into the Lab portal on [DATE] at 6:27 am with the results not yet received. Surveyor was provided with a copy of R55's Chest Xray Radiology report which was electronically signed on [DATE] at 11:39 am. The Xray results documented Lungs: No focal consolidation. Pulmonary vasculature is within normal limits. Pleura: No pneumothorax. No pleural effusion. Conclusion: No acute cardiopulmonary process. Electronically signed by MD CC. The vital signs taken on [DATE] at 8:43 am includes: Blood Pressure: ,d+[DATE] lying left arm (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Temperature: 97.8 Forehead non-contact Pulse: 112 Respiration: 20 [DATE] 11:31 (am) Nurses Note Resident status has changed, blood pressure low and heart rate increased. No fever noted. Resident appears drained. COVID test negative, chest C-ray and labs completed waiting for results. Writer called Access RN to placed IV for dehydration. Normal Saline 100ml/hr. PRN Nebulizer treatment administered. Writer will continue to monitor for any new concerns. Surveyor noted this was written by LPN Q. [DATE] 13:55 (1:55 pm) Nurses Note Text: Access RN placed IV in resident's right forearm. Writer started Normal Saline @100ml/hr for a total of 1L for dehydration. Writer will continue to monitor. [DATE] 22:39 (10:39 pm) Nurses Note Text: Resident completed NS IV solution this PM shift. IV site dressing to right hand is clean, dry, intact. Resident continues to be lethargic and moderate body twitches, arousable and responsive to touch and verbal tactile. Resident denies any pain or discomfort. Resident fed by writer this shift and ate 75% of dinner tray. Resident vitals obtained this shift is stable, afebrile. This is documented by LPN JJ. Surveyor noted R55 is referenced as being lethargic with moderate body twitches and that R55 was fed by the staff member eating 75% of the dinner tray. R55's [DATE] MDS had indicated R55 only required supervision oversight with encouragement or cueing and set up help only. There is no indication the decline in ability or noted body twitching was discussed with the nurse practitioner or physician. Vital signs obtained on [DATE] at 2:24 a.m. are Pulse: 100 Respirations: 20 O2: 93% Vital signs obtained on [DATE] at 8:43 a.m. are Blood Pressure: ,d+[DATE] Lying Left arm. Temperature: 97.8 Forehead, non-contact Pulse: 112 Respirations: 20 O2: 96% Vital signs obtained on [DATE] at (6:48p.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Blood pressure: ,d+[DATE] sitting left arm. Temperature: 96.9 oral Pulse: 109 Respirations: 20 O2: 96% Surveyor also was provided with a copy of the facility's 24-hour report/change of condition report dated [DATE] which documents: AM shift: [R55 as having] STAT CBC, BMP, CXR, Nebulizer treatment, call placed IV normal saline 150 ml/hr. , decreased blood pressure, increased heart rate, no fever. PM shift: IV right hand, C, D, I, afebrile, VSS. Surveyor noted there is no follow up reference to the [DATE] 6:00 am STAT CBC, BMP, and CXR order. R55's medical record continues: [DATE] 03:46 (am) Nurses Note Text: Res easily aroused responds appropriately when questioned, lungs with diminished sounds, 02@8LPM via NC, no apparent resp. distress pox 93%, twitching noted entire body continuously, skin warm and dry, Tylenol given res denies pain, right wrist PIV intact no s/s of infiltration. This is documented by LPN N. Vital signs obtained on [DATE] at 5:39 a.m. are: Blood Pressure: ,d+[DATE] lying left arm Temperature: 102.2 Oral Pulse: 85 bpm Respiration: O2: 93.0 Oxygen via nasal cannula. [DATE] 05:46 (am) Nurses Note Text: Tylenol suppository given d/t res pocketing meds. This was documented by LPN N. Surveyor noted R55's oxygen was at 93% at 2 LPM via NC and R55's body was noted to have continuous twitching with skin warm and dry. Surveyor also noted R55 was given an Acetaminophen/Tylenol suppository verses tablet form. Additionally, Surveyor did not observe any lab results that had previously been ordered on [DATE] at 6:00 am. Surveyor noted no RN assessment and no call to the physician or NP. R55's medical record continues: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] 07:15 (am) SNF Progress Note [DATE] . [NAME] Note ***CHIEF COMPLAINT*** fever, tachycardia, AMS, hypoxia ***SUBJECTIVE*** Patient is seen lying in bed. She remains lethargic with jerking body movements. She is minimally responsive. She continues to require increased oxygen levels. She is tachycardic and febrile. She was given 1 L NS last evening. CXR was unremarkable. Labs were not performed. Patient will be sent out to evaluation and treatment. ***LAB RESULTS*** Not Recorded ***MICROBIOLOGY RESULTS*** Not Recorded Chronic obstructive lung disease: Oxygen saturation 89% on 3 L, will increase to 8 L currently. AMS (Altered Mental Status) noted. Awaiting chest x-ray and lab results. Maintain oxygen saturation greater than 90%. Continue DuoNeb treatments as needed and prescribed inhalers. Monitor closely. CXR was unremarkable. Required 8L NC. Fever, unspecified: Fever 102.2 this am. Tachycardia, unspecified: rates in the 100s-110s. Appears regular. Related to fever likely. Altered mental status, unspecified: Lethargic with jerking body movements. Minimally responsive. Labs were not drawn and not sure when we can get them, so will send patient out for evaluation and treatment. ***FOLLOW-UP*** Time spent during visit today was 35 minutes, of which greater than 50% of the time was spent in confirming history, reviewing recent hospitalization records regarding multiple medical problems, assessing patient, reviewing facility EHR and collaboration of plan of care with patient/ nursing staff / collaborating providers as detailed above. Provider: (NP X), Signed Date: [DATE] 16:52:17 (4:52:17 pm). Surveyor noted on [DATE] at 07:15 am, NP X's progress note documents R55 remains lethargic with jerking body movements, is minimally responsive, continues to require increased oxygen and was febrile. The progress note also documents labs were not performed and that R55 would be sent out to evaluate and treat. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R55's medical record continues: [DATE] 08:45 (am) Health Status Note Text: resident was sent to (name of) hospital, resident had a temp of 102.2, NP X notified, left voicemail for guardian ., bed hold obtained. [DATE] 15:35 (3:35 pm) Nurses Note Text: Writer received call from (name of) hospital and spoke with nurse . Writer informed that resident is being admitted to hospital for sepsis at this time. [DATE] 14:26 (2:26pm) Social Service Progress Note Text: . Later contacted (name of hospital); spoke to nurse; . admitted for severe sepsis, UTI (urinary tract infection), with acute renal failure, hyponatremia, and pneumonia versus a lung mass. Is going to have an ID consult. Social Services-J [DATE] 15:11 (3:11 pm) Nurses Note Text: Discharge summary of medications reviewed with NO n (sic) preparation for today's admit. All medications reviewed and changes made as ordered. PO ATB (antibiotic) to continue x 5 days. [DATE] 20:09 (8:09 pm) Nurses Note Text: Resident returned . (name of hospital) earlier this evening. Resident is alert and oriented baseline. Vitals obtained stable. Resident denies any pain or discomfort. Able to make needs known. Resident has two large dark purple bruises to bilateral AC space, light green bruises to bilateral dorsal hand. Abdomen soft non-tender, Bowel sounds active X4, Lungs clear. Resident is currently resting in bed watching TV, appears to be adjusting well to room. Call-light and water within reach. Surveyor reviewed the Hospitalist Discharge Summary dated [DATE] which indicated in-part: Discharge diagnosis: Severe Sepsis due to and UTI from Klebsiella (bacteria) Altered Mental Status: Improved Possible pneumonia/lung mass (ruled out) Hypernatremia: Improved Hyperkalemia: Improved Acute renal failure: Improved Peripheral artery disease status post intervention in 2019 Type 2 diabetes mellitus COPD Hospital Course/Synopsis: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	. [AGE] year-old female . alert and oriented X2. She was noted to have less responsive and had fever. The patient is unable to give history .patient arrived on 12 L oxygen. She was febrile with a temperature of 102.8, heart rate 118 but blood pressure has remained normal, was weaned off O2 in ER room, was saturated 93% room air, Chest Xray showed three patchy right perihilar opacity which may be due to an early infiltrate .UA is positive for UTI .Urine culture is positive Klebsiella, pneumonia. She was treated with IV Ceftriaxone. Creatinine and Hypernatremia improved with IV fluids. Her Mental status improved to baseline. CT chest negative for lung mass. R55's medical record continues: [DATE] 02:35 Nurse note: Re-admit-res easily aroused, lungs .resp. Even and non-labored, abd (abdomen) soft round non-tender bsX4, skin warm and dry no edema noted, purple bruise on AC from needle sticks, res denies pain at present time, left safe call light in reach. LPN N [DATE] 05:53 (am) Nurses note NP X and (name) guardian notified of res with no signs of life and 911 here at facility with resident. On [DATE] 7:18 am Surveyor interviewed Director of Nursing (DON) B. Surveyor shared that R55 was noted to be experiencing a change in condition. Surveyor reported R55's medical record indicated a STAT order was received on [DATE] at 6:00 am and as of [DATE] at 7:15 am (24 hours later) NP X's documentation indicates labs were not performed .Labs were not drawn . DON B reported on [DATE] the facility switched labs with the labs first day being [DATE]. DON B stated the order for CBC and BMP was created on [DATE] on the new labs online portal however there was some initial confusion. The new lab did not have their STAT lab set up yet and the lab was going to send out samples which would take longer to get results back. DON B reported she was not sure if anyone came to draw blood or not. DON B stated, in this situation it doesn't look like anyone came out. DON B stated the Phlebotomist now comes to the facility and the lab is working on getting equipment so that they can do the CBCs and BMPs. DON B stated since then, they have worked out wrinkles with the new lab. DON B stated once the problem was recognized they ran all STAT orders through their former Lab until the new lab could get set up. During this conversation, DON B stated she would ask the Phlebotomist to check to see if the lab was drawn on [R55] on [DATE]. DON B stated the STAT lab orders were discontinued on [DATE] when [R55] passed away. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor spoke to DON B again on [DATE] at 11:52 am. Surveyor shared concerns with DON B that it appeared no one was following up on the STAT lab ordered on [DATE] at 6:00 am. DON B stated, the on-line portal information say no results, I haven't asked what happened to the blood draw as [R55] passed away. Procedures are for the nurses to get the result of the lab and call the NP even though the NP says she was checking. When blood work is STAT ordered, we put the order in, and it will go nurse to nurse until passed on in report. Generally, we have a routine lab day and NP X will look since she knows she ordered it, will keep an eye out for them. With the blood draw and them not resulted, doesn't know where the ball was dropped but yes shift to shift is the expectation and at some point, for someone to call the NP saying we haven't gotten the lab back and go on from there. On [DATE] 07:45 AM Surveyor interviewed NP X regarding the ,d+[DATE] STAT CBC and BMP order. NP X stated she saw [R55] twice (,d+[DATE] and ,d+[DATE]). NP X informed Surveyor We weren't sure what was expected from the lab what we needed to do to get the lab, the whole process wasn't really clear, we needed to work out kinks with the new lab and we knew everyone was aware of the new lab, most of time I keep track and check the labs because I see the patients daily, we didn't see anything, so I sent her out. I look at lab results and then I talk to nursing, so they don't always know, even with old lab can be common not to get the labs when we order them. I don't think any treatment was delayed as a result of not getting the STAT lab, we sent her out as soon as we could, saw [R55's] mentation wasn't getting any better. She did get IV first night I saw her. She had Sepsis from UTI (urinary tract infection). Labs at the hospital were high, normally [R55] is very stable so we don't have to check labs, rarely gets a UTI, wasn't first thing on my monitor. It would have been nice to know the labs because the labs were bad. I am here Monday through Friday mostly all day, not weekends. I work for Dr. Y who is the Medical Director here. On [DATE] 08:07 AM, Surveyor interviewed Phlebotomist FF who works for the new lab and who stated, this is her only facility. Phlebotomist FF reported, [R55's] orders were given to her, I came to do them. I did draw the patient [R55] on [DATE], I collected the specimen, and took it over to the lab. I personally dropped it off at the lab. The lab is a 3rd party that does STAT lab XXX[DATE] was a Friday (Surveyor noted it was actually a Thursday). There is usually about a 4 hour turn around. They (the facility) should have gotten results. I remember when I brought it to the lab it was almost closing time, I handed it (specimen) over to her. Usually, the results are not handled on our end, usually management's end. If asked I can call out, see what's going on. The lab was new to the facility that day, I'm not sure if there was a different process for STATs. Surveyor reinterviewed Phlebotomist FF on [DATE] at 02:30 PM. who stated, on [DATE], I took R55's blood draw more in the noonish, anytime between 1 and when I left around 3 pm. I took the specimen to the lab on 36th street. All STATs that come in I have it documented the time they bring it to me. I was here in building and given the STAT order by an RN can't recall the exact RN who gave the STAT order. I can go get the order for you .as the new lab Management agency has office upstairs. Anytime there is a STAT draw and UA the RN fills out form and they give it to lab upstairs. The RN gives it to me, the RN fills out a requisition form and gives it to me. I see what labs need to be drawn I collect the blood and I send out the UA if requested on a form. I will either get specimen packaged for pick up or if it is around the time I leave, I will drop it off. , d+[DATE] was Thursday the first day I was here. On [DATE] 11:22 AM Surveyor interviewed Dr. Y. who stated, the facility switched Labs. Resident's (R55) fever was 102.2 and the best thing to do was to send her out on [DATE]. (continued on next page)

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Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Phlebotomist FF is here Monday through Friday from 5:00 am to 9:00 am, long enough to do the lab that is scheduled and after that she is available to come in to draw labs until 3 pm. I have no idea when she drew it, and we can get it from lab. She would have come back to do the lab draw. Corporate Consultant H stated they obtained the new lab because they couldn't get labs from old lab. The new lab is located out of state .We are their only customer in Wisconsin, they have an office upstairs in facility. The phlebotomist is a full-time employee of the lab. This was the only STAT lab on [DATE]. Corporate Consultant H was not aware of other residents with routine lab concerns occurring on [DATE]. DON B discussed sending a Resident out to the hospital for a STAT lab as back up if needed. Corporate Consultant I stated we would send our patient to the hospital for a lab draw. Corporate Consultant I stated, thinks they have 6 to 8 hours to report pm a STAT lab. Staff know if there is a change in condition and the phlebotomist is not here to do the draw staff would notify DON B or NP X or (name) Medical who is on ,d+[DATE] and they would discuss Resident going out to the hospital. In this case, there was no lab result, staff would call DON B or NP X, DON B would follow up with the lab or the NP would give an order to send out. We allow 6 to 8 hours to get the STAT lab. The STAT time would include the time to do the draw and processing time which would be 6 to 8 hours. After 6 to 8 hours would start investigation, would call MD/NP whoever is on call and the get order to send out, if they still would want resident sent. Surveyor shared that the STAT order was placed into the portal on [DATE] at 6:27 am, given 4 hours allowed to draw the lab and 4 hours to process and result the lab, the facility should have had the lab results on [DATE] by 2:30 pm. Facility staff should have started following up with the lab and consultation with the physician/NP on [DATE] by 2:30 pm, which was not done. Surveyor indicated if the phlebotomist would have drawn up the blood on [DATE] at 3:00 pm, 8 hours later would have been [DATE] at 11:00 pm. Surveyor informed the administrative team there was no follow up to this STAT CBC and BMP order while R55 was experiencing a change in condition. There was no consultation with the physician/NP on [DATE] to discuss that the lab results had not been received. Additionally, it is noted in the early morning of [DATE] R55 was demonstrating additional changes in her condition including continuous muscle twitching and pocketing of meds leading to a Tylenol suppository administration. There is no indication these changes were assessed by an RN or communicated with the nurse practitioner or physician for consultation. 42037 2. R3 was admitted to the facility on [DATE] with diagnoses of morbid obesity, urinary retention and muscle weakness. R3's Admission Minimum Data Set (MDS) dated [DATE] notes R3 requires extensive to total assistance with activities of daily living. R3 was admitted to the facility with a urinary catheter in place and is frequently incontinent of bowel. R3 has a history of UTI (Urinary Tract Infections). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:33 PM, Surveyor conducted an interview with R3. R3 told Surveyor that they have had UTIs in the past and they are scared they could get sick again if staff aren't paying attention and helping to monitor her catheter and toileting. R3 was alert and appeared to be free from obvious signs and symptoms of infection at the time of the interview. Surveyor reviewed R3's medical record, including Nurse Practitioner progress notes. Surveyor reviewed Nurse Practitioner X's progress note dated [DATE] reads: .Leukocytosis (a high level of white blood cells, indicating possible infection) was noted on today's labs at 17. UA will be sent. On [DATE], Surveyor reviewed R3's medical record, including lab work and urinalysis results for November and December of 2022. Surveyor did not locate any urinalysis results for R3 for [DATE]. Surveyor located urinalysis results for [DATE], indicating R3 was positive for urine abnormalities. On [DATE], R3 was started on antibiotic therapy for a urinary tract infection. On [DATE] at 11:50 AM, Surveyor conducted interview with Nurse Practitioner X. Surveyor asked Nurse Practitioner X if diagnost [TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46214 Based on observation, interview, and record review, the Facility did not provide the necessary care and services to prevent development of pressure injuries and promote healing of pressure injuries for 3 (R28, R78, & R50) of 10 Residents. * R28 was discovered to have a full thickness pressure injury to the left ischium without a treatment in place and without monitoring. * R78 sustained a deep tissue injury to the right medial hand after wearing protective mitts. This pressure injury deteriorated to an unstageable pressure injury with eschar. The Facility did not follow physician orders to discontinue the mitt use and use freedom splints. * R50 had a pressure injury to the right buttocks. The facility did not follow physician orders to limit time up in Broda chair to 2 hours. R50's pressure injury declined and became an unstageable pressure injury. Findings include: The facility policy, entitled Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised in April 2018, states, Assessment and Recognition . 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue Cause and Identification 1.The physician will help identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state, and macerated or friable skin . Treatment and Management .3. The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors, for example: a. Healing or Prevention Likely: The resident's underlying physical condition, prognosis, personal goals and wishes, care instructions, and the ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. b. Healing or Prevention Possible: Healing may be delayed or may occur only partially; wounds may occur despite appropriate preventive efforts. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. R28 was admitted to the facility on [DATE] and has diagnoses that include: Unspecified paraplegia, Neuromuscular Dysfunction of Bladder with Suprapubic catheter placement, Spina Bifida, Pressure Ulcer of Left Hip and Pressure Ulcer of left Buttock, unspecified stage. R28's quarterly MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 09/02/2022 documents R28 has a BIMS (Brief Interview for Mental Status) of 14 indicating R28 is cognitively intact; documents R28 does not have a behavior of refusing cares; R28 needs extensive staff assistance with activities of daily living including needing the assistance of 2 plus staff for bed mobility and R28 is at risk for developing pressure ulcers but has no current pressure ulcers. The 12/03/2022 quarterly MDS indicates R28 has a BIMS of 12 indicating R28 is cognitively intact and continues to require extensive assist for ADL's including 2 plus staff for bed mobility. This MDS indicates R28 is at risk for pressure injuries and currently does not have a pressure injury. Additionally, this MDS indicates R28 did not demonstrate the behavior of rejecting cares. R28's most recent Braden score on 08/23/2022 was a 13, indicating R28 is at a moderate risk to develop pressure injuries. R28's Care Plan, last revised on 11/29/2022 with a target date of 02/27/2023, states: [name of resident] is at risk for impaired skin integrity r/t (related to): diagnosis of spina bifida, paraplegia, depression, pain, impaired sensation, impaired mobility, and incontinence. Resident is frequently non-compliant with interventions despite understanding of risks. Interventions include: Address pain as needed for resident comfort to encourage adherence to interventions to maintain skin integrity. (R28)'s pain is managed with repositioning, offloading, and medication. Apply house moisturizing lotion as needed to keep skin hydrated. Avoid applying between toes and other moist areas. Edema management--apply tubigrips (size E) or compression socks (provided by family) to BLE (Bilateral Lower Extremities) on in AM, off at HS (Hour of Sleep). Resident is frequently non-compliant with use of tubigrips despite frequent education on risks. Encourage resident to elevate BLE when at rest. Resident is frequently noncompliant with elevating BLE despite frequent education on risks. Encourage resident to keep head of bed below 30 degrees. May have head of bed elevated for meals. Moisture management--insure abdominal, groin, and chest folds are cleaned and thoroughly dried twice daily with AM/PM cares. Utilize Ultrasorb pads as needed for areas of high moisture. Monitor skin under/around medical devices (suprapubic catheter) once a shift and as needed. Utilize securement devices and cushion areas of contact to prevent skin irritation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nursing will assess skin upon admission, weekly on day of scheduled shower, PRN (as needed), and with any change in condition. Any abnormalities will be documented in chart and reported to primary physician and Wound Care Team for follow up. Offload resident to reduce direct pressure on bony prominences. Utilize heel boots and/or pillows to keep heels floated as resident allows. Monitor offloading devices with each encounter to ensure proper positioning. Avoid positioning devices directly over wounds/bony prominences. Resident is frequently non-compliant with use of heel boots and floating heels despite frequent education. Provide resident reminders and assistance with repositioning every 2-3 hours when in bed. [name of resident] was educated regarding pulling down briefs rather than trying to tear them off. Re-educate as needed. Support surfaces for pressure reduction: alternating pressure/low air loss mattress and Roho cushion. Evaluate for effectiveness/proper function with each resident encounter. On 12/06/22 at 9:47 AM, Surveyor observed R28 lying in bed on back, HOB (head of bed) elevated less than 30 degrees, heel boots on to bilateral lower extremities. Surveyor interviewed R28 and asked if R28 had any open areas. R28 informed Surveyor there was an open area located on their bottom and staff were putting cream on it. Surveyor reviewed R28's medical record and noted the following active physician's order .After gentle cleansing and drying, apply Triad cream to posterior scrotum & buttocks . This order was scheduled for every shift and did not specify why the cream was being used. Surveyor reviewed R28's medical record and noted R28 had been readmitted to the facility on [DATE] after a hospital stay. The following was documented in a nurses progress note on 08/23/2022, Resident readmitted to facility from [name of hospital], transported by EMS (Emergency Medical Services) .Stage 2 pressure injuries to left ischium and peri-rectum noted on hospital discharge summary. Resident reports no awareness of skin breakdown and denied knowledge of any treatment in the hospital. WCT (wound care team) notified of reported skin issues .Resident also has orders in place for Triad cream and hygiene routine for past issues with MASD (moisture associated skin damage) to groin/buttock r/t (related to) poor hygiene and leaking suprapubic catheter . Surveyor reviewed the hospital discharge summary dated 08/23/2022 which documented, Stage II to perineal wound, present on admission, continue with wound care. On 08/23/22 a Skin Only Evaluation documented, Resident deferred full assessment at this time--playing board games with brother; Per hospital report, resident has stage 2 pressure injuries to left ischium and peri-rectum. Surveyor reviewed additional Skin Only Evaluations and noted the following documented: On 08/26/2022 NO new skin issues as a result of this sliding from the bed. On 09/07/2022 No new bruises or injuries (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/31/2022 Skin intact; On 11/07/2022 No new skin issues noted On 11/14/2022 No new skin concerns. Being followed by wound team for area to butt/scrotum. On 11/21/2022 Treatment to butt/scrotum in place. On 11/28/2022 Treatment to butt/scrotum in place. On 12/05/2022 No new skin issues noted Surveyor noted the most recent wound care team assessment was from 9/23/22 and documented, Weekly assessment completed by Wound Care Team .Triad cream to peri-rectal area MASD (Moisture Associated Dermatitis) with cares. Braden score 13. Risk factors unchanged from previous assessment. Recent weight is 171.2lbs. Intakes adequate and blood sugars not monitored. Interventions in place and include: every 2-hour turning/repositioning (refuses), offloading, heel boots (non-adherent), edema management (non-adherent with LE elevation), pain management, alternating pressure mattress, Roho cushion, incontinence cares, and weekly skin assessment by nursing. Resident educated on current skin condition, interventions, and risks of non-adherence- verbalized understanding, but often non-compliant and hangs leg over edge of bed. WCT (Wound Care Team) will no longer follow. Nursing to notify WCT of any concern or change in skin condition. Surveyor could not locate facility documentation of a pressure injury to the ischium area per hospital discharge summary. Surveyor also noted the Braden score referenced was the assessment from 8/23/22. On 12/08/22 at 7:39 AM, Surveyor observed R28 lying in bed, clean shaven, heel boots on to bilateral lower extremities. R28 gave Surveyor permission to view morning cares. On 12/08/22 at 7:44 AM, CNA (Certified Nursing Assistant)-M prepared to assist R28 with morning cares. CNA-M donned the appropriate PPE (Personal Protective Equipment) for enhanced barrier precautions and performed hand hygiene per professional standards. CNA-M gathered supplies and explained the procedure to R28. CNA-M could not find R28's tubigrips, doffed all PPE, performed hand hygiene and left the room to ask for another pair of tubigrips. On 12/08/22 at 7:54 AM, CNA-M returned, donned appropriate PPE, and performed hand hygiene per professional standards. CNA-M began assisting R28 with morning hygiene cares. Surveyor did not have any issues with cares. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/08/22 at 8:00 AM, CNA-M assisted R28 onto their left side and began washing R28's back and buttocks area. Surveyor did not have any issues with cares. During this time, Surveyor viewed R28's buttocks and perineal area. Surveyor noted a circular open area to the left posterior buttocks. The area appeared to have depth, with edges that appeared to have epiboly (rolled or curled-under closed wound edges that may be dried, callused or hyperkeratonic which can impede wound healing). The open area appeared clean, and Surveyor did not note any signs or symptoms of infection. Surveyor pointed to the area and asked CNA-M if the area was open. CNA-M confirmed the area was open. Surveyor asked CNA-M how long R28 had the open area. CNA-M informed Surveyor R28 has had the open area for a while, it clears up and then comes back. Surveyor asked CNA-M what was being done for the wound. CNA-M informed Surveyor the staff attempt to keep the area clean and dry and put a cream on it. CNA-M pointed to the Triad cream that was on R28's bedside dresser. CNA-M stated the area is getting better. On 12/08/22 at 8:05 AM, CNA-M applied a thin layer of triad wound cream to R28's buttocks including the open area. On 12/08/22 at 8:07 AM, R28 informed Surveyor the open area was a problem a month or so ago because the catheter (Suprapubic) was leaking; now the catheter does not seem to be leaking but being incontinent of bowels does not help. CNA-M continued assisting R28 with morning cares. Surveyor did not have any issues with how cares were performed or hand hygiene. On 12/08/22 at 8:13 AM, Surveyor asked CNA-M what she would do if she noticed any new skin conditions. CNA-M replied she would report it the nurse and if the wound care team was in the facility she would report it to them as well. On 12/08/22 at 10:33 AM, Surveyor interviewed Unit Manager, RN (Registered Nurse)-N and Unit Manager, RN-L. Surveyor asked both RN-N and RN-L if R28 had any skin issues. RN-N informed Surveyor R28 had excoriation/denuded skin to buttocks/scrotum. RN-N was not certain of the last time she had assessed R28's bottom. RN-N informed Surveyor the wound care team usually does the follow up for wounds but was uncertain when the wound care team last saw R28. Surveyor informed RN-N the last wound care team note documented in R28's chart was from 09/23/2022. RN-N thought maybe there was something documented in the progress notes and would look through R28's chart. Surveyor explained a concerning issue was noted during morning cares and asked if RN-N would view R28's buttocks with Surveyor. RN-N stated yes, and she would let Surveyor know when R28 was ready to lay down. On 12/08/22 at 11:52 AM, Surveyor asked RN-N if she had any additional information and when would be a good time to view R28's skin. RN-N informed surveyor she was on phone with the wound care team and needed to check downstairs and would touch base with Surveyor. On 12/08/22 at 1:51 PM, Surveyors observed R28 lying in bed. R28 gave permission for both Surveyors to be in the room with RN-N while she assessed R28's skin. RN-N proceeded to don the appropriate PPE and enter R28's room. On 12/08/22 at 2:01 PM, RN-N and Surveyors observed R28's buttocks. Surveyor pointed to the area observed previously and RN-N informed Surveyor the area is open and R28 has had open areas there previously. RN-N stated she will measure the wound and contact the NP (Nurse Practitioner) to obtain a treatment order. Surveyor asked RN-N to update Surveyor with measurements and wound care orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/08/22 at 3:25 PM, Surveyor interviewed RN-N. RN-N informed Surveyor the area looked like pressure and RN-N had given the measurements to DON (Director of Nursing)-B. Surveyor brought up concerns regarding the hospital discharge summary from 08/23/2022 that mentions a stage 2 pressure injury to the left perineum and lack of facility documentation acknowledging whether that wound was present or not. RN-N informed Surveyor the area has been opened before and it will heal and then reappear. Surveyor brought up concerns about not knowing how long R28 had the current open area with no treatment in place. Surveyor asked RN-N about the Triad cream and if a CNA or nurse should be applying the cream. RN-N informed Surveyor the wound care team did give permission for the CNAs to apply that cream since it was only for maceration. Surveyor asked RN-N when a nurse should assess the skin. RN-N informed Surveyor at some point during the shift, a nurse should apply the triad cream and assess the skin. Otherwise, the skin assessments are weekly during showers. Surveyor asked if there should be measurements for maceration and RN-N replied no, staff would not measure the macerated area. On 12/08/22 at 3:47 PM, Surveyor interviewed DON-B. DON-B informed Surveyor the measurements for the open area were 3cm (centimeters) x 3cm x 2cm. DON-B informed Surveyor she would stage it as a 3, however she will wait for the wound care team to assess and have an extra set of eyes. DON-B informed Surveyor she would not document the stage until the resident is seen by the wound care team. DON-B informed Surveyor there would be no measurements for maceration and the CNAs are allowed to apply the triad cream. DON-B stated the nurses would not need to assess the skin every shift because the cream was only for maceration and skin checks would be done weekly. DON-B informed Surveyor the CNAs may need additional training on recognizing the differences between maceration and an open area. Surveyor asked for any additional information on this wound. On 12/12/2022, Surveyor reviewed R28's medical record and noted the following physician's order, Cleanse wound to left posterior ischium with Puracyn. Place calcium alginate and secure with border foam dressing. Every day shift every Mon, Wed, Fri for Wound care. This order had a start date of 12/08/2022. Surveyor also noted the following documented in a Skin Only Evaluation by DON-B: Wound noted to left ischium, near scrotum. Wound appears clean and moist, with pink, granulated base. Moderate serous drainage noted. No odor . 3x3x2. There is no staging documented in this assessment. Surveyor could not locate an assessment from the wound care team. On 12/12/22 at 3:50 PM, Surveyor asked NHA (Nursing Home Administrator)-A if R28 was seen by the wound care and could Surveyor have a copy of the assessment. NHA-A was uncertain if R28 was seen by wound care but would find out and give Surveyor a copy of the assessment. Surveyor was not given this information prior to survey exit on 12/12/2022. On 12/20/22 the facility provided to Surveyor the assessment completed by the nurse practitioner/wound team. This assessment is dated 12/13/22 and indicates R28 has a full thickness wound measuring 2.5 x 2.1 x 1.5 cm with a wound bed with 100% moist pink with a small amount of hyper-granulation tissue - moderate serosanguinous drainage. Peri-wound is moist with blanchable erythema. The treatment is cleanse with wound cleanser, tuck calcium alginate into wound bed leaving tail out to facilitate removal, cover with bordered foam. Surveyor noted the facility did not specifically stage this pressure injury as part of their assessment. 2.) R78 was admitted to the facility on [DATE] and has diagnoses that include acute respiratory failure with hypoxia, dysphagia, and hypotension. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R78's Quarterly Minimum Data Set (MDS) assessment, dated 10/19/22 documents a Brief Interview for Mental Status (BIMS) was scored at 0 indicating severe mental impairment. Section G: Personal Hygiene documents R78 requires total dependence for maintaining personal hygiene and 2+person's physical assist. Upper extremity documents impairment on both sides. It documents that resident is at risk for developing pressure ulcers and at the time of the assessment did not have any unhealed pressure ulcers present. Limb restraints documents daily use. On 12/06/22, at 10:34 AM, Surveyor observed R78 lying in bed wearing white bilateral padded mitts that tie at the wrist. On 12/06/22, at 2:16 PM, Surveyor observed R78 lying in bed wearing white bilateral padded mitts that tie at the wrist. On 12/07/22, at 3:43 PM, Surveyor observed R78 lying in bed wearing white bilateral padded mitts that tie at the wrist. On 12/07/22, at 10:53 AM, Surveyor interviewed Licensed Practical Nurse-S (LPN-S) and asked him what R78 was wearing on his hands. LPN-S stated he was not sure and was not sure why R78 was wearing them but would ask his supervisor. On 12/07/22, at 1:40 PM, Surveyor interviewed Rehabilitation Director-W (Rehab Director). Surveyor asked if the therapy department is usually involved in the assessment for restraint use. Rehab Dir-W stated that they usually are not involved. She stated that typically restraint use is driven by nursing department. We may participate in discussion with the team, but we alone do not make the decision. The Rehab Director informed Surveyor that the restorative aide usually gives residents who wear restraints a break from them when they are doing therapy or restorative services. Our therapist or restorative aide will remove the restraint and complete services and then reapply the restraint. Surveyor asked Rehab Director-W if the therapy staff and restorative aides were trained on the different restraint and splint devices used at the facility. She stated yes. On 12/08/22, at 7:36 AM, Surveyor interviewed LPN-Q. Surveyor asked her what R78 was wearing on his hands. LPN-Q informed surveyor that R78 was wearing protective mitts to protect his trach so he doesn't pull it out. She stated that they check his skin every shift and document it on the medication administration record (MAR). Surveyor asked LPN-Q to show Surveyor where this was being documented. LPN-Q pulled up R78 electronic MAR and pointed to the order for freedom splints and stated this is where we document he is wearing the mitts and the skin checks. Surveyor asked LPN-Q if she was aware of R78 having a DTI to his hand. LPN-Q stated that he has a very small wound on hand, however it is healing. Surveyor asked LPN-Q if it was okay for R78 to be wearing the mitts while the DTI is healing, and she stated yes. On 12/08/22, at 7:39 AM, Surveyor observed R78 lying in bed wearing white bilateral padded mitts that tie at the wrist. On 12/08/22, at 8:08 AM, Surveyor interviewed Certified Nursing Assistant-T (CNA). CNA-T informed Surveyor that R78 was wearing mitts to prevent him from pulling at his tubing. CNA-T stated that R78 wears the mitts almost all the time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed the most recent Braden assessment with a date of 11/14/22. The Braden scale for predicting pressure ulcer risk is scored at 11 indicating R78 is at moderate risk for the development of pressure injuries. Surveyor reviewed R78's medical record and noted an active physician's order documenting, Trial resident off of restraints, monitor for safety/behaviors; every shift. This order was dated12/5/2022. Another active physician order documents, Freedom splints to bilateral hands at all times to protect trach integrity; Nurse to check placement and skin integrity every shift. This order was dated 11/15/2022. Surveyor noted a discontinued physician order stating, Mitts to bilateral hands at all times to protect trach integrity; Nurse to check placement and skin integrity every shift. This order has a start date of 9/13/2022 and a discontinued date of 11/15/2022. Surveyor could not locate a current physician order for mitts. (Cross-reference F604). 12/08/22 Surveyor reviewed R78's current Care Plan, dated 7/13/22. Care Plan documents, Don/doff protective mitts to prevent pt (patient) from injuring self. This intervention was initiated on 08/10/2022. R78's Care Plan also documents, has impaired skin integrity, as evidenced by unstageable (previously DTI (device-related)) pressure injury to right lateral hand, acquired in facility. Date initiated was 11/14/2022 and revised on 12/06/2022. Interventions include, Mitt restraint dc'd (discontinued)- freedom splint to be used in place. This intervention was initiated on 11/14/2022. R78 uses bilateral freedom splints d/t (due to) pulling at medical devices such as trach, G (gastrostomy)-tube and vent tubing. This intervention was initiated on 7/19/2022 and revised on 11/15/2022. It also documents that R78 will have, Wound assessment/measurement performed weekly/PRN (as needed) by Wound Care Team. This intervention was initiated on 11/14/2022. Surveyor notes that this current Care Plan has not been updated consistently in all related sections to reflect that the protective mitts were discontinued on 11/15/22 and there are new orders for freedom splints to be use instead of protective mitts. Surveyor review R78 Kardex dated 12/7/22. It documents, Don bilateral resting hand splints daily for 6-8 hours to prevent contractures of digits and hands. Don/doff protective mitts to prevent pt (patient) from injuring self. Surveyor notes that the Kardex still documents the use of protective mitts when these mitts were discontinued on 11/15/22 due to R78 forming a deep tissue injury (DTI) to his right lateral hand and does not document the use of freedom splints. The Kardex does not document any current DTI and interventions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R78's Medication Administration Record (MAR) for November and December 2022. November MAR documents, Mitts to bilateral hands at all times to protect trach integrity; nurse to check placement and skin integrity every shift. Start date 9/13/22 and discontinued date 11/15/22. Documentation of protective mitts is completed for 11/1/22 through 11/15/22. November MAR also documents, Freedom splints to bilateral hands at all times to protect trach integrity, nurse to check placement and skin integrity every shift. Start date 11/15/22 at 1400. Documentation of freedom splint is noted 11/15/22 through 11/30/22. December MAR continues to document the use of freedom splints. Documentation has been completed 12/1/22-12/7/22. Surveyor notes that through observation of R78 on 12/6/22, 12/7/22 and 12/8/22, R78 was wearing protective mitts and not the freedom splints. The December MAR however has staff documenting the protective mitt use under the freedom splints. This is inaccurate documentation of a restraint device. Surveyor reviewed the skin only evaluations for R78. The skin only evaluation dated 11/14/2022 documents a right lateral wrist with a stage of suspected deep tissue injury, depth unknown. Measuring 1 x 1.1. Wound bed is epithelial. Skin notes documents, Resident seen by Wound Care Team at request of nursing for reported bruising to right wrist. Upon assessment, DTI observed to right lateral hand near wrist (device related- mitt). Root cause is mitt restraint. Removed by nursing & freedom splint ordered. Braden score is 13. Surveyor reviewed the Nurse Practitioner progress notes dated 11/14/2022. It documents, Patient noted to have new DTI to right hand likely related to the mitt. Mitt currently off, hand is edematous-we will leave the mitt off to rest for a while. Unspecified open wound of unspecified hand, initial encounter: Deep tissue injury noted to right hand secondary to mitt. The mitt will remain off for a bit to rest. Wound care team following. make sure that the mitt is not too tight around the wrist-continue to monitor. Skin only evaluation dated 11/18/2022 documents a pressure ulcer/injury on right lateral hand with suspected deep tissue injury depth unknow. Measuring 0.8 x 0.9. Skin note documents, Resident seen by Wound Care Team for weekly assessment. Right hand DTI improved and reabsorbing. Braden score is 13. Nurse Practitioner progress note dated 11/21/1022 documents, Patient noted to have new DTI to right hand last week likely related to the mitt. Mitts were removed and Freedom splints placed. Respiratory status stable. No other concerns per nursing - Unspecified open wound of unspecified hand, initial encounter: Deep tissue injury noted to right hand secondary to mitt. The mitt will remain off and freedom splints were placed. Wound care team following. Resolving. Skin only evaluation dated 11/22/2022 documents a pressure ulcer/injury on right lateral hand that is unstageable. Measuring 0.4 x 0.3 x 0.1. Wound bed is necrotic. Skin note documents, Resident seen by Wound Care Team for weekly assessment. Right hand DTI now unstageable as area evolved and now dry eschar- improved/smaller. Braden score is 13. Skin only evaluation dated 11/29/2022 documents a pressure ulcer/injury on right lateral hand that is unstageable. Measuring 0.3 x 0.3 x 0.1 with necrotic tissue. Skin note documents, Resident seen by Wound Care Team for weekly assessment. Right lateral hand slightly improved- eschar edges lifting. Braden score is 13. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Skin only evaluation dated 12/02/2022 documents a pressure ulcer/injury to right lateral hand that is unstageable. Measuring 0.3 x 0.3 x 0.1 with necrotic tissue. Skin note documents, Weekly assessment completed by Wound Care Team. Right lateral hand stable- dry eschar and OTA (open to air). Braden score 13. Skin only evaluation dated 12/09/2022 documents, Weekly assessment completed by Wound Care Team. Right lateral hand is now resolved. Braden score 13. On 12/08/22, at 8:32 AM, Surveyor interviewed Registered Nurse Manager-V (RN Manager-V). Surveyor and RN Manager-V spoke outside of R78's room. Surveyor asked RN Manager to identify what R78 was wearing on his hands noting observation on this date. RN Manager-V stated that they call them mitts. Surveyor asked RN Manager if she was familiar with freedom splints. RN Manger-V stated that she was familiar, and that freedom splint are like a plastic material and is applied around the elbow area to prevent the elbow from bending. Surveyor asked how often a resident wearing mitts are monitored. She stated that the skin is checked once per shift or whatever is in the physician order. RN Manager-V stated that residents wear the mitts 24 hours a day, but the skin is checked, and they may also be out of the mitts if they have restorative services and wear a comfy blue bilateral splint. Surveyor asked RN Manager-V if she was aware of R78 having a pressure injury to his hand. RN Manager-V stated yes. Surveyor asked RN Manager-V if there was a current order for the mitts. She stated that there should be an order for the mitts if we are using them. Surveyor asked RN Manager to clarify what an order that states trial resident off of restraints - monitor for safety/behaviors; every shift. RN Manager stated that if there is an order for a trial then I would expect to see no mitts on R78. On 12/08/22, at 3:24 PM, Surveyor interviewed the Director of Nursing (DON-B). Surveyor asked DON-B if she was aware that there currently is no physician order for the protective mitts and R78 was observed wearing protective mitts on 12/6/22, 12/7/22 and 12/8/22. DON-B informed Surveyor that she heard about this. She stated that R78 was switched to freedom splints after receiving a DTI to his hand, however the restorative aide saw the protective mitts in R78's room and continued to put them on him after services. Surveyor asked DON-B if staff are trained on restraint and splint devices at the facility. DON-B stated that staff should be trained and referred Surveyor to the Staff Development Coordinator (SDC-U). Surveyor asked DON-B if she was aware that staff are continuing to document the use of the padded mitts under in the MAR under the current physician order for the freedom splints. DON-B stated she was not aware. When asked who should be monitoring that documentation the DON-B stated the nursing supervisors and myself. On 12/12/22, at 9:45 AM, Surveyor interviewed the Nursing Home Administrator (NHA-A) regarding the above concerns. NHA-A was not sure why R78 would still be wearing protective mitts without a physician order. Surveyor asked NHA-A who was responsible to monitor restraint documentation. NHA-A informed Surveyor that it is everyone's responsibility, however the nursing supervisor should be reviewing nurse documentation. The NHA-A did recall discussing R78 at morning meetings with her staff and his protective mitts in the past but did not recall any concerns recently. No additional information was provided. 3.) R50 was admitted to the facility on [DATE], with diagnoses of acute respiratory failure, cognitive communication deficit, dysphagia, and chronic kidney disease. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R50's Quarterly Minimum Data Set (MDS) dated [DATE], documents R50's Brief Interview for Mental Status (BIMS) score of 00 which indicates R50 is severely impaired. Section G: Personal Hygiene documents R50 requires extensive assistance for maintaining personal hygiene and one-person physical assist. Upper and lower extremities documents impairment on both sides. Section M: Skin, documents no pressure ulcer/injury at the time of the assessment and documents he is at risk of developing a pressure ulcer/injury. On 12/07/22, at 1:12 PM, Surveyor observed R50 in Broda chair. On 12/07/22, at 3:44 PM, Surveyor observed R50 in Broda chair asleep. On 12/07/22, at 4:44 PM, Surveyor observed R50 in Broda chair. On 12/08/22, at 1:40 PM, Surveyor observed R50 awake in Broda chair. On 12/08/22, at 3:41 PM, Surveyor observed R50 in Broda chair asleep. Surveyor review R50's medical record and Care Plan dated 3/4/2021 and revised on 11/08/22 documents, Impaired skin integrity, as evidenced by shear injury to right medial buttock, developed in facility. Intervention include, Limit time up in wheelchair to 2 hours at a time. Assist resident to shift weight while up in chair at least once an hour. Nursing to monitor dressing integr [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45647 Based on observation, interview, and record review, the facility did not ensure 2 (R8 and R25) of 3 residents reviewed received adequate supervision and assistive devices to prevent accidents. *R8 had a fall on 10/20/22 while being transferred with a sit to stand lift by Certified Nursing Assistant (CNA)-M. CNA-M transferred R8 using the sit to stand lift without assistance from another staff member. CNA-M also did not properly secure the sling on R8 before transferring R8. *R25 had falls on 11/18/22, 11/22/22, and 11/28/22. The facility did not complete a thorough falls investigation, including a root cause analysis, and did not notify the physician or family of R25's falls. R25's care plan was also not updated with an appropriate intervention to prevent R25 from further falls. Findings Include: The facility policy, entitled Fall Management, with a revision date of 9/1/22, states (in part) .: .Response to a resident fall Evaluate and monitor the resident for 72 hours post fall . Complete a root cause analysis and determine an intervention base on the root cause. Implement intervention (immediate) after the fall. As the investigation continues the root cause analysis may trigger additional interventions to resident plan of care. Notify provider and family/responsible party. Update the care plan and CNA communication form with new intervention. Surveyor requested a policy and procedure on the use of mechanical lifts from the facility but was informed that the facility does not have one. 1. R8 was admitted to the facility on [DATE] with diagnoses of muscle weakness, chronic pain, Diabetes Mellitus, and anemia. R8's Quarterly MDS (Minimum Data Set) assessment, dated 11/29/22, documents a BIMS (Brief Interview for Mental Status) score of 11, indicating R8 is moderately cognitively impaired for daily decision making. Section G (Functional Status) documents R8 requires extensive assistance of two plus staff for physical assist with bed mobility and transfer assistance. R8's care plan documents that R8 is at risk for falls related to generalized weakness and urinary tract infection. The interventions section documents that R8 will be free from falls through the review date, 10/20/22- Employee education on safe transfers and proper use of mechanical lift, anticipate the residents needs, call light in reach at all times, follow facility fall protocol, and review information on past falls and attempt to determine cause of falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/06/22 at 10:12 AM, Surveyor interviewed R8. R8 reported to Surveyor that they had fallen while getting out of bed with the sit to stand lift because R8 was to take a shower. R8 reported that CNA-M was getting R8 out of bed and did not clip the sling in the front like it is supposed to be. R8 reported to Surveyor that R8 told CNA-M not to bother with the clip and just get R8 up. R8 reported that CNA-M was the only staff member in the room while getting R8 up with the sit to stand lift. R8 reported that when CNA-M was taking off R8's pants, R8 got tired and had to let go of the lift handles. R8 reported they slipped out of the sling and fell on to the ground. R8 reported that CNA-M stayed with them, and other staff members came to help right away. R8 reported they went to the hospital but did not have any injuries. Surveyor reviewed of the medical record which indicated R8 was admitted to the hospital on 10/20/22 with a urinary tract infection. Hospital documentation revealed R8 did not sustain any injuries due to the fall on 10/20/22. Surveyor reviewed R8's Falls Management-Post Fall Assessment Tool dated 10/20/22 that documented R8 had a witnessed fall on 10/20/22 and indicated CNA-M and Licensed Practical Nurse (LPN)-N were assigned to R8. Question 6 documents R8 believed they fell because the sling was not fastened. Under the section titled, Environmental status at the time of the fall documented that the sling was not fastened and R8 was transferred with 1 staff member while using the sit to stand lift. Surveyor reviewed R8's Nurse's Note, dated 10/23/2022 at 15:47 that documented, that on 10/20/22 R8 was being transferred using sit-to-stand lift. Per CNA-M, when they went to fasten the sling, resident told CNA-M not to bother with it and that R8 will be fine. During transfer, R8 slipped from lift to the floor. Root cause determined to be improper use of mechanical lift by CNA-M. Immediate education provided to CNA-M on proper transfer/lift use and able to demonstrate competency and understanding. On 12/07/22 at 03:31 PM, Surveyor interviewed CNA-M via phone. CNA-M reported that on 10/20/22, they were assigned to work on the second floor, and they generally work on the first floor. CNA-M reported they do not work with R8 often. CNA-M reported that it was R8's shower day and they were going to get R8 in the shower chair. CNA-M reported they went into R8's room with the sit to stand lift alone. CNA-M got R8 to be sitting on the side of the bed. CNA-M reported that when they went to clasp the clip on the sling that goes around R8, R8 told them not to bother with the clip. CNA-M reported they asked R8 if R8 was sure, and R8 stated yes, and not to worry about the clip. CNA-M reported that as they were lifting R8 up and removing R8's pants, R8 lost grip on the handles and CNA-M reported they lowered R8 to the ground. Surveyor asked CNA-M how many people are needed to transfer a resident with the sit to stand lift. CNA-M reported that they believe two people are required to transfer any resident with a mechanical lift. Surveyor asked CNA-M if they received any education after R8 had fallen. CNA-M reported that Director of Nursing (DON)-B provided them education on the proper use of lift equipment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/07/22 at 05:12 PM, Surveyor interviewed LPN-N. LPN-N reported that CNA-M usually works on the first floor. LPN-N reported they told CNA-M that it was R8's shower day. LPN-N reported they were informed that R8 had fallen, and they went to assist and when they asked R8 what happened, R8 said they got tired from holding onto the lift and had to let go. LPN-N reported R8 said the clip wasn't closed in the front. LPN-N reported they asked R8 who was with CNA-M and R8 reported to LPN-N that CNA-M was alone. LPN-N reported to Surveyor that they did not get any in service training on use the proper use of a mechanical lift. LPN-N reported that any mechanical lift requires two staff members to transfer a resident. On 12/08/22 at 07:35 AM, Surveyor interviewed CNA-O. CNA-O reported that a sit to stand lift requires two staff members to transfer a resident. On 12/08/22 at 10:44 AM, Surveyor interviewed DON-B. DON-B reported that two staff members are required to transfer a resident with a mechanical lift. DON-B reported that on 10/20/22, R8 fell from the sit to stand lift. DON-B reported that CNA-M was transferring R8 using the sit to stand lift alone and that R8 told CNA-M not to buckle the sling in the front. DON-B reported they educated CNA-M on the proper use of mechanical lift equipment. DON-B reported that the facility was going to have an all staff training on the proper use of lift equipment in November, however that was canceled. DON-B reported another training was scheduled the week of December 5, but was also canceled due to Surveyors being at the facility. Surveyor shared the concern regarding CNA-M transferring R8 on 10/20/22 with the sit to stand lift by themselves and not buckling the sling properly resulting in R8 falling from the lift with DON-B. On 12/08/22 at 03:11 PM, Surveyor shared the concern regarding CNA-M transferring R8 on 10/20/22 with the sit to stand lift by themselves and not buckling the sling properly resulting in R8 falling from the lift with Nursing Home Administrator (NHA)-A, DON-B, Corporate Consultant-H, and Corporate Consultant-I. There was no additional information provided by the facility. 38829 2. R25 was admitted to the facility on [DATE] with diagnoses of Unspecified Abnormalities of Gait and Mobility, Unspecified Lack of Coordination, Diabetes Mellitus, End Stage Renal Disease, Alzheimer's Disease, and Major Depressive Disorder. R25 is currently her own person but has a designated emergency contact documented in R25's medical record. Surveyor reviewed R25's Admission Minimum Data Set (MDS) which documents R25's Brief Interview For Mental Status (BIMS) score of 11, meaning R25 demonstrates moderately impaired skills for daily decision making. R25's MDS also documents that R25 requires limited assistance for bed mobility and extensive assistance for transfers, dressing, toileting, and hygiene. Surveyor reviewed R25's Falls Care Area Assessment (CAA) dated 11/21/22 which documents that R25 is at risk for falls due to weakness, cognitive loss, and use of antidepressant medication. R25 has had two falls without injury since admission due to confusion, weakness. R25 is receiving therapy for strengthening and rehabilitation. Extensive assistance from staff for transfers. Will proceed to care plan with interventions to reduce risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R25's comprehensive care plan for falls and notes the following: R25 is a high risk for falls due to new environment, weakness, current medications/potential side effects, and diminished safety awareness. Date Initiated: 11/16/2022 Revision on: 11/18/2022 The following interventions were implemented 11/17/22--Sign posted in room to remind resident to call for assistance prior to attempting to get up or transfer. Date Initiated: 11/17/2022 Revision on: 12/03/2022 11/18/22--staff educated on need to dry floor prior to assisting residents to ambulate after showers. Date Initiated: 11/18/2022 ACTUAL FALL ON 11/28/22--Provide resident with colored Dycem to wheelchair to help improve visual/spatial awareness when transferring to wheelchair. Date Initiated: 11/28/2022 Keep call light within reach. Date Initiated: 11/16/2022 Revision on: 11/18/2022 Schedule ophthalmology consult to evaluate visual impairment r/t glaucoma. Date Initiated: 11/28/2022 Keep frequently used items within reach. Date Initiated: 11/18/2022 Revision on: 11/18/2022 Fall risk assessment upon admission and at least quarterly. Date Initiated: 11/16/2022 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 11/18/2022 Ensure appropriate footwear when OOB (out of bed). Date Initiated: 11/16/2022 Revision on: 11/18/2022 Refer to PT/OT/ST (physical, occupational and speech therapy) as needed. Date Initiated: 11/16/2022 Revision on: 11/18/2022 Educated and remind resident of safety awareness such as locking breaks on w/c, asking for assistance before transferring and call light use. Date Initiated: 11/22/2022 Surveyor notes the following Fall Risk Evaluations were completed for R25: 11/15/22-Score of 8 NA 11/17/22-Score of 13 At Risk 11/18/22-Score of 10 At Risk 11/22/22-Score of 9 NA 11/28/22-Score of 22-At Risk Surveyor reviewed R25's falls and notes R25 has had 4 falls since admission to the facility. 11/17/22-Interdisciplinary Team (IDT) reviewed the fall and the intervention put into place was to place a sign in R25's room to remind R25 to use the call light for assistance. This intervention was revised on R25's care plan. Slid from bed with no injury. 11/18/22-IDT reviewed the fall and intervention put into place was education of staff to make sure the shower floor is dry before ambulating Residents. fell in shower room with no injury. This intervention was added to R25's care plan. On 11/22/22, R25 had an unwitnessed fall where R25 slid off the bed. The following was documented in R25's electronic medical record(EMR): 11/22/2022 10:43 PM Nurses Note Text: Called to the resident room by staff member reporting resident was on the floor. Resident stated she was sitting on the side of the bed waiting for the dinner and slid off the bed. VS (vital signs) stable. No injuries noted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes this was R25's second fall where R25 slid from the bed to the floor. There is no IDT review and no root/cause analysis completed for this fall. The intervention to educated and remind R25 of safety awareness such as locking breaks on w/c (wheelchair), asking for assistance before transferring and call light use was added, however, Surveyor notes this was already an intervention on R25's care plan. 11/28/22-IDT reviewed the fall and intervention put into place was to place colored Dycem on R25's wheelchair. R25 had slid off the wheelchair. Surveyor notes this intervention was added to R25's care plan. Surveyor notes the following documentation in regards to the intervention of 'colored Dycem': IDT REVIEW OF FALL ON 11/28/2022 Root cause determined to be poor visual/spatial awareness. Immediate intervention is to provide resident with colored Dycem to wheelchair to help improve visual/spatial awareness when transferring. Care plan reviewed and previous interventions remain appropriate. Staff will continue to assist resident as needed. On 12/6/22 at 10:10 AM, Surveyor observed R25's wheelchair with a white blanket in the seat of the wheelchair. On 12/7/22 at 3:57 PM, Surveyor observed blue Dycem on R25's wheelchair which is the same color as the wheelchair with a white blanket on top. On 12/8/22 at 12:33 PM, Surveyor shared the concern with Administrator (NHA-A), Director of Nursing (DON-B), Corporate Consultant (CC-I), Corporate Consultant (CC-H), and Administrator Assistant (AA-F) that there was no root/cause analysis completed for R25's fall on 11/22/22. Surveyor asked what does colored Dycem mean? DON-B stated that the Dycem to R25's chair should be a different color other than the color of the wheelchair. Surveyor informed NHA-A, DON-B, CC-I, CC-H, and AA-F that R25 had the same color Dycem as the wheelchair. NHA-A, DON-B, CC-I, CC-H, and AA-F understand the concerns in regards to R25's fall on 11/22/22 with no root/cause analysis completed and R25 did not have colored Dycem as documented as the intervention for R25's 11/28/22 fall. No further information was provided by the facility at this time.

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	525108	A. Building B. Wing	12/12/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45647 Based on interview and record review, the facility did not ensure 1 (R8) of 6 residents reviewed received appropriate treatment and services related to catheter care. *R8's medical record did not indicate what type/gauge catheter R8 had, did not include how often to change R8's catheter, and did not include a resident specific care plan. Findings include: The facility policy, entitled Orders for Indwelling Urinary Catheters and Catheter Care, with a revision date of 9/2017, states (in part) .: .Procedure .2. The physician's order for an indwelling catheter will be based on an appropriate medical justification, and will specify the type (Foley .), catheter size, and balloon capacity . R8 was admitted to the facility on [DATE] with diagnoses of muscle weakness, chronic pain, Diabetes Mellitus, and anemia. R8's Quarterly MDS (Minimum Data Set) assessment, dated 11/29/22, documents a BIMS (Brief Interview for Mental Status) score of 11, indicating R8 is moderately cognitively impaired for daily decision making. Section G (Functional Status) documents R8 requires extensive assistance of two plus person physical assist with bed mobility and transfer assistance. Section H (Bladder and Bowel) documents R8 has an indwelling catheter. R8 was admitted from the facility to the hospital on 10/20/22 and readmitted to the facility on [DATE] with a catheter in place. R8's care plan, initiated 11/8/2022, documents R8 has an indwelling catheter upon readmission. The interventions section documents, The resident has (SPECIFY: Condom/Intermittent/ Indwelling/Suprapubic) Catheter:, CATHETER: change per month and prn (as needed), CATHETER: last changed: (SPECIFY Date). Change catheter (FREQ). (SPECIFY (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Size) (SPECIFY Type), CATHETER: The resident has indwelling catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door, CATHETER: The resident has (SPECIFY Size) (SPECIFY Type of Catheter), Position catheter bag and tubing below the level of the bladder and away from entrance room door, Check tubing for kinks each shift, Check tubing for kinks [# TIMES] each shift, Monitor and document intake and output as per facility policy, Monitor/document for pain/discomfort due to catheter, Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Surveyor noted R8's care plan did not specify the type of catheter R8 had and the size of R8's catheter. R8's physician's progress note, dated 11/22/22, documented to continue Foley catheter for another 3 months until next urology follow-up. Change Foley catheter monthly or as needed. Surveyor reviewed R8's physician's orders and was unable to locate a physician order for R8's catheter to be changed monthly or as needed. On 12/08/22 at 08:38 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-P. LPN-P reported that it is documented in the physician's orders when a resident needs their catheter changed and would include the size and type. LPN-P reported catheter care is also documented in physician's orders. On 12/08/22 at 08:40 AM, Surveyor interviewed LPN-K. LPN-K reported catheter changes would be in the physician's orders for the resident. LPN-K reported that the order would include how often and the size to use to change the catheter. LPN-K reported there should also be an as needed order in physician's orders incase the resident's catheter would need to be changed. On 12/08/22 at 10:44 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B reported that catheter changes for residents should be kept in the physician's orders. DON-B reported that some residents have monthly catheter changes and some have as needed orders, but all that information would be kept in the physician's orders for the resident. Surveyor shared concerns regarding R8's physician's orders not including how often the resident's catheter should be changed, including an as needed order, as well as R8's care plan not being resident specific and filled out including the size/type of catheter R8 has. On 12/08/22 at approximately 2:30 PM, Surveyor reviewed R8's physician's orders, with a start date of 12/8/2022, which documented to document Foley catheter output every shift, Foley Catheter Size _16_Fr (French) with _10_cc (cubic centimeter) balloon, Secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction, Change Foley Catheter when occluded or unable to flow freely as needed for Maintain Patency, Change Catheter Bag as needed, Foley catheter care every shift and as needed every shift for urinary retention AND as needed. Surveyor noted this was after Surveyor started asking questions regarding R8's catheter. On 12/08/22 at 03:11 PM, Surveyor shared concerns regarding R8's physician's orders not including how often the resident's catheter should be changed, including an as needed order, as well as R8's care plan not being resident specific and filled out including the size/type of catheter R8 has with Nursing Home Administrator (NHA)-A, DON-B, Corporate Consultant-H, and Corporate Consultant-I. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided.