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	04/19/2023

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on observation, interviews, and record review, the facility failed to protect the resident's right (R9's right) to be free from sexual abuse by R10 of 6 sampled residents reviewed. On 3/5/23 R10 was observed in R9's room, while R9 was sleeping and partially disrobed. R10 was observed to be standing next to R9's bed and watching her sleep. Licensed Practical Nurse (LPN) K wrote a nurses note of her observation and reported her concerns that R10 should not be in R9 room and questioned why was R10 watching R9 sleeping. LPN K told LPN J her concerns and LPN J, who was also concerned with R10's behavior, told LPN K to report it to the supervisor. LPN K reported this concern to RN Supervisor I. Certified Nursing Assistant (CNA) N, who also observed R10 in R9's room while R9 was sleeping was concerned with R10's behavior. RN Supervisor I stated she didn't find the behavior unusual and stated she couldn't prevent R10 from walking around the facility, RN Supervisor I did not report this incident to administration. The facility did not investigate this further to determine why R10 was on the second floor of the facility and in R9's room while R9 was sleeping. R10 resides on the 1st floor of the facility. On 3/26/23 R10 was observed to be sucking on R9's breast, in the activity room. The facility separated the residents and placed R10 on 15-minute checks. The facility investigation revealed R9 expressed she did not like R10's sexual behavior and did not want it to occur again. The facility investigation also revealed the police were not called until 3/27/23. The facility's failure to investigate the 3/5/23 incident to understand what happened on 3/5/23 when 3 staff expressed concern about the incident lead to a failure to potentially safeguard R9 and assess possible need for increased supervision of R10. The facility did not further assess to determine why R10 was in R9's room while she was sleeping and partially undressed. During the Survey, facility administration insisted R9 and R10 were friends and nothing unusual happed on 3/5/23 despite the facility not completing a thorough investigation or a root cause analysis into the incident. The facility did not further assess R9 or R10 following the 3/5/23 incident to determine their ability to consent or understand relationships or sexual relations despite the facility insisting they were friends. The facility did not keep R9 safe from sexual abuse on 3/26/23 when R10 engaged in sucking on R9's breast in the activity room. This created a finding of immediate jeopardy that began on 3/26/23. Surveyor notified NHA (nursing home administrator) A of the immediate jeopardy on 4/12/23 at 11:45 p.m. The immediate jeopardy was removed on 4/14/23. However, the deficient practice continues at a scope/severity of (scope/severity) E (potential for harm/pattern) as the facility continues to implement its action plan. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: The facility's policy Protection of Residents during Abuse Investigations dated September 2022 indicates: Sexual Abuse 1. Sexual abuse is non-consensual sexual conduct of any type with a resident. Sexual abuse includes, but is not limited to: a. Unwanted intimate touching of any kind especially of breasts or perineal area; b. All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; c. Forced observation of masturbation and/or pornography; and d. Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident. 2. Generally, sexual contact is nonconsensual if: a. The resident appears to want the contact to occur, but lacks the cognitive ability to consent; b. The resident does not want the contact to occur; c. The resident is sedated, is temporarily unconscious, or is in a coma; or d. Consent is obtained through intimidation, coercion or fear, whether it is expressed by the resident or suspected by staff. 3. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. 4. Residents have the right to engage in consensual sexual activity. However, anytime there is a reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility will take steps to ensure that the resident is protected from abuse, including evaluation whether the resident has the capacity to consent to sexual activity. R9 was admitted to the facility on [DATE] with diagnoses of bipolar, CVA (cerebral vascular accident) dysphagia, aphasia and type 2 diabetes. R9 has a legal guardian appointed. R9's quarterly MDS (minimum data set) dated 2/22/23 indicate a BIMS (brief interview for mental status) score of 10, which indicates moderate cognitive impairment. It also indicates R9 needs extensive assistance with bed mobility, dressing and hygiene. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R10 was admitted to the facility on [DATE] with diagnoses of incomplete quadriplegia, type 2 diabetes and alcohol abuse. R10 was his own decision maker. R10's significant change MDS dated [DATE] indicate R10 has a BIMS score of 15, which indicates R10 is cognitively intact. It also indicates R10 needed limited assistance with walking and bed mobility and needed supervision with dressing and hygiene. On 4/10/23, at 9:12 a.m., Surveyor observed R9 in her room dressed and in her Broda chair. R9 was not receptive to Surveyor attempts to speak to R9 and Surveyor was unable to understand R9. Surveyor observed on 4/10/23, R9's room is located down a long hallway and around the corner. R9's room is across from the activity/dining room for the 2nd floor. R9 resides in a room without a roommate. R10 resides on the first floor. Review of a nurse's note dated 3/5/23, 14:50 (2:50 PM) indicates R10 was observed, in R9's room, standing with his walker next to R9's bed, while R9 was sleeping in bed. The nurse's note indicates R9 had a sheet over her with gown partly off due to BM (bowel movement) being present on gown and R9 had a brief on. The note continues to indicate that R10 was told to leave the room and that R10 should not be in R9's room. R10 apologized and left the room. The nurses note indicates the supervisor was made aware. The nurse's note dated 3/26/23 indicates CNA H observed R9 and R10 in the dining room. CNA H indicated he observed R9 with her shirt up and R10 sucking on R9's breast. Surveyor reviewed the facility investigation into this sexual incident. The facility investigation dated 3/26/23 indicates on Sunday, March 26th, after the activity (word list) was completed in the [NAME] activity room on the 2nd floor (CNA H) during his rounds around 2:45 pm, found R9 and R10 in the [NAME] activity room on the second floor. CNA H stated as he walked in (R9's 2nd floor room), R9 was not in her room. CNA H began to look for R9 and later found her in the activity room on the second floor with R10. CNA H stated he saw R9 holding up her shirt and R10 was being inappropriate with R9, precisely sucking her breast. R9 saw CNA H and CNA H indicated R9 was smiling; CNA H stopped them and notified the nurse. The investigation indicates R9 and R10 were separated and R9 was moved to her room. The investigation indicates no other residents were in the activity room at the time. The investigation indicates R10 was placed on 15-minute checks immediately after the incident. The investigation indicates the police were not immediately called but were called the following day on 3/27/23. (Cross-reference F609). The medical record indicates R10 was taken by the police on 3/27/23 and released from jail on 3/31/23. The medical record indicates R10 was not allowed back to the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility conducted skin checks on all non interviewable residents and other residents were interviewed to determine if anyone else was harmed. Medical Director M was in the facility, on 3/26/23, at the time of the incident. Medical Director M's progress note dated 3/26/23 indicates she evaluated R9 shortly after the incident with R10. Medical Director M's note indicates R9 stated R10 was sucking on her breast and denies R10 touched any other part of her body. The note indicates R9 told Medical Director M that R9 did not like or want it and admits R9 did not ask R10 to stop. R9 stated she did not want it to occur again and did not want to see R10 again. The note indicates R9 denies feeling unsafe or afraid but did admit to feeling anxious, but it is unclear if R9 was anxious about the situation or the questions/conversations. R9 also indicated this had not happened prior. Medical Director M's examination revealed no bruising or physical trauma noted. Medical Director M's note also indicates R9 was able to recall the events consistently, but it is unclear at this time if she can consent to sexual activities as she may not fully comprehend the consequences of her actions. Interview with R10 indicates R10 denied sucking R9's breast and was just helping her pull her shirt down. On 4/11/23, at 10:45 a.m., Surveyor interviewed Social Service Director (SSD) L. Surveyor asked SSD L if an assessment was completed for R9 and/or R10 regarding their ability to consent to a sexual relationship prior to the 3/26/23 incident. SSD L stated an assessment for consent was not completed. SSD L stated she completed a BIMS on R9 after the 3/26/23 incident and R9 scored 13 (cognitively intact). SSD L stated not everyone knows how to communicate with R9 and they need to take their time when communicating with R9. SSD L stated she communicated with R9 after the incident and R9 indicated she was fine and had no trauma as a result of the 3/26/23 incident. The facility completed interviews with staff regarding R10's behavior. CNA N's statement dated 3/29/23 indicates: Question: Did you ever see resident go into anyone's room? CNA N answer: Caught him 2 weekends ago standing over (R9) on AM shift and she was sleeping. He didn't touch her just looking at her. Told (LPN K). After that next day (R10) came back up there and (CNA N) told him to go back downstairs. When aide addressed him, he (R10) acted like he couldn't speak English and went back downstairs. After that saw him in the hallway but not in anyone's room. Question: Have you ever heard of the resident talking or being inappropriate with staff or residents? CNA N answer: No Question: Do you have any concerns with this resident? CNA N answer: Absolutely Resident (R10) shouldn't be upstairs and he shouldn't be up there with her (R9) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/11/23, at 12:30 p.m., Surveyor interviewed CNA N regarding his 3/29/23 statement. Surveyor asked CNA N if he was concerned when he found R10 standing over R9's bed. CNA N stated he was concerned because R9 was sleeping and often disrobes/undresses so R10 had no business in R9's room. CNA N stated even after being caught standing over R9 while she was sleeping, R10 would sneak upstairs. Surveyor asked CNA N if R10 had friends upstairs. CNA N stated R10 did not have any friends but would sometimes hang out with a male resident from the 2nd floor. The male resident resided on the other side of the building far from R9's room. CNA N stated there was no reason for R10 to be near R9. Surveyor asked CNA N if he told anyone about his observation of R10 and CNA N stated he told LPN K. The facility did not obtain an interview with LPN K regarding R10's behavior. On 4/11/23, at 12:45 p.m., Surveyor interviewed LPN K. Surveyor asked LPN K if she remembers the incident where CNA N told her that R10 was observed standing over R9 while she was in bed. LPN K stated she doesn't remember CNA N speaking to her but remembers around March 5th, LPN K's own observation of R10 standing over R9 while she was in bed sleeping. LPN K stated R10 usually was found eating lunch on the 2nd floor dining room or just hanging out in the dining room. LPN K stated she didn't think anything of R10 being upstairs on occasion until she observed him in R9's room. LPN K stated when she observed him in R9's room she told R10 he needed to leave the room and that he shouldn't be in R9's room. LPN K stated after finding R10 in R9's room she kept a closer eye on R10 if he was on the 2nd floor. LPN K stated this incident created a red flag regarding R10's behavior. LPN K stated she told RN Supervisor I of her concerns immediately. The facility obtained LPN J's statement on 3/30/23 regarding R10's behavior Question: Did you ever see resident go into anyone's room? LPN J answer: Yes .knew from (name of staff LPN K), then I started watching him closer. Stays in dining room north hall Question: Have you ever heard of the resident talking or being inappropriate with staff or residents? LPN J answer: No Question: Do you have any concerns with this resident? Yes, he spent extended time down that hallway. I assumed everyone knew what was going on.It's creepy to me because why does he keep going down there especially with her (R9) taking off her clothes coming in the hallway like she does all the time. On 4/11/23 at 2:15 p.m. Surveyor interviewed LPN J. LPN J stated LPN K told her that she found R10 in R9's room just standing over R9 while she was sleeping. LPN J stated she told LPN K that she needs to report that to the supervisor. LPN J stated she works on the other hall (hall opposite R9's hallway) but when she heard about R10 being in R9's room, she paid more attention to him. LPN J stated R9 isn't in her right mind and is known to masturbate and disrobe so R10 doesn't need to be down the hallway R9 resides. The facility interviewed RN Supervisor I on 3/29/23 regarding R10's behavior (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Question: Did you ever see resident go into anyone's room? RN Supervisor I answer: No Question: Have you ever heard of the resident talking or being inappropriate with staff or residents? RN Supervisor I answer: No Question: Do you have any concerns with this resident? RN Supervisor I answer: No On 4/12/23, at 8:10 a.m. Surveyor interviewed RN Supervisor I. Surveyor asked RN Supervisor I if she remembers the sexual incident with R9 and R10 on 3/26/23. RN Supervisor I stated she didn't hear about this incident. Surveyor asked RN Supervisor I does she remember LPN K telling RN Supervisor I her concerns regarding observing R10 standing beside R9's bed while R9 was sleeping. RN Supervisor I stated she remembers that conversation. RN Supervisor I stated she felt it was harmless and felt LPN K just didn't want R10 up on the 2nd floor. RN Supervisor I stated R10 walks all over the facility and had no concerns with R10. Surveyor reviewed R10's care plan and it does not indicate any increase supervision after the 3/5/23 observation. The facility does not have any investigation or root cause analysis related to the 3/5/23 observations of R10 in R9's room. Surveyor reviewed R9's care plan and it does not indicate R9 tends to disrobe/remove clothes and masturbates. The care plan does not indicate any privacy or safety measures have been put in place because R9 disrobes and masturbates. On 4/11/23, at 2:30 p.m. during the daily exit meeting with Director of Nursing (DON) B, Nursing Home Administrator (NHA) A and VP of Operations D, Surveyor explained the concern that on 3/5/23 R10 was observed in R9's room and the three staff involved (CNA N, LPN K and LPN J) were concerned about R10's behavior. There is no evidence this incident was investigated, there was no facility self-report and there was no increase in supervision for R10, in turn R10 was able to roam the 2nd floor and sexually assault R9 on 3/26/23. Surveyor also explained the concern the police were not called immediately, and this self-report was not reported to the state agency within 2 hours of the discovery. Surveyor also explained there is no evidence R9 and R10 had an assessment regarding the ability to consent to a sexual relationship. R9 did not have a trauma history assessment performed prior to the incident or after the incident. (Cross-reference F745). VP of Operations D stated in their opinion R9 and R10 were friends and so an assessment to consent to a sexual relationship was not needed. Surveyor asked for evidence of this friendship. Surveyor explained the interviews conducted with staff indicate there was no friendship between R9 and R10. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	VP of Operations D indicated R9 was seen smiling during the incident, implying it was consensual. Surveyor explained R9 told Medical Director M that she did not like or want the interaction with R10 and did not want to see R10 again. VP of Operations D continued to indicate R10 was just a friendly guy and had many friends including R9 without providing or sharing any evidence of these friendships. VP of Operations D indicated she didn't feel the 3/26/23 incident was abuse because R9 had a smile on her face when found and VP of Operations D stated R9 didn't say no despite having no knowledge of what led up to R10 engaging a sexual event with R9. VP of Operations D stated that no staff indicated through interviews that they were concerned with R10's behavior on 3/5/23 when R10 was found in R9's room. Surveyor explained the facility interviews indicate LPN J and CNA N had concerns with R10's behavior when interviewed by the facility and no follow up/investigation into the documented concerns was noted. Surveyor also explained LPN K was not interviewed by the facility but indicated when interviewed by Surveyor she was concerned by R10's behavior and even wrote a nurses note indicating her concern. VP of Operations D continued to reiterate R9 and R10 were friends and it was not strange for R10 to be standing beside R9, while R9 was in bed sleeping. VP of Operations D indicated R10 probably was checking R9 to see if she was awake. VP of Operations D reiterated she did not feel any of this was abuse. Surveyor reviewed the police report dated 3/27/23. The police report indicates on 3/27/23, the police officer attempted to speak with R9. It indicates R9 was unable to communicate with me and was only able to making (sic) grunting noises. The police report indicates they spoke with R10. R10 told the police he did not have any specific friends or people that he's met in the past 10 months he was at the facility. R10 told the police he likes to go to the activities room upstairs to play games. The police report indicates R9 was initially reported to be nonverbal and non-communicative due to a stroke she previously suffered. She is also diagnosed with bipolar disorder, altered mental status and disruptive mood dysregulation disorder. Due to (R9's) medical and mental health conditions, it was believed she was in a position where she could not give consent for sexual contact. The police report indicates R10 admitted he does not know R9 well and only knows her from attending several activities together. Activities sometimes happen four days a week, but R9 does not attend them all. R10 admitted he does see R9 on a weekly basis and sometimes more than once a week. The statement from R10 to the police officer indicated R10 stated he knows (R9) as she goes to activities a lot and her room is next to activities. (R10) stated he believed her name is (R9's name). R10 was asked if he has ever talked to her before and he responded she cannot talk. R10 stated he was just in the room and wasn't doing anything else. The report continues to indicate: Police Officer V asked (R10) if something took place between him and the female that would make people think that something happened between him and the (R9) and he responded no. R10 stated they were just talking and that sometimes she sits next to him but she cannot talk and sits in a wheelchair. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The detective's (Detective W's) narrative on 3/27/23 indicates (Detective W) asked (R10) if ever (sic) has any conversations with (R9). (R10) replied, she cannot talk and that someone needs to push her in her wheelchair. (Detective W) asked him if she (R9) can read or write, and he stated he did not know. (R10) has never had or attempted to have a conversation with (R9). (R10) then told me (R9) can talk but real slow. (R10) again confirmed that he has never talked with (R9). An interview on 3/27/23, at 1640 (4:40 PM) hours indicates (R10) stated he was in the room with a lady in a wheelchair (R9) and a guy named (name of guy) came in the room. R10 then said oh, okay. Bye (name of R9) and that he gave her a kiss on her cheek. (R10) claimed that was all that happened. (R9) is another resident (at the name of the facility) and R10 admitted this interaction took place in the activity room. After the activity residents attended was over, (R10) and (R9) stayed in the room and listened to the radio. (Detective W) asked who (the name of the other resident was named by R10), and he stated he was in the room with them, left to go to his room and then came back to the activity room. Surveyor noted there is no indication in the facility's investigation that they asked how R9 and R10 came to be in the activity room without supervision and when staff last saw the residents. Surveyor noted the facility investigation did not include details to determine if other residents were present or witness etc. The Detective W's interview continues indicating R10 was told an employee was accusing R9 of having her shirt up. (R10) stated she always have (sic) like this and lifted his shirt up to expose his belly. The report indicates R10 was told that an employee observed (R10's) mouth on (R9's) breast. (R10) stated the employee was lying and he has never had sexual contact with (R9). (R10) was asked if he knew that having sexual contact with (R9) would be wrong. (R10) stated Yeah. The detective goes on to tell R10 that she cannot communicate or consent and that she is confined to a wheelchair, (R10) agreed and that she does not have much mobility movement (sic). (R10) again denied kissing or placing his mouth on (R9's) breast and stated another resident named (name of resident) was there with them. (R10) believed (the name of other resident) may have observed him kissing (R9's) cheek. (R10) also claimed it was the first time he had kissed (R9) goodbye. The detective's (Detective W) note dated 3/27/23, at 5:30 p.m. indicates there was an interview with CNA H. It indicates CNA H confirmed he actually saw R10's mouth on R9's breast. CNA H stated when he walked in the room, he thought R10 would immediately stop but R10 did not remove his mouth from R9's breast until CNA H called out and confronted him. CNA H indicated there were no other residents in the room at the time. CNA H informed the detective R9 is able to communicate with someone she is comfortable with and R9 told CNA H that it was R10's idea to kiss R9's breast. The detective note indicates CNA H assisted the detective with R9 when answering the detective's questions. The note indicates with assistance of CNA H, R9 indicated she did not consent to having R10 touching her. R9 also indicated that this was not the first time R10 touched her. R9 again indicated she did not consent to R10 touching her. All of R9's responses were her shaking her head no and responded with saying no to the Detective W's questions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The failure to supervise R10, who had a history of being in R9's room, without R9 being aware R10 was in her room and subsequently on 3/26/23 R10 was observed to be sexually assaulting R9, created a finding of immediate jeopardy. The facility removed the jeopardy on 4/14/23 when it had completed the following: The facility initiated education on the facility's abuse policy and procedure including protecting residents during an investigation. Staff will be tested prior to staring their next shift. Residents with a BIMS score of 8 or above were interviewed. No allegations of abuse were received from residents. Skin evaluations were also completed on all residents with BIMS score of less than 8 with no negative findings. Social Service initiated a record review for all residents to ensure a Trauma informed care evaluation is completed and any triggers are appropriately care planned and added to nursing assistant kardex. Care plans will be updated as necessary. A sexuality screen will be completed on all current residents that are able to understand and able to answer the sexuality screening questions appropriately. Based on the outcome of the screening the facility will set up a care plan meeting with the resident's/participants guardian or other legal representative for health care decisions to discuss the resident's expression of sexuality along with the resident/participant. Residents who are incompetent or incapacitated or display diminished capacity to appraise personal conduct and also demonstrate an indicated need for additional sexuality screening based on factor including but not limited to resident interactions, relationship status, ongoing observations and history, the Social Worker/Designee will do an assessment of the residents/participants to consent to sexual activity using the guidelines in the facility Sexuality and Intimacy Policy. Once evaluations are completed a care plan will be developed for the staff to follow and kardex will be updated New admissions will have a trauma informed care evaluation completed by Social Services and a care plan will be initiated based on evaluation and kardex update. A sexuality screen will be completed on all new admissions that are able to understand and able to answer the sexuality screening questions appropriately. Based on the outcome of the screening the facility will set up a care plan meeting with the resident's/participants guardian or other legal representative for health care decisions to discuss the resident's expression of sexuality along with the resident/participant. New residents who are incompetent or incapacitated or display diminished capacity to appraise personal conduct and also demonstrate an indicated need for additional sexuality screening based on factor including but not limited to resident interactions, relationship status, ongoing observations and history, the Social Worker/Designee will do an assessment of the residents/participants to consent to sexual activity using the guidelines in the facility Sexuality and Intimacy Policy. Once the evaluation is completed a care plan will be developed for staff to follow and kardex will be updated. Assistant Administrator and DON were re-educated on the facility's Abuse Policy, including: abuse prevention; safeguarding the resident during a abuse investigation; reporting timeframes and requires under the Elder Justice Act; and timely reporting allegations to the appropriate agencies, including the state survey agency and local police. The Administrator was also educated on the procedure of notifying the [NAME] President of Operations and the Regional [NAME] President of Clinical Services with all allegations of Abuse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility staff will receive education on facility policy and procedure related to resident sexuality and intimacy to include any indicators that residents may be entering into a relationship and who and when to report any potential relationship to and when increased supervision may be needed to include a post test. A Performance Improvement Tool has been developed to monitor timely compliance of abuse reporting to state agencies and local law enforcement. The PI tool will be completed by the Director of Operations or the Regional [NAME] President of Clinical services with each state agency reportable to ensure timely notification of law enforcement and timely notification to state agencies for 3 months with results being forwarded to the QAPI committee for any further recommendations and/or resolution. A Performance Improvement Tool has been developed that will monitor compliance with Trauma Informed Care Evaluations for new admission, including care plan and Kardex updates. PI tool will be completed by the Administrator/Designee Monday through Friday with all new admissions for 30 days, then 2 times weekly for 30 days then monthly for 3 months to ensure Trauma informed evaluation, care plan and Kardex completed as necessary. Results will be forwarded to the QAPI for any further recommendations and/or resolution. A Performance Improvement Tool has been developed that will monitor compliance with newly admitted residents' ability to understand and consent to sexual activity. PI tool will be completed Monday through Friday by Administrator/Designee for 30 days, then 2 times weekly for 30 days then monthly for 3 months with results being forwarded to the QAPI committee for any further recommendations and/or resolution. A questionnaire has been developed and will be completed by 10 staff members to determine staff knowledge in regards to resident rights to have intimacy, identification of potential relationship, reporting of potential intimacy and increased supervision until capacity for intimacy has been determined, daily Monday through Friday for one month, then 2 times weekly for one month, then monthly for 3 months with results being forwarded to the QAPI committee for any further recommendations and/or resolution. New employees will receive resident sexuality and intimacy education upon hire.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 allegation of abuse involving R9 and R10 that was not reported timely to the police. Additionally, the facility did not ensure 3 of 5 resident reviewed with allegations of abuse had the investigations reported timely. This deficient practice has the potential to affect a pattern of residents residing in the facility as the facility did not take steps to report allegations of abuse. R9 had an allegation of sexual abuse and the police were not notified within 2 hours of the discovery of the allegation and the state agency was not notified of the allegation within 2 hours of the discovery. R4 had an allegation of abuse that their significant other hit R4 and the police were not notified. R5 had an allegation of abuse and it was not reported timely to the state agency. Findings include: Surveyor reviewed the facility's policy and procedure entitled: Freedom from Abuse and Neglect Policy, effective 10/30/19, which documents: .Training: 2. Each new employee will be informed of his/her responsibility to immediately report any violations or alleged violations to the (Nursing Home Administrator) NHA. Identification: 1. Staff will immediately report any suspicious event or injury that may constitute abuse, neglect, exploitation or misappropriation to the NHA. 2. The Resident will be immediately assessed and removed from any potential harm. 3. The facility will report the allegation to the State Survey agency in accordance with state law. Reporting and Response: 1. Allegations will be reported to the NHA immediately. 2. The facility will report all alleged violations and substantiated incidents to the State Agency and to all other agencies as required. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility and/or staff will report suspicion of a crime to local authorities and/or agencies as required. Reporting to Law Enforcement of crimes occurring in federally funded long-term care facilities If the events that cause suspicion and or result in serious bodily injury, the facility shall report the suspicion immediately, but no later than 2 hours after forming the suspicion. Surveyor reviewed the facility's policy and procedure entitled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised April 2021, which documented: Policy Interpretation and Implementation . Reporting Allegations to the NHA-A and Authorities 1. If Resident abuse, exploitation, misappropriation of Resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the NHA and to other officials according to state law. 2. The NHA immediately reports to: a. The state licensing/certification agency responsible for surveying/licensing the facility b. Local/state ombudsman c. Resident's representative d. Adult Protective Services e. Law enforcement officials f. Resident's attending physician g. Medical Director 3. Immediately is defined as: a. Within 2 hours of an allegation involving abuse or result in serious bodily injury. 1.) R9 was admitted to the facility on [DATE] with diagnoses of bipolar, CVA (cerebral vascular accident) dysphagia, aphasia and type 2 diabetes. R9 has a legal guardian in place. R9 quarterly MDS (minimum data set) dated 2/22/23 indicate the BIMS (behavior interview for mental status) score of 10, which indicates moderate cognitive impairment. It also indicates R9 needs extensive assistance with bed mobility, dressing and hygiene. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R10 was admitted to the facility on [DATE] with diagnoses of incomplete quadriplegia, type 2 diabetes and alcohol abuse. R10 was his own decision maker. R10 significant change MDS dated [DATE] indicate R10 BIMS score of 15, which indicates cognitively intact. It also indicates R10 needed limited assistance with walking and bed mobility and needed supervision with dressing and hygiene. The facility self reported an allegation R10 was observed sucking on R9 breast, while in the activity room. The facility investigation indicate the residents were separated and the Director of Nursing (DON) B was made aware. R10 was placed on 15 minute checks. The facility investigation indicates the police were not called until 3/27/23. On 3/27/23 the police took R10 to the police station. The facility investigation indicates the state agency were not notified of this allegation within 2 hours of the discovery of this allegation. The investigation indicate Nursing Home Administrator (NHA) A was reeducated on the need to notify the police within 2 hours of a discovery of abuse. On 4/11/23 at 2:30 p.m. during the daily exit meeting with DON B, NHA A and VP of Operations D. Surveyor explained the concern the police were not called immediately and this self report was not reported to the state agency within 2 hours of the discovery. VP of Operations D stated she did not consider this abuse and R9 and R10 were friends. (Cross-reference F600). 42037 2.) R4 was admitted to the facility on [DATE]. R4 is no longer residing at the facility and was not available for interview. Surveyor reviewed a facility self report dated 1/11/23 which was submitted by facility's previous NHA (Nursing Home Administrator). Facility self report indicates that a male visitor of R4 was witnessed by another resident on an unknown date allegedly slap R4 on the head. The facility immediately initiated an investigation related to the allegation of a male visitor slapping R4 on the head. Surveyor did not note any documentation of the facility reporting the alleged abuse of R4 by a male visitor to law enforcement. On 4/12/23 at 8:35 AM, Surveyor conducted interview with Social Service Director-L. Surveyor asked Social Service Director-L if there is allegations of a resident being physically abused if law enforcement should be notified. Social Service Director-L told Surveyor that R4 and her male visitor would play fight and that they wouldn't consider it something to report to law enforcement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/12/23 at 11:10 AM, Surveyor conducted interview with VP of Operations-D. Surveyor inquired as to why the facility did not notify law enforcement when they became aware of the alleged physical abuse towards R4. VP of Operations-D responded that they do not understand why the facility's previous NHA did not report the allegation of abuse towards R4 by a male visitor to law enforcement immediately as it should have been. Surveyor shared concerns that the allegation of abuse towards R4 on 1/11/23 should have been reported to law enforcement immediately. No additional information was provided by the facility at this time. 46517 3.) R5 is a long-term resident at the facility originally admitted on [DATE] and has diagnoses including acute respiratory failure with ventilator dependency and cerebral infarction. R5's most recent Minimum Data Set Assessment documented R5 had a Brief Interview for Mental Status score of 15 indicating R5 is cognitively intact. On 01/06/2023, R5 reported an allegation of abuse to a facility therapist. R5 alleged sometime during the night of 01/05/23-01/06/23, Certified Nursing Assistant (CNA) U was rough during cares, used bleach wipes on R5's body, told R5 to shut up, and when R5 asked CNA-U to leave their room, CNA-U refused and continued doing cares. The facility was made aware of this allegation on 01/06/23, however, the facility did not submit an initial abuse report until 01/10/2023. The facility started an investigation on 01/06/23 and did submit a completed investigation within the required timeframe. Surveyor reviewed the facility's copy of the self-report and noted staff interviews, resident interviews, and resident skin checks. Surveyor noted the Nursing Home Administrator listed as the individual who filed the self-report is no longer employed at the facility. Surveyor also noted the facility's Director of Nursing at the time of the alleged incident is no longer with the facility. On 04/10/23 at 1:55 PM, Surveyor interviewed [NAME] President of Operations (VPO) -D and Assistant Administrator (AA)-T. VPO-D informed Surveyor she remembered R5 reported the allegation to a therapist the morning of 01/06/23 and the therapist reported it the Director of Nursing. Per VPO-D, the administrator was off that day, which was a Friday, and from what she, VPO-D, could remember the Director of Nursing did not feel the allegation was abuse and did not report it. Both VPO-D and AA-T informed Surveyor they did not have enough evidence to substantiate R5's allegations. AA-T informed Surveyor at the time R5 made the allegation, the therapist confirmed there were bleach wipes in R5's room. Per AA-T, the therapist and CNA-U had a confrontation regarding the bleach wipes. Surveyor expressed the concern the facility was aware of the alleged incident on 01/06/23 but did not report it to the State agency until 01/10/23. On 04/10/23 at 3:00 PM, during the end of the day meeting with Nursing Home Administrator-A, Director of Nursing-B, VPO-D and AA-T Surveyor expressed the concern the facility reported the allegation of abuse late. No additional information was given.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not ensure 1 (R9) of 5 investigations into allegations of abuse had a thorough investigation. The nurses note dated 3/5/23 indicate R10 was observed in R9's room, standing by R9/'s bed and watching her sleep. The nurses note indicate a supervisor was made aware and R10 was told he was not to be in R9's room. RN Supervisor I did not report this concern Licensed Practical Nurse (LPN) K voiced to her regarding R10's behavior. An investigation into the 3/5/23 incident was not completed. Findings include: Surveyor reviewed the facility's policy and procedure entitled: Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, revised April 2021, which documents: .Investigating Allegations 1. All allegations are thoroughly investigated. The Administrator initiates investigations. 3. The Administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. 4. The Administrator is responsible for keeping the Resident and his/her representative informed of the progress of the investigation. 7. The individual conducting the investigation as a minimum: a. Reviews the documentation and evidence e. Interviews any witnesses to the incident f. Interviews the Resident j. Interviews other Residents k. Reviews all events leading up to the alleged incident l. Documents the investigation completely and thoroughly 8. The following guidelines are used when conducting interviews: . d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement or the investigator may obtain a statement. 9. The investigator notifies the ombudsman that an abuse investigation is being conducted. The ombudsman is invited to participate in the review process. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the Administrator. Surveyor reviewed the facility's policy and procedure entitled: Freedom from Abuse and Neglect Policy, effective 10/30/19, which documents: .Investigation: 1. The facility will conduct an internal investigation and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within 5 working days of the incident or according to state law. 2. The facility will thoroughly investigate all alleged violations and take appropriate actions. 3. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions. The investigation will include, but is not limited to the following: . e. Interviews and or written statements from individuals with first hand knowledge of the incident. h. All material and documentation of the pertinent data to the investigation is collected, maintained, and safeguarded by the facility. R9 was admitted to the facility on [DATE] with diagnoses of bipolar, CVA (cerebral vascular accident) dysphagia, aphasia and type 2 diabetes. R9 has a legal guardian in place. R9's quarterly MDS (minimum data set) dated 2/22/23 indicate the BIMS (behavior interview for mental status) score of 10, which indicates moderate cognitive impairment. It also indicates R9 needs extensive assistance with bed mobility, dressing and hygiene. R10 was admitted to the facility on [DATE] with diagnoses of incomplete quadriplegia, type 2 diabetes and alcohol abuse. R10 was his own decision maker. R10's significant change MDS dated [DATE] indicate R10 BIMS score of 15, which indicates cognitively intact. It also indicates R10 needed limited assistance with walking and bed mobility and needed supervision with dressing and hygiene. The nurses note date 3/5/23 indicate R10 was observed, in R9's room, standing with his walker next to R9's bed, while R9 was sleeping in bed. The nurses note indicates R9 had a sheet over her with gown partly off due to BM (bowel movement) being present on gown and R9 had a brief on. The note continues to indicate that R10 was told to leave the room and that R10 should not be in R9's room. R10 apologized and left the room. The nurses note indicates the supervisor was made aware. On 3/26/23 the facility observed R10 alone with R9 and R10 was sucking on R9 breast. The facility separated the residents and conducted an investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	While investigating the 3/26/23 sexual incident, the facility interviewed staff and Certified Nursing Assistant (CNA) N and LPN J indicated in their statement they observed R10 in R9 room while R9 was sleeping. LPN J statement indicate she thought it was creepy that R10 was in R9 room. On 4/11/23 at 12:30 p.m. Surveyor interviewed CNA N regarding his 3/29/23 statement. Surveyor asked CNA N if he was concerned when he found R10 standing over R9's bed. CNA N stated he was concerned because R9 was sleeping and often disrobes/undress so R10 had no business in R9 room. CNA N stated even after being caught standing over R9 while she was sleeping, R10 would sneak upstairs. Surveyor asked CNA N if R10 had friends upstairs. CNA N stated R10 did not have any friends but would sometimes hang out with a male resident from the 2nd floor. The male resident resided on the other side of the building far from R9 room. CNA N stated there was no reason for R10 to be near R9. Surveyor asked CNA N if he told anyone about his observation of R10 and CNA A stated he told LPN K. On 4/11/23 at 2:15 p.m. Surveyor interviewed LPN J. LPN J stated LPN K told her that she found R10 in R9 room just standing over R9 while she was sleeping. LPN J stated she told LPN K that she needs to report that to the supervisor. LPN J stated she works on the other hall (hall opposite R9 hallway) but when she heard about R10 being in R9's room, she paid more attention to him. LPN J stated R9 isn't in her right mind and is known to masturbate and disrobe so R10 doesn't need to be down the hallway R9 resides. On 4/11/23 at 12:45 p.m. Surveyor interviewed LPN K. Surveyor asked LPN K if she remembers the incident where CNA N told her that R10 was observed standing over R9 while she was in bed. LPN K stated she doesn't remember CNA N speaking to her but remembers around March 5th, LPN K's own observation of R10 standing over R9 while she was in bed sleeping. LPN K stated R10 usually was found eating lunch on the 2nd floor dining/activity room or just hanging out in the dining/activity room. LPN K stated she didn't think anything of R10 being upstairs on occasion until she observed him in R9's room. LPN K stated when she observed him in R9's room she told R10 he needed to leave the room and that he shouldn't be in R9 room. LPN K stated after finding R10 in R9's room she kept a closer eye on R10 if he was on the 2nd floor. LPN K stated this incident created a red flag regarding R10 behavior. LPN K stated she told RN Supervisor I her concerns immediately. On 4/12/23 at 8:10 a.m. Surveyor interviewed RN Supervisor I. Surveyor asked RN Supervisor I if she remembers the sexual incident with R9 and R10 on 3/26/23. RN Supervisor I stated she didn't hear about this incident. Surveyor asked RN Supervisor I does she remember LPN K telling you her concerns regarding observing R10 standing beside R9's bed while R9 was sleeping. RN Supervisor I stated she remembers that conversation. RN Supervisor I stated she felt it was harmless and felt LPN K just didn't want R10 up on the 2nd floor. RN Supervisor I stated R10 walks all over the facility and had no concerns with R10. On 4/11/23 at 2:30 p.m. during the daily exit meeting with NHA A, DON B and VP of Operations D. Surveyor explained the concern LPN K wrote on 3/5/23 regarding R10 behavior. Surveyor explained the three staff interviewed all express concern regarding R10 behavior and calling it creepy and RN Supervisor I did not consider it unusual so she did not report this to administration. Surveyor explained an investigation into R10's behavior on 3/5/23 was not conducted. VP of Operations D stated the facility was not aware of the 3/5/23 incident until they started investigating the 3/26/23 allegation of sexual abuse. VP of Operations D indicate R10's behavior didn't seem unusual so an investigation was not needed. Surveyor explained three staff thought R10's behavior required more supervision and was unusual. Surveyor explained the concerns from the three staff should have been investigated.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not give proper discharge notice to 1 (R10) of 1 residents reviewed. On 3/26/23 R10 was arrested for an allegation of sexual assault. On 3/31/23 R10 was released from jail but the facility did not allow R10 to return to the facility. The facility did not ensure a safe discharged was completed and did not give R10 a 30 day notice for discharge. Findings include: R10 was admitted to the facility on [DATE] with diagnoses of incomplete quadriplegia, type 2 diabetes and alcohol abuse. R10 was his own decision maker. R10's significant change MDS dated [DATE] indicates R10's BIMS score of 15, which indicates cognitively intact. It also indicates R10 needed limited assistance with walking and bed mobility and needed supervision with dressing and hygiene. The nurses note indicate R10 was arrested on 3/27/23 because of an allegation of sexual assault. The social service note date 3/31/23 indicates R10's brother called the facility to let them know R10 was being released from jail on that day. The note indicates R10's brother was informed that R10 was not able to return to the facility due to requiring 1:1 and (facility) being unable to provide this level of staffing. The social service note dated 4/1/23 indicates R10's medications were called into a community pharmacy and R10's brother was notified of this and to pick up R10's belongings at the facility. There is no evidence R10 was given a 30 day discharge notice. On 4/11/23 at 2:30 p.m. during the daily exit meeting with Director of Nursing (DON) B, Nursing Home Administrator (NHA) A and VP of Operations D, Surveyor explained the concern R10 was not given a proper 30 day discharge notice. VP of Operations D stated they were unable to allow R10 to return because the facility has a policy of not admitting anyone convicted of sexual assault. Surveyor explained R10 was not convicted and the social service note indicated it was because the facility was unable to provide a 1:1 for R10. VP of Operations stated this is not correct and it was because he was arrested for an allegation of sexual assault. Surveyor explained R10 would have needed a 30 day written notice of discharge and that was not done. VP of Operations stated she knew that but the facility still could not allow R10 to return to the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, record review, and interview, the facility did not ensure residents were comprehensively assessed on readmission to receive treatment and care in accordance with professional standards of practice for 1 (R7) of 3 residents reviewed for alterations in skin integrity. R7 was readmitted to the facility on [DATE] with discharge orders from the hospital for wound care. Those orders were not transcribed and R7's readmission assessment was not completed until 3/21/2023. R7's skin was not comprehensively assessed until 3/24/2023, four days after readmission. R7 was readmitted to the facility on [DATE] and R7's skin was not comprehensively assessed until 4/6/2023. A treatment was not put in place until 4/6/2023 to the left posterior scalp Unstageable pressure injury. Findings include: The facility policy and procedure entitled Skin and Wound Care Management Program, undated, states: Procedure: Assessment . Admission: -Nursing will complete the Clinical Admission Documentation observation upon admission to assess the resident from head to toe to determine the resident's current skin condition. -Clinical observation upon admission or by the following shift. -Ulcers identified as pressure, arterial, vascular, or diabetic will be documented in Wound Management and all other wounds i.e. bruises, skin tears, lacerations, surgical wounds will be documented in a Non-Pressure Wound Observation. Weekly: -A licensed nurse performs a head to toe skin check of the resident and documents the findings on the Treatment Administration Record (TAR). The licensed nurse documents using the following (For the order template, see Admission Standing Orders in PCC) I=Skin Intact, N=Skin not Intact If N is documented, then a corresponding Wound Management entry or Non Pressure Wound Observation is initiated or available with wound information. -Weekly Wound Rounds are completed for residents with wounds. Rounds include wound assessment and measurements of wounds documented in Wound Management or Non Pressure Wound Observations as appropriate. R7 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia and ventilator-dependent with a tracheostomy, cerebral infarction, hemiplegia and hemiparesis to the left side, peripheral vascular disease, schizophrenia, epilepsy, heart failure, and dysphagia with a gastrostomy tube for all nutrition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's annual Minimum Data Set (MDS) assessment dated [DATE] indicated R7 was severely cognitively impaired per staff assessment and needed total assistance with all activities of daily living. R7 had a Guardian. On 3/8/2023 at 9:15 AM in the progress notes, nursing charted R7 was being transported via ambulance to an orthopedic appointment and the paramedics determined R7 had an elevated pulse and brought R7 to the emergency room . At 11:38 AM in the progress notes, nursing charted R7 was being admitted to the hospital for tachycardia and fluid on the lungs. On 3/20/2023 on the hospital Discharge Summary, the Nurse Practitioner (NP) documented R7 had a wound on the back appearing in a pattern as if R7 had been laying on an object causing a ruptured/healing blister to the upper aspect of the wound. Wound care was consulted, and frequent turns and pressure offloading were implemented. The Discharge Instructions on the Discharge Summary stated the following: Wound Care to Back Midline: 1. Cleanse wounds with Puracyn Plus, a hypochlorous acid solution, by spraying topically on the wound beds and allowing the solution to penetrate the wounds for approximately 3-5 minutes. Do not rinse. 2. Pat dry. 3. Apply 3M Cavilon barrier to peri-wound skin. 4. Apply Cuticerin or vaseline gauze over blisters in a thin strip. 5. Cover with Mepilex Border (we used a Sacral Mepilex cut in half the long way). 6. Assess wounds daily by peeling back Mepliex [sic] and change dressing every other day. Surveyor reviewed R7's Medication Administration Record (MAR) and Treatment Administration Record (TAR). No wound treatment orders were found for R7's back wound. On 3/20/2023 at 2:50 PM in the progress notes, respiratory therapy charted R7 was readmitted to the facility with no signs of respiratory distress. Respiratory therapy charted R7 was on 4 liters of oxygen bleed in with tracheostomy in place and secure. On 3/20/2023 at 6:41 PM in the progress notes, Registered Nurse (RN)-G charted R7 was readmitted in no acute distress and all orders were verified with the NP. On 3/20/2023 at 7:20 PM in the progress notes, nursing charted R7 arrived at the facility from the hospital at approximately 2:30 PM. Nursing charted R7 was tachycardic with a heart rate of 127 and the NP was informed. Nursing charted the elevated heart rate was the new baseline for R7. On 3/21/2023 at 7:46 AM in the progress notes, the NP put in a late entry for 3/20/2023 at 3:15 AM. (Surveyor noted the time stamp the NP wrote was prior to R7 returning to the facility.) The NP charted R7 was seen that day resting in bed, nonresponsive which was baseline. The NP charted R7 was tachycardic in the 120s and vital signs were stable and afebrile. The NP charted R7 was on baseline vent settings, the gastrostomy tube and indwelling urinary catheter were patent, and no other concerns were brought forward by nursing or respiratory therapy. On 3/21/2023 at 10:44 AM, a day after R7 was readmitted , on the Admission/Re-admission Nursing Evaluation form, nursing documented in each section R7's status. In the Skin Section of the form, nursing charted R7 had a Suspected Deep Tissue pressure injury to the right medial ankle, deroofed, a dried blister to the right heel, and an intact blister to the back. No measurements, characteristics, or etiologies of the wounds were documented. No other skin assessments were found. No documentation was found indicating the physician or NP were notified of the wounds and no treatments were ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/2023 at 9:43 AM in the progress notes, the physician put in a late entry for 3/21/2023 at 4:30 AM. The physician documented R7 was seen lying in bed on a ventilator, not responsive to questions or commands. The physician documented care was reviewed with the RN who stated R7 had been clinically stable over the last 24 hours. Surveyor noted the physician did not document any skin concerns or any conversation regarding skin concerns for R7. On 3/24/2023 at 4:27 AM, four days after readmission, on the Skin Only Evaluation form, RN-F charted R7 had a Suspected Deep Tissue pressure injury to the left index finger that measured 0.3 cm x 0.4 cm. The wound did not have any color description or etiology of how the pressure injury was obtained. RN-F charted R7 was seen by the wound care team for a weekly assessment. RN-F charted the left middle finger resolved and the left index finger improved by reabsorbing. Surveyor did not find any previous documentation of a wound to the left middle finger or the left index finger to determine the left middle finger wound had resolved or to determine the left index finger had improved. No documentation was found for the wounds on the right medial ankle, the right heel or the back that were noted on Admission/Re-admission Nursing Evaluation form on 3/21/2023. On 3/24/2023 at 8:15 AM in the progress notes, the physician documented R7 had a decline in the last 12-24 hours with the systolic blood pressure in the 80s with no improvement after Midodrine and had been hypothermic with temperature below 96 degrees consistently. The physician documented R7 remained tachycardic with increased edema. The physician documented there was a concern for sepsis and R7 was sent to the hospital to rule out sepsis. At 12:00 PM in the progress notes, nursing charted R7 was sent to the hospital via ambulance. On 4/5/2023 at 2:13 PM in the progress notes, nursing charted R7 was readmitted to the facility at 2:00 PM and was at baseline. Orders were verified with the NP. On 4/5/2023 at 3:46 PM on the Admission/Re-admission Nursing Evaluation form, nursing documented in each section R7's status. In the Skin Section of the form, nursing charted to see skin evaluation completed by floor nurse. Surveyor did not find any skin documentation on 4/5/2023. Surveyor requested from Nursing Home Administrator (NHA)-A on 4/12/2023 at 10:13 AM for any skin documentation on 4/5/2023 that was referenced in the Skin section of the Admission/Re-admission Nursing Evaluation Form; no documentation was provided. On 4/6/2023 on the Skin Only Evaluation form, RN-F documented the following wounds: -Left middle finger Suspected Deep Tissue pressure injury measuring 0.3 cm x 0.2 cm. -Left lateral foot Suspected Deep Tissue pressure injury measuring 1.2 cm x 2.5 cm. -Left posterior scalp Unstageable pressure injury measuring 1.1 cm x 0.7 cm x 0.1 cm with slough. RN-F charted the pressure injuries were all present on re-admission and a treatment to paint the left scalp wound with betadine twice daily was obtained. Surveyor noted the skin assessment was completed one day after R7 returned to the facility and the treatment to the left scalp wound was not initiated until 4/6/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/2023 at 9:40 AM, Surveyor went with RN-E to look at R7's skin. Surveyor observed R7 in bed on an air mattress with heel boots on. RN-E stated R7 had a vascular wound to the right shin that had a history of opening, healing, and then opening again. Surveyor noted the right shin had an area of discoloration from a previous wound but was healed with no open areas. RN-E rolled R7 onto the right side and Surveyor observed an area of dark discoloration to the mid upper back along the spine that measured approximately 5 cm x 2 cm. The area appeared to have been a wound at some point but was healed with no open areas. RN-E pushed on the area and the skin blanched. RN-E stated RN-E had never seen any wounds on R7's back. Surveyor asked RN-E if R7 had an open wound to the left scalp. RN-E stated RN-E was not aware of any wounds to the scalp. RN-E looked at R7's scalp and RN-E stated RN-E did not see any open areas. Surveyor observed a small area approximately 1 cm x 1 cm with a yellow wound base to the lower left scalp just behind the left ear. Surveyor shared with RN-E when R7 was readmitted on [DATE], the Admission/Re-admission Nursing Evaluation form was not completed until 3/21/2023. RN-E stated RN-E was not at the facility when R7 came back so was not sure how quickly the form was done. Surveyor asked RN-E when a resident is admitted or readmitted to the facility, when is an assessment expected to be completed. RN-E stated everything, like the skin assessment, should be completed on the resident in twelve hours. In an interview on 4/11/2023 at 11:38 AM, RN-F stated RN-F was the wound nurse for the facility and worked at the facility Monday through Friday completing all the daily wound treatments and assessing all wounds weekly. RN-F stated full wound rounds were completed by RN-F with the wound NP on Fridays. Surveyor asked RN-F who does the initial skin assessments on newly admitted or readmitted residents. RN-F stated the nurse on the floor should do the initial assessment and then RN-F sees the resident within 24 hours if it is during the week or within 72 hours if it is on the weekend. Surveyor clarified with RN-F that the nurse on the floor is expected to do the initial skin assessment with documentation of all wounds including measurements and wound descriptions. RN-F stated yes. Surveyor discussed R7's readmission on 3/20/2023 RN-F. RN-F stated R7 had two deep tissue injuries on the left fingers that looked like they were from having a pulse oximeter on when in the hospital. Surveyor shared with RN-F the Admission/Re-Admission Nursing Evaluation form documenting R7 had a deep tissue injury to the right medial ankle, a dried blister to the right heel, and an intact blister to the back. RN-F stated on 3/20/2023 R7 had a bandage on the back and did not know if the nurse who did the initial assessment peeled back the dressing or just went by what the hospital discharge paperwork said. RN-F stated R7 had a birthmark on the on the heel or ankle area and they followed it as a deep tissue injury until they realized it was a birthmark and not a deep tissue injury. RN-F stated the right heel had very dry skin so the nurse must have misinterpreted what they saw on the right heel. Surveyor asked RN-F if RN-F had observed R7's back. RN-F stated R7 did not have anything on the back and then stated R7 had a ring of dry skin with no open areas on the back. Surveyor shared with RN-F the documentation from the hospital Discharge Summary and the treatment order for the wound to the back. RN-F stated, These are generic standing orders. Surveyor noted the Discharge Summary treatment orders for R7's wound to the back were specific and individualized for R7's wound. RN-F stated R7's wound to the back could have happened when R7 was on the gurney in the hospital or ambulance and R7 was very edematous. RN-F was not aware of any treatment orders for the blister with open area to R7's back. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/12/2023 at 7:21 AM, RN-G stated RN-G was the PM and night shift supervisor and would help cover staff call-ins and assist nurses when there was a new admission or readmission. Surveyor asked RN-G where the orders are found for new admissions or readmissions. RN-G stated a discharge packet is sent with the resident from the hospital, or an after visit summary (AVS), and the nurse can see the medication list. RN-G stated the hospital wound care team would put in treatment orders or a wound consult and that would not usually be with the medication list but somewhere else in the discharge paperwork. Surveyor shared with RN-G that RN-G had written in R7's progress notes on 3/20/2023 that RN-G had verified the orders with the NP. Surveyor showed RN-G R7's Discharge Summary with the medication list. RN-G stated yes, that was where the nurse would find the medication orders that would be verified with the NP. Surveyor showed RN-G R7's Discharge Summary with the wound orders. RN-G stated RN-G did not recall seeing the wound orders for R7. Surveyor asked RN-G if RN-G had assessed R7's back wound. RN-G stated if RN-G had assessed it, RN-G would have charted the assessment. RN-G stated the skin assessment must have been done by the other RN. Surveyor shared with RN-G the concern R7 did not have a comprehensive skin assessment on 3/20/2023 when readmitted to the facility and the skin assessment that was documented on 3/21/2023 was not comprehensive with measurements, descriptors, or etiology of the wounds. RN-G stated RN-G would look to see if RN-G could find any more information. At 10:09 AM, RN-G met again with Surveyor and stated RN-G had been working a 12-hour shift on 3/20/2023 and there were four admissions/readmissions that day. RN-G stated RN-G verified R7's orders with the NP. RN-G stated R7 was not in acute distress so RN-G pushed R7's assessment to the next shift. RN-G did not remember seeing R7's wound treatment in the discharge paperwork. RN-G stated R7 was turned every two hours so if the dressing had drainage or an odor, the Certified Nursing Assistant (CNA) or nurse would have told RN-G. RN-G stated the orders must be verified and put into the computer charting system so the pharmacy can get the medications to the facility so that is the first priority. RN-G stated RN-G did that right away and then had the next shift nurse do the nursing assessment. Surveyor noted R7 had arrived at the facility on 3/20/2023 at 2:30 PM and did not have a nursing assessment until 3/21/2023 at 10:44 AM. On 4/12/2023 at 10:13 AM, Surveyor shared with NHA-A, Director of Nursing (DON)-B, and [NAME] President of Operations-D the concern with R7's skin assessments upon readmission to the facility. Surveyor shared the following concerns: R7 was readmitted to the facility on [DATE] at 2:30 PM with wound care orders from the hospital Discharge Summary for an open blister to the back that was not transcribed; the skin was not assessed until 3/21/2023 at 10:44 AM documenting a deep tissue pressure injury to the right medial ankle, a dried blister to the right heel, and an intact blister to the back with no measurements, descriptors, or etiology of the wounds; RN-F did a comprehensive assessment of the skin on 3/24/2023, four days after readmission, that described a deep tissue injury to the left middle finger that had resolved with no prior documentation of its existence and a deep tissue injury to the left index finger that was improving with no prior documentation of its existence; no follow up documentation of the skin impairments that were identified on 3/21/2023; R7 was readmitted to the facility on [DATE] and the nurse doing the readmission assessment documented to see the skin evaluation completed by the floor nurse and no documentation was found; RN-F did a comprehensive assessment of the skin on 4/6/2023, the day after readmission, documenting a deep tissue pressure injury to the left middle finger, a deep tissue pressure injury to the left lateral foot, and an Unstageable pressure injury to the left posterior scalp; the Unstageable pressure injury to the scalp did not have a percentage of the amount of slough in the wound base; the Unstageable pressure injury to the scalp did not have a treatment in place until 4/6/2023. DON-B stated they will look to see if there is any additional information to help fill in the blanks. No further information was provided at that time.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not ensure that 1 (R9) of 1 residents reviewed were provided medical related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. R9 has diagnoses of bipolar, CVA (cerebral vascular accident) aphasia and dysphagia. Through interviews R9 has a history of disrobing and masturbating in public area. The facility did not complete a trauma assessment or complete a care plan that indicates interventions to keep R9 safe while she disrobes and/or masturbates. Findings include: R9 was admitted to the facility on [DATE] with diagnoses of bipolar, CVA (cerebral vascular accident) dysphagia, aphasia and type 2 diabetes. R9 has a legal guardian in place. R9's quarterly MDS (minimum data set) dated 2/22/23 indicate the BIMS (behavior interview for mental status) score of 10, which indicates moderate cognitive impairment. It also indicates R9 needs extensive assistance with bed mobility, dressing and hygiene. On 3/26/23 Certified Nursing Assistant (CNA) H observed R9 and R10 in the activity room. CNA H observed R10 sucking on R9's breast. CNA H separated the residents and reported the incident to the nurse. On 3/26/23 R9 was assessed by Medical Director M. Medical Director M's note indicates R9 told Medical Director M that R9 did not like or want it and admits R9 did not ask R10 to stop. R9 stated she did not want it to occur again and did not want to see R10 again. The note indicates R9 denies feeling unsafe or afraid but did admit to feeling anxious but it is unclear if R9 was anxious about the situation or the questions/conversations. R9 also indicated this had not happened prior. Medical Director M's examination revealed no bruising or physical trauma noted. Medical Director M's note also indicates R9 was able to recall the events consistently, but it is unclear at this time if she can consent to sexual activities as she may not fully comprehend the consequences of her actions. Surveyor interviewed Licensed Practical Nurse (LPN) J, LPN K and CNA N, and all three staff indicate R9 is known to disrobe and masturbate in public and staff have to move R9 back to her room during those times. Surveyor noted R9's room is across from the activity/dining room that R10 would visit. R9's care plan does not indicate R9 has a behavior to disrobe and masturbate in public. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/23 at 10:45 a.m. Surveyor interviewed Social Service Director (SSD) L. Surveyor asked SSD L if a trauma history assessment was completed prior to the 3/26/23 sexual incident with R10. SSD L stated R9 does not have a trauma history assessment completed. Surveyor asked SSD L if the facility conducted an assessment regarding R9's ability to consent to a sexual relationship prior to 3/26/23. SSD L stated the facility does not conduct sexual consent assessments. SSD L stated she conducted a BIMS on R9 after the incident and the BIMS was 13, which indicated cognitively intact. SSD L stated not many people can communicate with R9 and able to understand R9 and SSD L does which is why she was able to assess R9 BIMS at 13. On 4/11/23 at 2:30 p.m. during the daily exit meeting with director of Nursing (DON) B, Nursing Home Administrator (NHA) A and VP of Operations D, Surveyor explained the concern R9 did not have a trauma history assessment conducted. Surveyor explained R9's care plan did not address R9's behavior regarding disrobing and masturbating in public. VP of Operations D stated R9's BIMS was a 13 and was able to consent. Surveyor asked what assessment tool was used to assess R9 was capable of consenting to a sexual relationship. VP of Operations stated they don't have an assessment tool in regards to establishing a resident's ability to consent to a sexual relationship and isn't sure when this type of assessment would need to be done. On 4/14/23 the facility provided a sexuality screen completed with R9 on 4/13/23, after Surveyor expressed concerns regarding R9. The screen completed by SSD L indicates R9 has no relationship in the facility and answered yes questions to determine ability to consent. Surveyor noted this is contradictory to the police determination following the incident between R10 and R9. On 4/14/23 the facility provided a trauma screen for R9 that was completed on 4/12/23, after Surveyor expressed concern. Surveyor review of the trauma screen indicated R9 had a history of trauma that was not previously assessed or addressed in care plan for R9.

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F 0849 Level of Harm - Actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on record review and interviews, the facility did not ensure 1 (R2) of 1 resident's reviewed receiving hospice services had effective coordination of care between the facility and hospice services to ensure care was provided as indicated. *R2 was admitted to hospice services on 7/21/2022. R2's hospice care plan and facility care plan were not similar resulting in lack or coordination between hospice and the facility. Hospice was not part of R2's care conferences to coordinate care for R2, and hospice staff did not communicate with facility staff upon exiting the building on 12/16/2022 to allow the facility to intervene when R2 was refusing to have their bed lowered resulting in R2 having an unwitnessed fall out of bed that resulted in a major injury. Findings include: The facility policy, entitled Falls and Fall Risk, managing, revised March 2018, states: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: . c. incorrect bed height or width . 2. Resident conditions that may contribute to the risk of falls include: . c. delirium and other cognitive impairment; d. pain; e. lower extremity weakness; f. poor grip strength; g. medication side effects; . i. functional impairments; j. visual deficits; k. incontinence. (continued on next page)

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F 0849 Level of Harm - Actual harm Residents Affected - Few	The HOSPICE SERVICES AGREEMENT, effective June 24, 2021, states: . 2. RESPONSIBILITIES OF FACILITY . h) Facility shall designate a member of facility's interdisciplinary team who is responsible for working with hospice to coordinate care provided by facility staff and hospice staff to any resident under hospice's care. Such interdisciplinary team member shall be responsible for the following: (I) collaborating with hospice and coordinating facility staff participating in the hospice care planning process for those residents who are under hospice's care; (II) communicating with hospice and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family; . (IV) obtaining the following information from hospice: (A) the most recent hospice plan of care specific to each resident. (V) ensuring the facility provides to hospice an orientation with respect to the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements. Facility shall notify hospice promptly of any change in the designated interdisciplinary team member. I) Facility shall ensure that each residents written plan of care includes both the most recent hospice plan of care if applicable and a description of the services furnished by the facility to attain or maintain the residents highest practicable physical, mental, and psychosocial well being . 3. COMMUNICATION a) General, hospice and facility shall communicate regarding the provision of care to each resident under hospice's care. b) Communication Protocol, Prior to admission of any resident to hospice, hospice and facility shall work together to develop a written communication protocol governing how they will communicate all information needed for residents care, ., including how such communication will be documented to ensure that the needs of residents are addressed and met 24 hours a day. The communication protocol shall include, . a procedure that that clearly outlines the chain of communication between the parties in the event . changes to the hospice plan of care are indicated c) Care Planning. Hospice and facility shall permit each other to attend care planning meetings involving any resident under hospice's care. Each party may reasonably request that a care planning meeting be held with the other . R2 was admitted to the facility on [DATE], R2 transitioned to hospice care on 7/21/2022 and passed away on 12/20/2022 in the facility. R2's diagnoses included muscle weakness, unspecified lack of coordination, unspecified protein-calorie malnutrition, pain, type 2 diabetes, . and a history of falling. R2's quarterly minimum data set (MDS) assessment dated [DATE] assessed R2 needing extensive assist with bed mobility, transfers, dressing, eating, toileting, hygiene cares, and bathing. R2 was immobile and used a Hoyer lift for transfers into a wheelchair. R2's Brief Interview for Mental Status (BIMS) and PHQ-9 were not assessed and R2 had no behaviors. R2 was always incontinent of bowel and urine and wore adult briefs. R2's Risk for falls care plan was initiated on 2/7/2021 with the following interventions: - Anticipate and meet R2's needs. - Be sure R2's call light is within reach and encourage R2 to use it for assistance as needed. R2 needs prompt response to all requests for assistance. - Follow fall protocol. - Provide R2 with mat on floor at bedside. - PT/OT evaluate and treat as ordered or as needed. (continued on next page)

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	04/19/2023

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.

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F 0849 Level of Harm - Actual harm Residents Affected - Few	- Review information on past falls and attempt to determine cause of falls. Record root causes. Alter any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team (IDT) as to causes. - Therapy eval. (initiated 2/8/2021) - Fall mat bedside bed. (initiated 2/8/2021) - Bed in low position with wheels locked when not providing cares. (initiated 4/19/2021) - Bolsters applied to mattress. (initiated 7/2/2021) - Body pillow to left side to keep R2's body positioned in center of bed. Keep bed in low position when not performing cares- Notify nursing if R2 is refusing to allow staff to lower bed. (Initiated 12/16/2022) R2's Hospice Care plan was initiated on 8/16/2022 with the following interventions: - Administer medications as ordered. - Assess coping strategies and respect wishes. - Encourage R2 to express feelings, listen with non-judgmental acceptance and compassion. - Encourage support system to family and friends. - Honor resident and family preferences. - Hospice to provide Spiritual counseling to resident and family as needed. - Notify hospice of any changes in R2's condition. - Observe for pain and discomfort. - Provide education to resident and family as needed. On 12/16/2022 at 1:30 PM in the progress notes, nursing charted R2 had been found on the floor with a head injury. Nursing charted that R2 was lying on R2's right side, a hematoma (bruise) and bleeding was noted to R2's head. Nursing called hospice who stated hospice would be at the facility soon. The Nurse Practitioner (NP) assessed R2 and assisted putting R2 back into R2's bed using a Hoyer lift with the assistance of another registered nurse (RN) and two certified nursing assistants (CNA). RN-P from hospice arrived and called ambulance to transport to hospital per approval of R2's Power of Attorney. (continued on next page)

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F 0849 Level of Harm - Actual harm Residents Affected - Few	On 12/16/2022 at 9:32 PM in the progress notes, RN-G charted R2 returned from emergency department with three neck fractures and a cervical collar to wear at all times. R2 was screaming in pain upon arrival back to facility. RN-G wrote RN-G contacted hospice and obtained a verbal order for increased dose of morphine for R2's pain. RN-G charted safety precautions maintained with bed mobility and assist of one and safety mat at bedside. Surveyor reviewed R2's hospital records from 12/16/2022 visit to the emergency department. R2 had lab tests, chest x-ray, and CT of the cervical spine, and head completed. R2 was diagnosed with: -Closed nondisplaced fracture of the 6th and 7th vertebra (bottom of neck) - Compression fracture of T1 vertebra (top of the spine) On 12/19/2022 the IDT did a root cause of R2's fall and was determined to be poor safety awareness and weakness. Immediate intervention was to place body pillow to left side of R2 to keep R2 positioned in center of R2's bed. Staff was educated to keep beds in low position when not performing cares and notifying nursing if R2 is refusing to let staff lower bed. IDT wrote that upon further investigation and staff interviews it was determined that the hospice CNA-R left R2's bed in high position and left the facility without notifying facility staff of the positioning of R2's bed. On 12/20/2022 at 5:25 AM in progress notes, RN-G charted R2 was observed without a pulse or respirations. Hospice notified. On 4/11/2023 Surveyor reviewed R2's care plans from the facility and hospice. R2's facility care plan documented fall prevention interventions which included fall matt bedside bed initiated 2/8/21, Bed in low position with wheels locked when not providing cares (initiated 4/19/21, and bolsters applied to mattress (initiated 27/2/21). R2's hospice care plan did not identify the facility's safety precautions to prevent potential falls. There is no indication that Hospice services were aware of the facility's fall precautions for R2. Neither the facility or the hospice care plans indicate communication between hospice and nursing home staff when hospice staff are leaving for the day. Surveyor noted R2's care plans for the facility and hospice did not have consistency with interventions which resulted in lack of consistent care between the facility and hospice and staff having different interventions in place for R2. Surveyor also noted hospice was not present at R2's care conferences. On 4/11/2023, at 9:05 AM, Surveyor interviewed RN unit manager (RNUM)-O who stated RNUM-O does not recall what fall interventions were supposed to be in place for R2. RNUM-O stated when RNUM-O called the hospice RN-P who was on their way to the facility. RNUM-O stated did not recall how R2 was when found on the floor. RNUM-O could not recall if a floor mat was in place at the time of R2's fall. RNUM-O stated R2 was not restless while lying in bed but R2 did get squirmy at times but never attempted to get out of bed. RNUM-O recalled the hospice CNA-R was with R2 prior to R2's fall on 12/16/2022. RNUM-O stated the hospice CNA-R did not report off to RNUM-O when hospice CNA-R left. RNUM-O stated not all hospice staff report off when they leave. RNUM-O stated the facility is trying to work on better communication with other agencies for better consistency of care. (continued on next page)

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F 0849 Level of Harm - Actual harm Residents Affected - Few	On 4/11/2023, at 11:06 AM, Surveyor interviewed hospice RN-P who stated RN-P walked into R2's room after the fall to assess and R2 was already back in R2's bed. RN-P attempted to get vital signs on R2, but paramedics arrived to take R2 to the hospital. RN-P stated R2 appeared comfortable, lethargic, and was moaning per R2's baseline and the bleeding on R2's head had stopped. RN-P stated R2's demeanor was mostly laying in bed, very lethargic, not restless at all. RN-P stated R2 had been declining the last few months and diminished verbally. RN-P did not recall if a floor mat was in place at time of R2's fall. R2 had not had any falls prior while R2 was on hospice. On 4/11/2023, at 12:32 PM, Surveyor interviewed hospice CNA-R who stated CNA-R arrived at the facility at 11:15 AM to provide cares for R2. CNA-R stated CNA-R got assistance from a CNA at the facility to reposition R2 onto R2's left side. CNA-R cleaned up R2's room, finished up care for R2, and when CNA-R was lowering R2's bed CNA-R stated R2 told CNA-R not to lower it anymore. CNA-R stated there was not a fall mat in the room that CNA-R has ever seen and did not put a mat on the floor on 12/16/2022 before leaving the facility. CNA-R stated safety precautions were put in place and CNA-R did not recall if CNA-R reported off to staff from the facility at 12:00 PM when CNA-R left the facility. CNA-R stated CNA-R usually reports off to staff but could not recall if CNA-R reported off that day (12/16/2022 at 12:00 PM). Surveyor asked CNA-R to clarify what safety precautions were put in place. CNA-R stated on the hospice care plan for hospice, R2's safety precautions are: - Put items in easy reach of R2. - Use grab bars when showering or toileting R2. - Make sure R2's bed is against the wall. - Remove clutter from R2's room. - Keep R2's floor clean. - Use a wheelchair for transporting. - Check to make sure R2's air mattress was on correct setting and working. CNA-R stated there was nothing regarding keeping bed low or using floor mat for R2. Surveyor noted that R2's care plan for the facility and care plan for hospice were not consistent and did not have the same interventions in place that resulted in inconsistencies with coordination of care between the facility and hospice. Surveyor noted that R2 was admitted into hospice on 7/21/2022 but a significant change MDS was not done until 8/11/2022 and the facility did not initiate a hospice care plan until 8/16/2022. (continued on next page)

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F 0849 Level of Harm - Actual harm Residents Affected - Few	On 4/11/2023, at 1:30 PM, Surveyor interviewed MDS coordinator (MDSc)-S who state MDSc-S worked remotely and someone that is in-house set up a schedule for MDSc-S to follow. MDSc-S did not recall who set those schedules at the time. MDSc-S stated that MDSc-S will open the schedule, start at the bottom, and work up for the MDS assessments that need to be completed. MDSc-S will look through the residents' charts and fill information in based off the information found. If there is information MDSc-S is unable to find and email gets sent out. MDSc-S stated that Social Services will usually initiate care plans, but if MDSc-S sees a care plan that has not been initiated that should have been, MDSc-S will initiate the care plan. On 4/11/2023, at 2:09 PM, Surveyor interviewed Social Services Director (SSD)-L who stated SSD-L started at the facility on 8/8/2022 and had to go back and make up a bunch of care conferences for residents. SSD-L stated SSD-L usually communicates with hospice when care conferences are. Surveyor asked SSD-L regarding the care conference for R2 on 11/30/2022 if hospice was invited. SSD-L did not recall if hospice was called but is written on R2's form that hospice could not make. Surveyor confirmed with SSD-L that no other staff was present at the care conference for R2 on 11/30/2022 and that R2's code status was reviewed. SSD-L was not sure if hospice had access to the facility's care plans but stated hospice staff had access to point click care (healthcare software provider). On 4/11/2023, 2:33 PM, Surveyor interviewed hospice RN-P who states hospice staff did not have access to point click care at the facility R2 was residing at. RN-P stated they never were told or shown how to access point click care. Surveyor asked RN-P if hospice was ever told about or invited to R2's care conferences. RN-P denied being invited or being made aware of R2's care conferences. RN-P stated hospice sent care plans and visit notes to the facility monthly for R2 but did not receive information back from the facility. On 4/12/2023, at 7:21 AM, Surveyor interviewed RN-G who stated R2 returned to the facility on [DATE] from the emergency department following R2's unwitnessed fall out of bed. RN-G stated R2 had a neck brace on that needed to remain in place at all times. RN-G states RN-G put a fall mat in place by R2's bed and initiated hourly checks when R2 arrived back to the facility. RN-G did not recall what interventions were in place prior to R2's fall. RN-G state R2 squirmed a little in bed, R2 would always move to back if R2 was lying on R2's side, but R2 never attempted to get out of bed. On 4/12/2023 at 10:34 AM the Nursing Home administrator was informed of Surveyors concern regarding lack of communication and coordination of care plans between the facility and hospice. Surveyor was handed paperwork that showed trainings hospice did regarding R2's fall and an email between hospice and SSD-L. Surveyor expressed concern that the paperwork received showed how hospice communicated with the facility, but the facility had nothing in place to communicate with hospice. No further information provided at this time.