STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525318	A. Building B. Wing	01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Health and Rehabilitation Center	8400 Sheridan Rd Kenosha, WI 53143

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 38829 Based on observation, staff interview, and record review the facility did not ensure contact information for all pertinent State agencies and advocacy groups, was posted. Further, a statement that the Resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to Resident abuse or neglect, and non-compliance with the advanced directives requirements, and requests for information regarding returning to the community was not posted. This practice had the potential to effect all 69 residents of the facility. * The facility did not have posted a list of names, addresses (mailing and emailing), and telephone numbers for all pertinent State agencies and advocacy groups such as adult protective services where state law provides for jurisdiction in long term care facilities, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit, and a statement that the Resident may file a complaint with the State Survey Agency. The facility's admission packet did contain the required information of all pertinent State agencies, including the name, address, and phone number of the Office of the State Long-Term Care Ombudsman program. Findings Include: On 1/19/22 at 7:25 AM, Surveyor reviewed the facility's admission packet that is given to every Resident and/or representative upon admission to the facility. Surveyor notes that the admission packet does not contain a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as State Survey agency, the State licensure office, adult protective services, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit. Surveyor also notes there was no statement that the Resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to Resident abuse or neglect, and non-compliance with the advanced directives requirements, and requests for information regarding returning to the community located in the facility's admission packet. (continued on next page)

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

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

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	On 1/19/22 at 7:43 AM, Surveyor interviewed the Admissions Director (AD-J) who has been in that position since September 20, 2021. Surveyor asked AD-J if AD-J gave any other information to the Residents and/or representative containing all required agencies and their contact information and the statement that a Resident and/or representative may file a complaint with the State Survey Agency. AD-J stated no, this packet is everything I give to the Resident and/or representative. Surveyor asked if AD-J if she provides the name and contact information for the Office of the State Long-Term Care Ombudsman program to Residents or representitive. AD-J stated no, I don't even know the name and information for our ombudsman. On 1/19/22 at 8:40 AM, Surveyor observed the facility's postings located across from the main dining room. Surveyor notes there is the required State Long-Term Care Ombudsman program information posted but it does not contain the name of the facility's assigned State Long-Term Care Ombudsman. Surveyor also notes that the only other posting is the contact information for the State Survey Agency. Surveyor notes there are no other agencies listed with required contact information and there is no statement that a Resident may file a complaint with the State Survey Agency. On 1/19/22 at 9:20 AM, Surveyor interviewed Social Worker (SW-G) in regards to the State Long-Term Care Ombudsman. SW-G stated SW-G only gives the State Long-Term Care Ombudsman information to a Resident, if the Resident requests or needs the information. SW-G stated all the required information on agencies should be posted somewhere. On 1/19/22 at 4:15 PM, Surveyor shared the concern with Administrator (NHA-A) and Director of Nursing (DON-B) that the required information of the State agencies and the statement that a Resident may file a complaint with the State Survey Agency was not posted within the facility. Surveyor also shared the concern that the admission packet did not contain the required information of all State agencies including the name, address, and phone number of the Office of the State Long-Term Care Ombudsman program. No further information was provided at this time.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not notify the physician of an elevated blood sugar as ordered and did not notify the Health Care Power of Attorney (HCPOA) of a resident's significant change in condition and transfer to the hospital for 1 (R6) of 7 residents reviewed for a change in condition. R6 had parameters to notify the physician if the blood sugar was less than 60 or greater than 400. R6 had an elevated blood sugar of 437 on 9/14/2021 and the physician was not notified at that time of the elevated blood sugar. R6 had a change in mental status and an elevated blood sugar of 482 on 9/17/2021 and was sent to the emergency room for evaluation and treatment. The activated HCPOA was not notified of the significant change in condition or of the transfer to the hospital. Findings: The facility policy and procedure entitled Change in a Resident's Condition or Status dated 5/2017 states: 1. The nurse will notify the resident's Attending Physician of physician on call when there has been a(an): . i. specific instruction to notify the Physician of changes in the resident's condition. 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: . b. There is a significant change in the resident's physical, mental, or psychosocial status; . e. It is necessary to transfer the resident to a hospital/treatment center. R6 was admitted to the facility on [DATE] with diagnoses of COVID-19, fracture of the neck of the left femur, Parkinson's disease, cerebral infarction, dementia, coronary artery disease, chronic pancreatitis, chronic obstructive pulmonary disease, and diabetes. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated R6 needed extensive assistance with all activities of daily living and took insulin daily. R6 had admission orders to check blood sugars four times daily, before each meal and at bedtime, and notify the physician if the blood sugar was less than 60 or greater than 400. On 9/14/2021 at 11:58 AM, documented on R6's Blood Sugar Summary, R6 had a blood sugar of 437. Per the physician orders, the physician was to be notified of a blood sugar greater than 400. No documentation was found indicating the physician was notified of this elevated blood sugar. The blood sugar result was documented on the Medication Administration Record (MAR) and signed by Registered Nurse (RN)-D. In an interview on 1/19/2022 at 2:45 PM, Surveyor asked RN-D if the physician had been notified on 9/14/2021 when R6's blood sugar was 437. RN-D could not recall if the physician had been called on 9/14/2021 to report the elevated blood sugar. RN-D agreed documentation should have been completed if and when the physician was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2021 at 2:27 PM, R6's progress notes document, nursing charted the Nurse Practitioner was spoken to regarding R6's blood sugar of 505. The nurse gave insulin and was advised to wait and monitor R6 and then recheck the blood sugar in 15 minutes. The updated blood sugar 15 minutes later was 493 and the Nurse Practitioner was updated with the blood sugar reading. The Nurse Practitioner gave a verbal order to start Metformin 500 mg, an oral hypoglycemic medication, once daily. The nurse documented R6 would be continued to be monitored. On 9/17/2021 at 5:47 PM, R6's progress notes document, the Medical Director documented R6 was visited that day for an initial visit. The Medical Director documented R6's blood sugar levels range from 180 to 437 and R6 was sleeping soundly at the time of the visit and when awakened, did not contribute to the medical history given R6 had dementia and was non-verbal at baseline. On 9/17/2021 at 8:45 PM, R6's progress notes document, Director of Nursing (DON)-B documented R6 was seen remotely by the Medical Director and no concerns were noted or expressed; R6 remained in stable condition. On 9/17/2021 at 9:53 PM, R6's progress notes document, RN-C charted the Nurse Practitioner was called regarding a change in condition for R6; blood sugar 482, temperature 97.7, respirations 20, blood pressure 117/65, and heart rate 112. The Nurse Practitioner ordered R6 to go to the emergency room for further evaluation and treatment. (These vital signs were documented only in the progress notes and were not documented in the Vital Sign section of the electronic charting system.) No documentation was found indicating R6's HCPOA was notified of the elevated blood sugar or the order for R6 to be sent to the hospital. In an interview on 1/18/2022 at 2:04 PM, Surveyor asked DON-B what is the facility's protocol for notifying the HCPOA of a change in condition or transfer to the hospital. DON-B stated the facility protocol is to notify the HCPOA at the time of transfer. DON-B stated DON-B could not say for certain if the HCPOA was notified or not due to lack of documentation. DON-B stated the staff should also notify DON-B of any resident going out of the facility and DON-B could not recall having a conversation with RN-C on 9/17/2021 indicating R6 was being transferred to the hospital. Surveyor shared with DON-B concern R6's HCPOA was not notified of the change in condition or the transfer to the hospital for evaluation and treatment. DON-B agreed the documentation was lacking and could not tell if the HCPOA was notified. DON-B stated the communication with the HCPOA should have been documented. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/19/2022 at 10:20 AM, RN-C stated on 9/17/2021 RN-C started work late on second shift around 4:30 PM or 5:00 PM. RN-C stated the day shift nurse had written down report on all the residents prior to leaving the facility and R6 was being monitored for high blood sugar. No symptoms of high blood sugar were reported from the day shift nurse. RN-C stated when RN-C was passing medications at approximately 5:00 PM, R6 was not responding like R6 normally did. RN-C stated that was the first time RN-C had worked with R6 and discussed with a Certified Nursing Assistant (CNA) if that was normal behavior for R6. RN-C stated the CNA informed RN-C that R6 usually talked and R6 was not responding verbally to anything. Surveyor asked RN-C if R6 was alert or if eyes were open and for more details of how R6 was acting. RN-C stated R6 was in bed with eyes open and head lifted, but could tell something was not right when RN-C was talking to R6. RN-C did not elaborate any more with what RN-C thought was not right with R6, but denied R6 was coding or anything like that. RN-C stated R6 had a high blood sugar and when RN-C noticed the change of condition at about 5:00 PM, called the Nurse Practitioner right away, called 911, and sent R6 immediately to the hospital. Surveyor asked RN-C if R6's HCPOA was notified of the change in condition and transfer to the hospital. RN-C stated RN-C called the HCPOA but nobody answered the phone. RN-C could not recall if a message was left for the HCPOA, but was sure RN-C called the HCPOA. On 1/19/2022 at 4:10 PM, Surveyor met with Nursing Home Administrator (NHA)-A and DON-B and shared the concern that there was no documentation indicating R6's HCPOA was notified when there was a change in condition and when R6 was sent out to the hospital via 911. DON-B agreed the HCPOA should have been notified and it should have been documented at that time. No further information was provided at that time.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for diabetic and rehabilitation residents for 2 (R6 and R4) of 7 sampled residents. R6 had a change in condition including an elevated blood sugar on 9/17/2021 that was not thoroughly assessed or documented to identify timely interventions to prevent further decline or events from happening. Documentation did not show a timeline of events to determine when the change of condition occurred or if interventions were implemented. R4 had physician orders for evaluation and treatment by physical and occupational therapy dated 12/14/21 and this was not completed. R4 had orders schedule appointments with both optometry and podiatry dated 10/20/21 and these were not completed. Findings: The facility policy and procedure entitled Change in a Resident's Condition or Status dated 5/2017 states: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; . i. specific instruction to notify the Physician of changes in the resident's condition. 3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (Situation, Background, Assessment, Recommendation) Communication Form. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Per the American Diabetes Association, https://www.diabetes.org/diabetes/dka-ketoacidosis-ketones, Diabetic Ketoacidosis (DKA) usually develops slowly, but can be life-threatening. Early symptoms include thirst or very dry mouth, frequent urination, high blood sugar levels, and high levels of ketones in the urine. Later symptoms include constantly feeling tired, dry or flushed skin, nausea/vomiting/abdominal pain, difficulty breathing, fruity odor on breath, and a hard time paying attention or confusion. Warning! DKA is dangerous and serious. If you have any of the above symptoms, contact your health care provider IMMEDIATELY, or go to the nearest emergency room of your local hospital. R6 was admitted to the facility on [DATE] with diagnoses of COVID-19, fracture of the neck of the left femur, Parkinson's disease, cerebral infarction, dementia, coronary artery disease, chronic pancreatitis, chronic obstructive pulmonary disease, and diabetes. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated R6 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 and R6 needed extensive assistance with all activities of daily living and took insulin daily. R6 had an activated Power of Attorney and had a Full Code status. On 9/2/2021 on the hospital Discharge Summary, the discharge medication list and orders included: -insulin lispro (Humalog): Inject 6 Units subcutaneously 3 times daily with meals. Max Daily Dose= 30 units. Use based insulin dosing chart: Breakfast= 6+2; Lunch= 6+2; Supper= 6+2. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-insulin glargine (Lantus): Inject 20 units subcutaneously every morning. -Test blood sugars four times daily. Surveyor reviewed the September 2021 Medication Administration Record (MAR) and the order for the Humalog insulin was not found while R6 was a resident at the facility. R6 had admission orders dated 9/2/2021: -to check blood sugars four times daily, before each meal and at bedtime, and -notify the physician if the blood sugar was less than 60 or greater than 400. Surveyor identified R6's blood sugars ranged from 138 to 496 with an average of 277. (An average was calculated with the fifty blood sugar checks recorded in R6's Blood Sugar Summary from 9/2/2021 until discharge on [DATE].) The blood sugars were trending upwards from 9/14/2021 to 9/17/2021 ranging from 215 to 496 with an average of 365. (An average was calculated with the thirteen blood sugar checks recorded in R6's Blood Sugar Summary from 9/14/2021 to 9/17/2021.) On 9/14/2021 at 11:58 AM, R6's Blood Sugar Summary documented R6 had a blood sugar of 437. Per the physician orders, the physician was to be notified of a blood sugar greater than 400. No documentation was found indicating the physician was notified of this elevated blood sugar. The blood sugar result was documented on the Medication Administration Record (MAR) and signed by Registered Nurse (RN)-D. In an interview on 1/19/2022 at 2:45 PM, Surveyor asked RN-D if the physician had been notified on 9/14/2021 when R6's blood sugar was 437. RN-D could not recall if the physician had been called on 9/14/2021 to report the elevated blood sugar. RN-D agreed documentation should have been completed if and when the physician was notified. On 9/17/2021 at 8:04 AM R6's Blood Sugar Summary documented, R6 had a blood sugar of 389. On 9/17/2021 at 11:00 AM on the September 2021 MAR, R6 was documented as having a blood sugar of 496. No documentation was found indicating the physician was notified of this elevated blood sugar. On 9/17/2021 at 2:27 PM in the progress notes, nursing charted the Nurse Practitioner (NP) was spoken to regarding R6's blood sugar of 505; the nurse gave insulin and was advised to wait and monitor R6 and then recheck the blood sugar in 15 minutes. Nursing charted the updated blood sugar 15 minutes later as 493 and the NP was updated with the blood sugar reading. Nursing charted the NP gave a verbal order to start Metformin 500 mg, an oral hypoglycemic medication, once daily. The nurse documented R6 would continue to be monitored. No other interventions were put into place that would lower R6's blood sugar. The new order obtained to start Metformin 500 mg was scheduled to be started on 9/18/2021. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The documentation in the progress note on 9/17/2021 at 2:27 PM indicated blood sugar readings of 505 and 493 were not documented on the Blood Sugar Summary and the time was not documented to indicate when the elevated blood sugars occurred. The note does not include the type of insulin given, the dose of insulin given, or when the insulin was given. The note does not indicate the insulin given was effective in lowering the blood sugar and no other immediate interventions were put into place to lower R6's blood sugar. No comprehensive assessment was completed to determine the cause of the high blood sugar or how R6 presented medically with the high blood sugar. Review of the September 2021 MAR did not document any additional type of insulin was ordered or administered on 9/17/2021 other than Glargine 20 units at 9:00 AM per admission orders. The nurse that wrote the progress note on 9/17/2021 was no longer employed by the facility and was unavailable for interview at the time of survey. The NP that gave the order for insulin was no longer employed by the facility and was unavailable for interview at the time of survey. On 9/17/2021 at 4:03 PM, R6's Blood Sugar Summary documented R6 had a blood sugar of 496. No documentation was found indicating R6's physician was notified of the elevated blood sugar of over 400 per physician orders. No documentation could be found that indicated a comprehensive assessment of R6 was completed. On 9/17/2021 at 5:47 PM in the progress notes, the Medical Director (MD) documented R6 was visited that day for an initial visit. The actual time of the visit was not documented. The MD documented R6's blood sugar levels range from 180 to 437 and R6 was sleeping soundly at the time of the visit and when awakened, did not contribute to the medical history given R6 had dementia and was non-verbal at baseline. The MD documented under the Assessment/Plan section of the note: T2DM (Type 2 Diabetes Mellitus): IDDM (Insulin-Dependent Diabetes Mellitus) . increase Lantus 25 mg qd (daily), Lispro (Humalog) TID (three times daily) AC (before meals) per SSI (sliding scale insulin). Start Januvia 25 mg qd. Review of the September 2021 MAR documented the Lantus was increased from 20 units to 25 units with a start date of 9/18/2021 and Januvia 25 mg was scheduled to start on 9/18/2021. The MAR did not document an order for Lispro (Humalog) insulin with a sliding scale. R6's hospital discharge orders documented Lispro (Humalog) to be ordered as: Inject 6 Units subcutaneously 3 times daily with meals. Max Daily Dose= 30 units. Use based insulin dosing chart: Breakfast= 6+2; Lunch= 6+2; Supper= 6+2. However, Lispro (Humalog) was not included as part of R6's facility admission orders or added to R6's orders after the visit with the MD on 9/17/21. On 9/17/2021 at 8:45 PM in the progress notes, Director of Nursing (DON)-B documented R6 was seen remotely by the MD and no concerns were noted or expressed; R6 remained in stable condition. DON-B documented new orders were provided to adjust the long-acting insulin and add an oral hypoglycemic mediation to the current medication regimen. The progress note did not address any sliding scale insulin. On 9/17/2021 at 8:45 PM on the Blood Sugar Summary, R6 had a blood sugar of 492. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/17/2021 at 9:53 PM in the progress notes, RN-C charted the NP was called regarding a change in condition for R6; blood sugar 482, temperature 97.7, respirations 20, blood pressure 117/65, and heart rate 112. The NP ordered R6 to go to the emergency room for further evaluation and treatment. These vital signs were documented only in the progress notes and were not documented in the Vital Sign section of the electronic charting system. (When a resident is transferred out of the facility, the pertinent vital signs are pulled from the Vital Sign Summary and if the vital signs are only documented in the Progress Notes, they will not be available for review at the accepting facility.) The blood sugar of 482 in the 9/17/2021 9:53 PM progress note did not correlate with the blood sugar of 492 charted on 9/17/2021 at 8:45 PM on Blood Sugar Summary. Surveyor could not locate documentation that the Nurse Practitioner was called regarding the 492 blood sugar at 8:45 PM. No documentation was found on 9/17/2021 indicating, other than an elevated blood sugar and an elevated heart rate, what the change in condition consisted of for R6 at 9:53 PM, such as mentation, alertness, responsiveness, or general presentation. No documentation was found indicating what time the change of condition occurred, what time the NP was notified, who was called for transport (911 or a local ambulance company), or what time emergency personnel arrived. On 9/17/2021 at 9:58 PM, the Fire Administration Emergency Medical Service (EMS) report documented 911 was activated by the facility. Per the report, R6 had altered mental status that started on 9/17/2021 at 9:41 PM. The narrative section of the report stated: MED2 E2 DISPATCHED TO MANAGED CARE FACILITY FOR (R6) W/ (with) DIABETIC ISSUE. ARRIVED TO FIND (R6) LYING IN BED RESPONSIVE TO PAIN. STAFF STATES THAT PT (patient) IS SUPPOSED TO RECEIVE 8 UNITS OF HUMALOG 3X (three times) DAILY. STAFF STATE THAT (R6) HAS ONLY HAD 8 UNITS ONE TIME TODAY. STAFF UNABLE TO STATE WHY. UNABLE TO GET FURTHER PT (patient) HX (history) FROM STAFF. PT VITALS TAKEN. BG (blood glucose) 486. IV STARTED. 200CC BOLUS ADMIN TO CONTERRACT HYPERGYLCEMIA. Surveyor could not determine if any Humalog insulin had been administered as stated on the EMS report. In an interview on 1/18/2022 at 2:04 PM, Surveyor reviewed with DON-B the documentation completed by DON-B on 9/17/2021. DON-B stated R6 was cognitively impaired and when asked a yes or no question, would not answer consistently with a yes or a no appropriately. Surveyor asked DON-B how R6 presented on 9/17/2021. DON-B stated DON-B was with R6 during the tele-visit with the MD and R6 was at baseline with minimal verbalization. Surveyor asked DON-B at what time of day was the MD visit. DON-B could not recall the exact time of day, but thought it was in the morning. DON-B stated the MD would document on all the residents that were seen that day after all the rounds were completed so the note was not done in real time but at the end of the day. DON-B stated the charting DON-B did on 9/17/2021 was completed remotely from home after leaving the facility and not right after the visit occurred. Surveyor asked DON-B if DON-B was aware of R6's elevated blood sugars and change in condition that caused R6 to be transferred to the hospital. DON-B stated the staff should have notified DON-B of any resident going out of the facility and DON-B could not recall having a conversation with RN-C on 9/17/2021 indicating R6 was being transferred to the hospital or of having a conversation about elevated blood sugars. Surveyor shared with DON-B the concern the documentation surrounding R6's change of condition on 9/17/2021 was not descriptive of the events that happened with a timeline showing the progression of what occurred and what was done by facility staff when the change of condition was discovered. DON-B agreed the documentation was lacking and could not tell the extent of the change of condition just by reading what was documented in R6's medical record. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/19/2022 at 9:10 AM, Surveyor asked DON-B what hospital R6 was transferred to since R6's medical record did not have that information documented and did R6 go out of the facility with 911 or was an ambulance service called. DON-B stated R6 would have gone to the closest hospital and provided that information, but agreed there was no documentation to confirm where R6 was transferred to. DON-B stated DON-B did not know if 911 was called for R6 or if an ambulance service was called to transport R6 to the hospital. In an interview on 1/19/2022 at 10:20 AM, RN-C stated on 9/17/2021 RN-C started work late on second shift around 4:30 PM or 5:00 PM. RN-C stated the day shift nurse had written down report on all the residents prior to leaving the facility and R6 was being monitored for high blood sugar. RN-C stated the report from the day shift nurse did not state if R6 was exhibiting any symptoms of high blood sugar. RN-C stated when RN-C was passing medications at approximately 5:00 PM, R6 was not responding like R6 normally did. RN-C stated that was the first time RN-C had worked with R6 and discussed with a Certified Nursing Assistant (CNA) if that was normal behavior for R6. RN-C stated the CNA informed RN-C that R6 usually talked and R6 was not responding verbally to anything. Surveyor asked RN-C if R6 was alert or if eyes were open and for more details of how R6 was acting. RN-C stated R6 was in bed with eyes open and head lifted, but could tell something was not right when RN-C was talking to R6. RN-C did not elaborate any more with what RN-C thought was not right with R6, but denied R6 was coding or anything like that. RN-C stated R6 had a high blood sugar and when RN-C noticed the change of condition at about 5:00 PM, called the Nurse Practitioner right away, called 911, and sent R6 immediately to the hospital. (Per the EMS report, 911 was not activated until 9:58 PM.) Surveyor reviewed the staff schedule for 9/17/2021 and the day shift nurse was scheduled from 6:30 AM to 3:00 PM and RN-C was on the schedule to start the shift at 2:30 PM. There was no indication on the schedule that RN-C would be reporting at 4:30 PM or 5:00 PM after the shift started. There was no indication on the schedule who was covering the residents from 3:00 PM until RN-C arrived between 4:30 PM and 5:00 PM. R6 was to be monitored for signs and symptoms of hyperglycemia and Surveyor could not determine what staff member was monitoring R6 for one and a half to two hours from 3:00 PM until 4:30/5:00 PM. In an interview on 1/19/2022 at 3:20 PM, CNA-E stated on 9/17/2021 R6 was sleepy and tired and not responsive like usual. CNA-E stated R6 felt hot to the touch so CNA-E told the nurse. CNA-E stated R6's eyes were open, but R6 did not respond like usual. CNA-E stated R6 would not eat anything at supper time. Surveyor asked CNA-E what time was R6 sent out to the hospital. CNA-E stated R6 was sent out after supper but could not recall the exact time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/21/2022 at 11:04 AM, Surveyor asked DON-B to clarify how tele-visit was completed with the MD and R6 on 9/17/2021. DON-B stated there is a computer-type device that DON-B logs into and connects with the MD and the device is brought to the resident room. DON-B stated there are two cameras on the device, one on the computer itself and one on a wand-like device. DON-B stated the camera on the computer allows the MD to see the staff member and the camera on the wand allows a close-up view of the resident to see a wound or in the ears, whatever the MD wants to see close up. DON-B stated there is a stethoscope connected to the computer that allows the MD to hear the heart and lungs. Surveyor asked DON-B how new orders are conveyed during a tele-visit. DON-B stated DON-B takes notes while doing rounds with the MD and then at the end of the day, the MD will email or fax any new orders for the resident; the faxed or emailed orders are kept in the resident's medical record. DON-B stated the MD changed the amount of Lantus insulin that was ordered and started Januvia on 9/17/2021. DON-B provided the faxed order dated 9/17/2021 at 4:51 PM that showed those two orders. The orders were signed by DON-B on 9/17/2021 at 8:53 PM. Humalog sliding scale was not ordered per that fax. Surveyor asked DON-B about the Humalog that was on the hospital Discharge Summary and written in the MD progress note on 9/17/2021. DON-B stated the NP discontinued the Humalog order on admission and was monitoring the blood sugars, but DON-B did not know what happened with the Lispro three times daily order that the MD documented in the progress note on 9/17/2021. Surveyor shared with DON-B the concerns surrounding R6's change in condition on 9/17/2021 and the inability to determine when the change of condition happened starting with the progress note on 9/17/2021 at 2:27 PM and continuing through the final progress note on 9/17/2021 at 9:53 PM. DON-B stated the nurses have a habit of doing all their documentation at the end of their shift so nothing is charted in real time. DON-B agreed it was difficult to determine when the blood sugar was elevated and when the NP was notified. Surveyor shared with DON-B the following concerns. R6 had an elevated blood sugar of 505 at some time on 9/17/2021 but there is no documentation as to when that blood sugar was obtained. No orders were transcribed to administer insulin, the blood sugar continued at the elevated rate with no further interventions completed to bring the blood sugar to a range that was not dangerous, and no comprehensive assessments were completed or documented to show how R6 was reacting to the elevated blood sugars. Surveyor was unable to determine when the change of condition started, who was notified of the continuing elevated blood sugars, and R6 was not being monitored at the change of shift from day shift to pm shift on 9/17/2021 for up to two hours. Through interview, RN-C stated R6 had a significant change in condition at 5:00 PM when RN-C was doing rounds and passing medications, but per the EMS record, the change of condition started at 9:41 PM and 911 was called at 9:58 PM. Per the EMS record the nursing staff was unable to give any accounts of the day that led to the change in condition and was unable to provide any of R6's medical history to EMS. Surveyor was unable to determine the accuracy of the statement to EMS that the change of condition started at 9:41 PM. No further information was provided at that time. On 1/28/2022 at 2:58 PM, DON-B sent additional information to Surveyor for review. The information consisted of a statement from RN-C that read as follows: After reviewing the Medical Record and Charting I am making this statement, it is an estimate of the events that took place on 9/17/2021 during my shift. -8:45PM-9PM Administered medications to Resident, Resident was alert and consistent with earlier assessment, no changes were noted; alert & responsive, appropriate. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-9:15PM-9:30PM- Went to Resident's Room to obtain HS (Hour of Sleep) BGL (bedtime blood glucose level) which was 482, Resident appeared more Lethargic, VS (vital signs) taken. -9:30PM-9:45PM- Call was placed to (medical service), spoke with (Physician Assistant) and orders were obtained to send Resident to ER (emergency room) for further evaluation. -9:53PM- 911 called. -10PM- EMS (emergency medical services) arrived; Resident taken to (hospital) ER. The statement was signed by RN-C and was undated. Surveyor reviewed statement provided. RN-C entered the BGL into R6's medical record at 8:45 PM, not 9:15 PM-9:30 PM indicating the blood sugar was obtained at least half an hour prior to what the statement indicated. 911 was called at 9:58 PM after the progress note was written at 9:53 PM indicating over an hour had gone by from the time the blood sugar level was obtained and 911 was called. The statement provided does not indicate the NP or physician was notified earlier in the day or earlier in the shift when blood sugar levels remained extremely elevated and no interventions were put in place to lower the blood sugar levels. 38829 2) Surveyor reviewed the facility's policy and procedure on physician orders reviewed May 2021 and notes the following: Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. Policy: 10. A monthly review of the physician orders will be completed to assure appropriateness, accuracy, and completeness. Surveyor also reviewed the facility's policy and procedure on physician service dated April 2013 and notes the following: Policy Interpretation and Implementation 5. Physician visits, frequency of visits, emergency care of Residents, etc., are provided in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. Consultative services shall be made available from community-based consultants or from a local hospital or medical center. R4 was admitted to the facility on [DATE] with diagnoses of Other Specified Arthritis, Left Knee, Morbid Obesity, Type 1 Diabetes Mellitus, End Stage Renal Disease, and Hypothyroidism. R4 is her own decision maker. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R4's Admission Minimum Data Set (MDS) dated [DATE] documents R4's Brief Interview for Mental Status (BIMS) score of 15, indicating R4's decision making skills are intact. R4's MDS also documents that R4 requires extensive assistance for bed mobility and dressing and requires total assistance for transfers and toileting. Surveyor reviewed R4's electronic medical record (EMR) and notes the following physician progress note dated 10/20/21: History of Present Illness: R4 reports that R4 needs to see podiatrist for routine nail care. States R4 has very long toenails on R4's right foot. R4 also complains of poor vision and states that R4 has not seen an eye doctor in some time due to prolonged hospitalization . Additional Orders: Podiatry evaluation for routine nail care Schedule eye exam for routine evaluation Surveyor reviewed R4's current physician orders and notes the following: Set up Optometry appointment-Annual Wellness Check-Order date 10/20/21 Set-Up Podiatry Appointment-Routine Foot Care-Order date 10/20/21 R4's physician orders also contain the following: Opthamology consult-Diabetic with worsening eyesight-Order date 12/14/21 Podiatry consult-Diabetic with overgrown toenails-Order date 12/14/21 Surveyor reviewed R4's electronic medical record (EMR) and notes the following physician progress note dated 12/14/21: History of Present Illness: R4 has been getting increased clouding of vision has not seen an ophthalmologist in several years. R4 has not been getting therapy since in the building the last time I tried to see R4 she was at dialysis. R4 is very discouraged. Care Plan/Assessment: Needs to see podiatrist as well as ophthalmologist for ongoing care and will get out of bed 3 times a day and ask Physical Therapy(PT) and Occupational Therapy(OT) to see. Surveyor reviewed R4's current physician orders and notes the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	PT/OT Eval and Treat-Order dated 12/14/21 On 1/18/22 at 1:27 PM, Surveyor interviewed R4 who confirmed R4 has not seen a podiatrist or an eye doctor. R4 stated that R4 had a couple of weeks of PT and OT when first admitted to the facility but has not had any PT or OT since. On 1/19/22 at 9:10 AM, Surveyor spoke with Social Worker (SW-G) in regards to R4 receiving podiatry and eye services. SW-G confirmed that SW-G manages the eye, podiatry, and dental services. SW-G stated R4 has been put on a list to be seen by the eye doctor on 1/28/22. SW-G stated that R4 had been seen by the podiatrist on 12/17/21. Surveyor requested documentation of the podiatrist visit. SW-G was unaware there was a physician order dated 10/20/21 to see the podiatrist and eye doctor. Surveyor reviewed the progress note from the podiatrist dated 12/17/21 which states, R4 was scheduled to be treated today, but was not treated. Reason: R4 was unavailable: at dialysis. On 1/19/22 at 9:31 AM, Surveyor spoke with Rehabilitation Manager (RM-H) who confirmed that R4 had received both PT and OT upon admission (10/13/21) and was discharged from therapy on 11/12/21. RM-H completed a therapy screen on R4 on 12/22/21 because she kept asking for therapy. RM-H explained that a therapy screen is very different from an evaluation and treat order. RM-H explained that a screen is based on a request of a Resident. With an order, therapy has to get prior approval from insurance. RM-H stated if this had been done for R4, R4 would most likely have been denied by insurance due to history, but there would be documentation of that denial. RM-H confirmed there is no documentation of that being done for R4. RM-H stated new orders for therapy are gone over in morning meeting and the therapy department is notified of any new orders for a Resident. RM-H confirmed that RM-H was unaware there was an order dated 12/14/21 for an evaluation and treatment for therapy for R4. Surveyor notes that RM-H explained that R4 was discharged from therapy due to making no progress and being uncooperative with therapy's plan of care. Surveyor reviewed OT's initial evaluation and plan of treatment dated 10/14/21 Goals: R4 will wash upper body with mod (moderate) assist max (maximum) assist-baseline R4 will tolerate 10 minutes of bilateral upper extremity activity to complete upper body cares-assist of 2 for bed mobility, R4 made no movement to assist-baseline R4 will wash upper body seated at the sink-dependent, R4 stated R4 has been bedridden for years-baseline The initial OT evaluation documents that R4 had received therapy at other facilities and the hospital. It is documented that R4 was refusing to answers to how long R4 had been bedbound or when the last time R4 was in R4's home. R4 unrealistic since therapist was told R4 has been bedridden for years and would not answer last time R4 walked. Surveyor reviewed OT's discharge summary dated 11/12/21. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Goals: R4 refused to wash upper body-max assist R4 made no movement to assist with bilateral upper extremity activity to complete upper body cares R4 does not get out of bed except to go to dialysis-mod-total assist The OT summary documents R4 did not make any progress and was discharged due to being non-compliant. Surveyor reviewed PT's initial evaluation and plan of treatment dated 10/16/21: R4 to improve bilateral lower extremity to facilitate bed mobility and transfers R4 able to roll with max assist to facilitate progression-max assist x2 (with 2 staff)/total R4 to improve bilateral lower extremity to facilitate bed mobility and transfers R4 able to roll with mod assist to facilitate progression-max assist x 2/dependent R4 to complete supine sit with max assist-unable R4 to tolerate sit to stand x 1 minute to facilitate transfers-unable Surveyor reviewed R4's PT discharge summary dated 11/12/21 and R4 made no improvement in the above goals with refusals. It is documented that a restorative program was not indicated at the time of discharge. On 1/19/22 at 4:14 PM, Surveyor shared the concern with Administrator (NHA-A) and Director of Nursing (DON-B) that R4 had physician orders dated 10/20/21 to see the podiatrist and optometrist, physician orders dated 12/14/21 to receive an evaluation and treatment for PT and OT, and R4 did not receive any of the services. Surveyor shared the concern that these physician orders had not been carried through with. No further information was provided at this time.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not ensure medications were administered as ordered by the physician for 2 (R5 and R4) of 7 sampled residents. R5 did not receive all medications as ordered by the physician on admission to the facility. R4 did not receive all medications as ordered by the physician. Findings: The facility policy and procedure entitled Physician Orders dated 5/2021 states: 7. Medications will be ordered from the pharmacy to ensure prompt delivery. Medications available from the emergency drug supply shall be utilized for the first dose until a supply arrives from pharmacy. R5 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis, testicular hypo function, hereditary spastic paraplegia, and cellulitis. R5 had both testicles removed while in the hospital due to pain and abrasions with transfers. R5 left the facility against medical advice (AMA) on 11/27/2021. Per the admission progress note on 11/24/2021, R5 was wheelchair bound and could do a stand and pivot transfer with the assistance of two. R5 was resident-responsible. R5's hospital Discharge Summary dated 11/24/2021 had the following medication orders: -4-aminopyridine (Ampyra) 10 mg: 2 capsules in the morning and 1 capsule in the evening -acetaminophen 325 mg: 2 tablets every 4 hours as needed for pain -amantadine 100 mg: 2 capsules in the morning and 1 capsule in the evening -aspirin 81 mg daily -bacitracin ointment: topically 2 times daily to surgical incision for 5 days -baclofen 20 mg twice daily -bisacodyl 10 mg suppository daily as needed for constipation -carbidopa-levadopa 25-100 mg: 2 tablets twice daily -cholecalciferol 50 mcg: 2.5 tablets daily -docusate sodium-sennosides 50-8.6 mg: 2 tablets daily as needed for constipation -hydrocodone-acetaminophen 5-325 mg: 1 table every 6 hours as needed for pain (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-linaclotide 145 mcg: 1 table daily before breakfast; do not start before 11/23/2021 -lipoflavonoid plus PO twice daily -pantoprazole 40 mg nightly -pregabalin 50 mg: 1 capsule twice daily -Testosterone cypionate 200 mg/ml: inject 0.25 ml twice a week on Monday and Thursday -Urinozinc twice daily Review of R5's medication orders showed the orders were transcribed as written except for: -Ampyra tablet ER 12 hour 10 mg (Dalfampyridine ER) twice daily (should have been entered as 20 mg in the morning and 10 mg in the evening) The following medications were not administered as ordered per review of R5's 11/2021 Medication Administration Record (MAR): AMPYRA 10 mg twice daily: was not administered on 11/25/2021 in the AM, 11/26/2021 in the AM and PM, and 11/27/2021 in the AM. On 11/25/2021 at 9:30 AM in the MAR, nursing charted a 1 as the administration code indicating Hold/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. On 11/25/2021 in the evening dose section of the MAR, nursing initialed the MAR indicating the medication was administered. On 11/26/2021 at 9:58 AM in the progress notes, nursing charted the reason Ampyra was not administered was because it was unavailable for administration. On 11/26/2021 at 6:21 PM in the progress notes, nursing charted the reason Ampyra was not administered was because it was on order. On 11/27/2021 at 11:06 AM in the MAR, nursing charted a 4 as the administration code indicating Other/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. AMANTADINE 200 mg in the morning: was not administered on 11/25/2021. On 11/25/2021 at 9:30 AM in the MAR, nursing charted a 1 as the administration code indicating Hold/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/2021 at 11:02 AM in the progress notes, nursing charted Amantadine was pending pharmacy delivery due to wrong medication delivered. The MAR had a signature indicating the medication was administered on 11/27/2021 for the morning dose. This contradicted the progress note. On 11/27/2021 at 12:45 PM in the progress notes, nursing charted the pharmacy was called regarding the delivery of amantadine stating the wrong medication had been delivered and the correct delivery would be coming to the facility. BACITRACIN OINTMENT topically twice daily to surgical incision: was not administered on 11/25/2021 in the AM or the PM. On 11/25/2021 at 9:31 AM in the MAR, nursing charted a 1 as the administration code indicating Hold/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. On 11/25/2021 at 9:35 PM in the progress notes, nursing charted the reason bacitracin ointment was not administered was because it was on order. LINACLOTIDE 145 mcg daily: was not administered 11/25/2021, 11/26/2021, or 11/27/2021. On 11/25/2021 at 1:05 PM in the progress notes, nursing charted the pharmacy had called stating the linaclotide was on back order and would not be delivered. On 11/25/2021 and 11/26/2021 on the MAR, no signature was provided leaving the signature box blank. On 11/27/2021 at 5:40 AM in the progress notes, nursing charted linaclotide did not arrive from the pharmacy at that time. R5 did not receive linaclotide while a resident at the facility. LIPOFLAVONOID twice daily: was not administered 11/25/2021, 11/26/2021 or 11/27/2021 for the AM and PM doses. On 11/25/2021 at 9:30 AM in the MAR, nursing charted a 1 as the administration code indicating Hold/See Nurse Notes. Nursing charted in the progress notes R5 was a new admission and the facility was waiting for pharmacy to deliver the medications. On 11/25/2021 at 6:58 PM in the progress notes, nursing charted the lipoflavonoid was not administered because it was on order. On 11/26/2021 at 9:57 AM in the progress notes, nursing charted the lipoflavonoid was not administered because it was unavailable. On 11/26/2021 at 5:53 PM in the progress notes, nursing charted the lipoflavonoid was not administered because it was on order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/2021 at 11:05 AM in the MAR, nursing charted a 4 as the administration code indicating Other/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. R5 did not receive lipoflavonoid while a resident at the facility. PANTOPRAZOLE 40 mg nightly: was not administered on 11/25/2021. On 11/25/2021 at 9:35 PM in the progress notes, nursing charted pantoprazole was not administered because it was on order. PREGABALIN 50 mg twice daily: was not administered on 11/25/2021 in the morning. On 11/25/2021 at 9:30 AM in the MAR, nursing charted a 1 as the administration code indicating Hold/See Nurse Notes. Nursing charted in the progress notes the facility was waiting for pharmacy to deliver the medication. TESTOSTERONE CYPIONATE 200 mg/ml inject 0.25 ml twice a week on Monday and Thursday: was not administered on Thursday 11/25/2021. On 11/25/2021 at 9:31 AM in the MAR, nursing charted a 1 as the administration code indicating Hold/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. URINOZINC capsule twice daily: was not administered on 11/25/2021, 11/26/2021, or 11/27/2021 for the AM and PM doses. On 11/25/2021 at 9:31 AM in the MAR, nursing charted a 1 as the administration code indicating Hold/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. On 11/25/2021 at 6:57 PM in the progress notes, nursing charted the urinozinc was not administered because it was awaiting delivery from the pharmacy. On 11/26/2021 at 9:58 AM in the progress notes, nursing charted the urinozinc was not administered because it was unavailable. On 11/26/2021 at 6:22 PM in the progress notes, nursing charted the urinozinc was not administered because it was on order. On 11/27/2021 at 11:07 AM in the MAR, nursing charted a 4 as the administration code indicating Other/See Nurse Notes. Nothing was documented in the progress notes as to why the medication was not administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/2021 at 12:23 PM in the progress notes, nursing charted the facility was pending the delivery of medications. Nursing charted the pharmacy stated the mediations would be delivered that day. Nursing charted the Nurse Practitioner (NP) was notified of R5 missing doses of medications and the family was aware and brought some of the medications from home with the approval of the NP to be administered until the medications arrive from the pharmacy. No documentation was found indicating the NP or physician was notified on 11/26/2021 that R5 had missed medications. On 11/27/2021 at 12:21 PM in the progress notes, nursing charted the physician was aware R5 had missed doses of medications with no new orders at that time and R5 was in no apparent distress due to missed medications. On 11/27/2021 at 1:44 PM in the progress notes, nursing charted R5 left the facility against medical advice (AMA) at 1:30 PM. In an interview on 1/18/2022 at 3:41 PM, Surveyor asked Licensed Practical Nurse (LPN)-F what was the facility's process for obtaining medications when a resident is newly admitted . LPN-F stated as soon as a new admission comes in, the discharge summary from the hospital is faxed to the pharmacy and then the orders are put into the computer charting system so all medications are in the computer for the nurses to see. LPN-F stated medications are pulled from contingency or called in to the pharmacy to get stat. LPN-F stated when you are signing out a medication on the MAR, the nurse can make a note to say the medication is not in contingency or is waiting for the pharmacy to deliver the medication. LPN-F stated when R5 got to the facility, LPN-F took over the admission process. Surveyor asked LPN-F if the family brought any medications in that were not available from the pharmacy. LPN-F recalled R5's family saying they would bring in medications that were needed, but was not there when any medications were brought in. In an interview on 1/19/2022 at 9:36 AM, Surveyor asked Registered Nurse (RN)-D about the facility obtaining R5's medications on admission. RN-D stated a lot of R5's medications were not delivered from the pharmacy and the family brought in medications from home. RN-D recalled multiple conversations between RN-D, the physician, and the family about being able to use the medications the family brought in. RN-D stated the physician agreed to use the home medications until the pharmacy could deliver the medications. RN-D stated RN-D called the pharmacy multiple times trying to get R5's medications and was told some of the medications needed preauthorization from the insurance company but did not recall which medications those were. RN-D stated the family brought in some of the needed medications but not all of them and could not recall which medications the family provided. RN-D stated RN-D should have documented which medications the family brought in. RN-D stated RN-D knew the family provided the injectable testosterone and another controlled medication because both of the medications had to be double locked. RN-D reviewed the medication list and determined gabapentin was the other medication that needed to be double locked because RN-D recalled having to count a large number of very small pills from the bottle brought in by the family at the change of every shift. Surveyor asked RN-D if the testosterone, that was scheduled to be administered on 11/25/2021 and not signed out on the MAR as being administered, had been given to R5. RN-D stated RN-D knew the medication was provided by the family but could not recall administering the testosterone injection. RN-D stated any medication that RN-D administers is signed out when it is given. RN-D stated R5 came to the facility the day before a holiday and RN-D thought the pharmacy did not have staff to deliver the medications as ordered when R5 was admitted . (continued on next page)

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	525318	A. Building B. Wing	01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Health and Rehabilitation Center	8400 Sheridan Rd Kenosha, WI 53143

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/19/2022 at 3:55 PM, Director of Nursing (DON)-B stated R5 was admitted over a holiday so the delivery of medications was delayed. DON-B stated the family brought medications from home and the nurse talked to the Nurse Practitioner to get approval to use those medications while they waited for the pharmacy to deliver the medications. DON-B stated not all the medications that were ordered from the hospital were brought in by the family and were not available in the facility contingency. DON-B stated the pharmacy itself has a back-up pharmacy so they can obtain backordered medications. Surveyor shared with DON-B the concern during Surveyor's review of R5's MAR with initials and coding numbers, it was difficult to discern what medications were given or the reason they were not given since the nurses did not document consistently. Surveyor shared the concern there was no documentation on 11/26/2021 that the physician was notified of medications not available or administered as ordered. DON-B agreed the pharmacy should have provided the medications as ordered and stated the facility was having difficulty with the pharmacy in obtaining medications in a timely manner. No further information was provided at that time. 38829 2) R4 was admitted to the facility on [DATE] with diagnoses of Other Specified Arthritis, Left Knee, Morbid Obesity, Type 1 Diabetes Mellitus, End Stage Renal Disease, and Hypothyroidism. R4 is her own decision maker. R4's Admission Minimum Data Set(MDS) dated [DATE] documents R4's Brief Interview for Mental Status(BIMS) score of 15, indicating R4's decision making skills are intact. Surveyor reviewed R4's current physician orders, medication administration records(MARS) for October 2021-January 2022, and R4's electronic medical record(EMR) containing documentation on R4's medication from October 2021-January 2022. In review of R4's medications, Surveyor notes there were multiple medications that were not available in the facility, consequently R4 did not receive the medication as prescribed and documented on R4's physician orders. The following was documented in R4's EMR: 1. Lanthanum Carbonate Tablet Chewable 500 mg 1 tablet with meals 10/20/21-pending refill 11/22/21-on order 11/23/21-medication not available-pharmacy aware 11/25/21, 8:50 AM-on order 11/25/21, 12:13 PM-do not have in building/on order 11/25/21, 6:05 PM-waiting for pharmacy to deliver 11/26/21-on order (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/7/21, 5:49 PM-med re ordered 12/7/21, 6:41 PM-writer spoke with pharmacy in regard to medication. Pharmacy awaiting prior authorization before delivery 12/28/21-on order 12/29/21, 9:05 AM-pending refill 12/29/21, 9:27 PM-waiting on pharmacy delivery 12/29/21 9:54 PM-R4 has concerns of medication not being delivered, called pharmacy, pharmacy stated they would send the medication tonight 12/29/21. R4 was updated and is happy now. 12/30/21, 10:44 AM-medication not available, pharmacy aware 12/30/21, 10:52 AM-writer called pharmacy regarding medication, prior authorization needs to be signed by nephrologist. 1/16/22-on order 1/17/22-medication not available. Pharmacy aware 2. R4 did not receive the Apixaban Tablet 2.5 mg on 11/28/21-on order 3. Synthroid Tablet 75 MCG 1 tablet in the morning 11/30/21-med unavailable, pharmacy contacted 4. R4 did not receive the Verapamil HCl Tablet 80 MG 1 tablet with meals, hold on dialysis days on 12/30/21, 7:23 PM-waiting on delivery from pharmacy 1/1/22, 8:18 AM-on order 1/1/22, 12:06 PM-do not have/on order 1/2/22,8:14 AM-do not have in building/on order 1/2/22, 12:28 PM-do not have on order 1/6/22, 2:47 PM-not available in contingency. Pharmacy has long waiting times 1/6/22, 2:47 PM-attempted to reach pharmacy multiple times on hold longer than 20 minutes 1/8/22, 8:21 AM-medication not available (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/18/22 at 1:27 PM, Surveyor spoke with R4 who indicated R4 frequently was without prescribed medication and was calling the pharmacy herself. R4 also indicated that R4 often was sent to dialysis without R4's Midodrine 10 MG. On 1/19/22 at 4:00 PM, Surveyor interviewed Director of Nursing(DON-B) in regards to pharmacy services. DON-B explained that if a medication is expensive the facility will only order a partial dose. DON-B explained some medications can be pulled from contingency, but contingency has run out as well. DON-B stated there has been problems with the current pharmacy. DON-B stated, I can't answer why the medications have not been sent for R4. DON-B further explained that if a Resident goes over 24 hours of not receiving a medication, the staff is supposed to communicate with DON-B. DON-B informed Surveyor at this time that DON-B understands the concern that medications have not been available for R4 to receive as prescribed. On 10/21/21 there is documentation from the physician that R4 had stated R4's medications were incorrect. The physician consulted with nursing who stated the medications are being administrated correctly. Surveyor notes there is no other documentation in R4's EMR that the physician was notified of any issues getting medications from the pharmacy. On 1/19/22 at 4:14 PM, Surveyor shared the concern with Administrator(NHA-A) and DON-B that R4's medication was not provided as prescribed by the physician. No further information was provided at this time.