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	03/22/2022

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on record review and interview, the facility did not comprehensively assess residents for their functional capacity either initially or periodically by documenting a summary of information regarding the care areas triggered when completing the Minimum Data Set (MDS) assessment for 15 (R9, R68, R57, R30, R49, R31, R50, R7, R19, R35, R55, R62, R59, R69 and R64) Care Area Assessments of a comprehensive MDS assessment. R9, R68, R57, R30, R49, R31, R50, R7, R19, R35, R55, R62, R59, R69, and R64 did not have Care Area Assessments completed with a summary of the triggered areas on comprehensive MDS assessments. Findings include: The facility policy and procedure entitled MDS 3.0 Process dated 10/2021 reads: . D. The center will address the needs and strengths of each resident through completion of the MDS 3.0 and the Care Area Assessments (CAA) to develop a comprehensive, individualized plan of care. E. Triggered Care Areas will be evaluated by the interdisciplinary team to determine the underlying causes, potential consequences and relationships to other triggered care areas. F. The Care Area Assessments (CAAs) process consists of the following steps: 1. Identify areas of concern triggered on the MDS: -This can be done using software or by manually using the CAT (Care Area Trigger) logic tables in the RAI (Resident Assessment Instrument) User's Manual. 2. Review the triggered CAAs by doing an in-depth, resident-specific assessment of the triggered condition: -History taking; -Physical assessment; -Gathering of relevant information (labs, tests, etc.); and (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sequencing of clinically significant events. 3. Define the problem (s): -Identify the functional, physical, and/or behavioral implications of the problem (s); -Identify the relationships between risk factors, triggers and problems; -Distinguish between causes and consequences; and -Look for common causes of multiple issues. 4. Make decisions about the care plan: -Determine whether the problem (s) needs intervention; -Evaluate the resident's goals, wishes, strengths and needs; -Design interventions that address causes, not symptoms; and -Establish which items need further assessment or additional review. 5. The IDT (Interdisciplinary Team) will employ tools and resources during the CAA process, including evidenced-based research and clinical practice guidelines, along with sound clinical decision making and problem-solving. 6. CAA documentation explains the basis for the care plan. This documentation should include: -Causes and contributing factors for the triggered care areas; -The nature of the condition or issue (i.e., What exactly is the problem and why is it a problem?); -Complications contributing to (or caused by) the care area; -Risk factors related to the condition; -Factors that should be considering in developing the care plan (including reasons to care plan or not to care plan particular findings); -Any need for further evaluation by the physician or other healthcare provider; -Resources and tools used for decision-making; -Conclusions that arose from the care area assessment process; and -Completion of Section V of the MDS. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) R9 was admitted to the facility on [DATE]. An Annual MDS assessment, dated 9/12//21, was completed. The Surveyor reviewed R9's Annual MDS assessment, dated 9/12/21, and the following CAAs were triggered on the assessment: Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, and Pressure Ulcer. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 2.) R68 was admitted to the facility on [DATE]. An Admission MDS assessment, dated 11/17/21, was completed. The Surveyor reviewed R68's Admission MDS assessment dated [DATE] and the following CAAs were triggered on the assessment: Delirium, Cognitive loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Activities, Falls, Tube Feeding, Dehydration/Fluid Maintenance, Pressure Ulcer, and Psychotropic Drug Use. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 3.) R57 was admitted to the facility on [DATE]. An Admission MDS assessment, dated 7/3/21, was completed. The Surveyor reviewed R57's Admission MDS assessment, dated 7/3/21, and the following CAAs were triggered on the assessment: Cognitive Loss/Dementia, ADL Functional/ Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use and Return to Community Referral. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 4.) R30 was admitted to the facility on [DATE]. An Annual MDS assessment dated [DATE] was completed. The Surveyor reviewed R30's Annual MDS assessment, dated 3/12/21, and the following CAAs were triggered on the assessment: Visual Function, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer and Psychotropic Drug Use. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 5.) R49 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Surveyor reviewed R49's Admission MDS assessment, dated 11/18/21, and the following CAAs were triggered on the assessment: ADL Functional/ Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use and Return to Community Referral. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 36161 6.) R31 was admitted to the facility on [DATE] with a diagnosis that included Dementia without Behavioral Disturbance, Diabetes Mellitus Type II, Sepsis and Dysphagia. R31's MDS (Minimum Data Set) dated 1/12/22 documents that R31 has short and long term memory problems. Section C1000 (Cognitive Skills for Daily Decision Making) documents that R31 has severely impaired cognitive skills for daily decision making. Section K (Swallowing/Nutritional Status) documents that R31 has not experienced any unplanned weight loss. R31's Nutritional Status CAA (Care Area Assessment), dated 1/12/22, documents that R31 triggered for further assessment for his nutritional status, however the Analysis of Findings and Care Plan Considerations sections were left blank and provided no additional information. 7.) R50 was admitted to the facility on [DATE] with a diagnosis that included Morbid Obesity, Right Artificial Hip Joint, Major Depressive Disorder and Bipolar Disorder. R50's Quarterly MDS (Minimum Data Set) dated 2/7/22 documents a BIMS (Brief Interview for Mental Status) score of 14, indicating that R50 is cognitively intact. Section N (Medications) documents that R50 had taken 7 out of 7 days of antidepressant medication during the assessment period. R50's Psychotropic Drug Use CAA (Care Area Assessment) dated 5/10/21, documents that R50 triggered for further assessment for the use of psychotropics medications, however the Analysis of Findings and Care Plan Considerations sections were left blank and provided no additional information. Interview with MDS RN (Registered Nurse)-I On 3/22/22,at 12:00 p.m., Surveyor informed MDS RN-I of the above findings. Surveyor asked MDS RN-I why the sections under the Analysis of Findings and Care Plan Considerations for the above residents were left blank and incomplete. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS RN-I informed Surveyor that she was not trained on how to fill out the CAAs and that she did not know that the Analysis of Findings and Care Plan Considerations section had to be filled out. MDS RN-I informed Surveyor that the week of 3/7/22 she received information on properly filling out the CAA assessments and that going forward she would ensure that the Analysis of Findings and Care Plan Considerations sections would be completed. MDS RN-I also informed Surveyor that she would not be going back to previous CAA assessments to correct them or add information into the Analysis of Findings and Care Plan Considerations sections. No additional information was provided. 38829 8) R7 was admitted to the facility on [DATE], with diagnoses of Encephalopathy, Unspecified Dementia with Behavioral Disturbances, and Major Depressive Disorder. R7 has a legal guardian. Surveyor reviewed R7's Admission Minimum Data Set (MDS) assessment, dated 5/21/21, and the following Care Area Assessment (CAAs) were triggered on the assessment: Delirium, Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Behavioral Symptoms, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Return to Community Referral. Surveyor notes the CAAs were not completed to include a summary of the triggered areas. 9) R19 was admitted to the facility on [DATE], with diagnoses of Multiple Sclerosis, Paraplegia, Neuromuscular Dysfunction of Bladder, and Colostomy Status. R19 is his own person. Surveyor reviewed R19's Admission Minimum Data Set (MDS) assessment, dated 10/13/21, and the following Care Area Assessment (CAAs) were triggered on the assessment: Activities of Daily Living(ADL) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Activities, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Pain, and Return to Community Referral. Surveyor notes the CAAs were not completed to include a summary of the triggered areas. 10) R35 was admitted to the facility on [DATE], with diagnoses of End Stage Renal Disease, Paroxysmal Atrial Fibrillation, Type 1 Diabetes Mellitus, and Morbid Obesity. R35 is her own person. Surveyor reviewed R35's Admission Minimum Data Set (MDS) assessment, dated 10/20/21, and the following Care Area Assessment (CAAs) were triggered on the assessment: Activities of Daily Living(ADL) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, and Pressure Ulcer. Surveyor notes the CAAs were not completed to include a summary of the triggered areas. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11) R55 was admitted to the facility on [DATE], with diagnoses of Nondisplaced Bimalleolar Fracture of Left Lower Leg, Type 1 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Bipolar Disease. R55 is her own person. Surveyor reviewed R55's Admission Minimum Data Set (MDS) assessment, dated 1/12/22, and the following Care Area Assessment (CAAs) were triggered on the assessment: Activities of Daily Living(ADL) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well Being, Mood State, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance, and Pressure Ulcer, Psychotropic Drug Use, and Return to Community Referral. Surveyor notes the Nutrition CAA was not completed to include a summary of the triggered areas. Surveyor also notes the other CAAs are all identical word for word in the summary of triggered areas. The above findings were shared with the Administrator (NHA-A) and Director of Nursing (DON-B) on 3/22/22, at 2:00 PM. Additional information was requested if available. None was provided. 42037 12.) R62 was admitted to the facility on [DATE]. R62 had an Admission MDS (Minimum Data Set) assessment, dated 11/5/21 completed. Surveyor reviewed R62's Admission MDS assessment dated [DATE]. The following CAAs were triggered on the assessment: Delirium, Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance and Pressure Ulcer. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with NHA-A and DON-B on 3/21/22 at 3:00 PM. Additional information was requested if available. The facility could not supply any additional information during the Survey. 13.) R59 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. Surveyor reviewed R59's Admission MDS assessment dated [DATE]. The following CAAs were triggered on the assessment: ADL Functional/Rehabilitation Potential, Urinary incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Pressure Ulcer. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with NHA-A and DON-B on 3/21/22 at 3:00 PM. Additional information was requested if available. The facility could not supply any additional information during the Survey. 14.) R69 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R69's Admission MDS assessment dated [DATE]. The following CAAs were triggered on the assessment: Delirium, Cognitive Loss/Dementia, Communication, Urinary incontinence, Psychosocial Well-Being, Mood State, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychosocial Drug use and Pain. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with NHA-A and DON-B on 3/21/22 at 3:00 PM. Additional information was requested if available. The facility could not supply any additional information during the Survey. 15.) R64 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. Surveyor reviewed R64's Admission MDS assessment dated [DATE]. The following CAAs were triggered on the assessment: ADL Functional/Rehabilitation Potential, Urinary incontinence, Psychosocial Well-Being, Mood State, Activities, Pressure Ulcer, Pain and Return to Community Referral. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with NHA-A and DON-B on 3/21/22 at 3:00 PM. Additional information was requested if available. The facility could not supply any additional information during the Survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observations, record reviews and interviews, the facility did not develop a comprehensive person-centered care plan for 3 (R64, R68, R3) of 18 sampled residents. *R64 requires extensive to total assistance with ADLs (Activities of Daily Living). The Facility did not develop a comprehensive car plan to acknowledge R64's ADL Functional Needs and provision of care. *R68 was observed wearing an abdominal binder. The Facility did not develop a comprehensive care plan to acknowledge initiation of R68's abdominal binder as a physical restraint. *R3 was enrolled in Hospice Services on 10/23/21. The Facility did not develop a comprehensive care plan to acknowledge R3's enrollment of Hospice Services and provision of care. Finding includes: Policy The facility's Comprehensive Care Plan Policy with a revision date of September 2013 reads: .1. A comprehensive care plan for each Resident is developed within 7 days of completion of the Resident Assessment (MDS). 2. The care plan is based on the Resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team . 1. R64 was admitted to the facility on [DATE] with diagnoses including Left Hip Fracture, Arthritis, Muscle Weakness and Cardiomyopathy. Surveyor reviewed R64's Admission MDS (Minimum Data Set) assessment dated [DATE] reads that R64 requires extensive to total assistance with ADLs, including personal hygiene and bathing. R64's MDS indicates that R64's preferences for bathing are Very Important to this resident. On 3/15/22 at 10:05 AM, Surveyor conducted an interview with R64. R64 told Surveyor that their skin and scalp are very dry and itchy. R64 shared that they haven't had a shower or tub bath in several weeks. R64 told Surveyor that staff will wash their peri area when resident is incontinent but they do not feel like a bed bath meets their hygiene needs as staff are cleaning the resident's perineal area and not their entire body. Surveyor notes R64 with dry, flaky skin and disheveled hair at the time of this interview. On 3/16/22, Surveyor reviewed R64's comprehensive care plan. Surveyor could not identify an ADL care plan to address R64's bathing needs and preferences. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/22 at 3:00 PM, Surveyor conducted interview with NHA (Nursing Home Administrator)-A. Surveyor asked who would be responsible for ensuring that resident's ADL care plan would be initiated. NHA-A told Surveyor that the facility had a previous MDS coordinator who should have been initiating comprehensive care plans for residents. Surveyor informed NHA-A of concerns related R64 not having a ADL care plan initiated to address their bathing needs and preferences. NHA-A told Surveyor that they would look into this matter further. No additional information was provided to Surveyor. 22692 2. R68 was admitted to the facility on [DATE] with diagnoses which included gastronomy tube use, dysphasia and Di [NAME] Syndrome. On 3/15/22 at 11:05 a.m. R68 was observed in bed on her back wearing a gown. An abdominal binder was observed around R68's abdominal covering her gastronomy tube. On 3/16/22 at 12:26 PM R68 was observed in bed on her back wearing a gown. Certified Nursing Assistant (CNA)-P was in the room and was asked to show the Surveyor R68's abdominal binder. CNA-P lifted R68's gown and the abdominal binder was observed around R68's abdomen. On 3/16/22 R68's current physician's orders were reviewed and read: Apply Abdominal Binder - gastronomy(G)-Tube protection, monitor skin underneath every shift start date 12/6/21. On 3/16/22 R68's current care plan was reviewed and the only mention of R68's abdominal binder was an intervention under the care plan for Alteration in gastrointestinal status dated 12/6/21 that read: Abdominal binder-G tube protection. On 3/16/22 at 3:00 PM Director of Nurses (DON)-B was interviewed and indicated the abdominal binder was placed after R68 pulled out her G-tube and it was being used to prevent her from doing it again. On 3/17/22 at 3:00 p.m. Administrator-A and DON-B were informed the observations of R68 having an abdominal binder without a care plan for the physical restraint. 38829 3. R3 was admitted to the facility on [DATE] with diagnoses of Hereditary and Idiopathic Neuropathy, Chronic Obstructive Pulmonary Disease (COPD), Adult Failure to Thrive, Dyspagia, and Anxiety Disorder. R3 is her own person. R3's Significant Change Minimum Data Set (MDS) dated [DATE] documents R3's short and long term memory is impaired, and R3 demonstrates severely impaired skills for daily decision making. Surveyor notes that R3's MDS documents R3 is receiving hospice care. The MDS also documents that R3 requires total dependence for bed mobility, transfers, dressing, toileting, and bathing. The MDS also documents that R3's PHQ-9 (Mood Score for the Patient Health Questionnaire) is 14 indicating that R3 has moderate depression. Surveyor notes that R3 elected to accept hospice care on 10/23/21. R3 then transferred to a new company on 3/11/22. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R3's comprehensive care plan on 3/16/22 which did not contain or document anywhere that R3 was hospice care. R3's care plan did not address R3's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment related to hospice care. On 3/21/22 at 3:14 PM, Surveyor shared the concern with Administrator(NHA-A) and Director of Nursing (DON-B) the concern that R3's comprehensive care plan did not address R3's comprehensive needs related to hospice care. No further information was provided at this time.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on interview and record review, the facility did not ensure that 4 (R9, R64, R59 and R10) of 4 Residents reviewed who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good hygiene. * R9, R64 and R59 did not receive showers according to their shower schedules. * R10 did not receive care of discharge from her tracheotomy sight. Findings include: 1. R9 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia. R9 's quarterly MDS (Minimum Data Set) assessment, with an assessment reference date of 12/13/21, documents a BIMS (Brief Interview Mental Status) score of 12 which indicates moderate cognitive impairment. R9 is dependent on two plus person physical assist from staff for bathing. The Surveyor reviewed R9's bathing schedule due to a concerns R9 was not receiving showers. On 3/15/22 at 12:33 PM R9 was interviewed and indicated he hadn't had a shower in about 2 months and he would like to get one once a week. On 3/17/22 R9's Certified Nursing Assistant (CNA) caretracker documentation for bathing was reviewed and R9 was not documented as having a shower from 12/27/21 to 3/16/22. On 3/17/22 R9's CNA kardex was reviewed and no shower day was on the kardex. On 3/17/22, R9's shower documentation was reviewed for February/ March 2022 and identified no documentation of R9 receiving a shower from 2/21/22 to 3/22/22. On 3/21/22, at 2:00 PM, Administrator-A was interviewed and indicated R9 should have showers on Mondays and she could not find any documentation that they were done. Administrator-A also indicated shower days should be on the CNA kardex and was not for R9. The above findings were shared with the Administrator and Director of Nurses on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 42037 2. R64 was admitted to the facility on [DATE] with diagnoses including Left Hip Fracture, Arthritis, Muscle Weakness and Cardiomyopathy. Surveyor reviewed R64's Admission MDS (Minimum Data Set) assessment dated [DATE] reads that R64 requires extensive to total assistance with ADLs, including personal hygiene and bathing. R64's MDS indicates that R64's preferences for bathing are Very Important to this resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/15/22 at 10:05 AM, Surveyor conducted an interview with R64. R64 told Surveyor that their skin and scalp are very dry and itchy. R64 shared that they haven't had a shower or tub bath in several weeks. R64 told Surveyor that staff will wash their peri area when resident is incontinent but they do not feel like a bed bath meets their hygiene needs as staff are cleaning the resident's perineal area and not their entire body. Surveyor notes R64 with dry, flaky skin and disheveled hair. On 3/16/22, Surveyor reviewed R64's Kardex. Surveyor could not identify which day R64 was scheduled for a shower or tub bath. Surveyor requested a copy of R64's bathing documentation for the last 30 days. On 3/17/22, Surveyor reviewed R64's bathing documentation for the last 30 days. R64's bathing documentation indicates that R64 last received a shower on 2/18/22. On 3/22/22 at 10:37 AM, Surveyor conducted interview with ADON (Assistant Director of Nursing)-D. ADON-D told Surveyor that residents should be receiving a shower or tub bath on at least a weekly basis. On 3/22/22 at 1:20 PM, Surveyor conducted interview with NHA-A. Surveyor asked how staff would be aware of how often a resident should be receiving a shower or tube bath. NHA-A told Surveyor that residents should receive a shower or tub bath at least weekly and that information should be in their medical record. Surveyor informed NHA-A of concerns related to R64 receiving 1 documented shower in the last 30 days and R64's preference of receiving a shower on at least a weekly basis. No additional information was provided at this time. 3. R59 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. The Surveyor reviewed R59's Admission MDS assessment dated [DATE]. R59's MDS indicates that R59 requires total assistance of 1 staff for bathing. R59's MDS indicates that the importance of taking a bath is Very Important to them. On 03/15/22 at 10:57 AM, Surveyor attempted to conduct interview with R59. R59 was noted in bed, lying on their back. R59 was found to be disheveled and unshaven. R59 was wearing a hospital gown at this time and their hands were noted with a brown substance underneath their fingernails. Surveyor asked how long it has been since they had a shower or bath. R59 declined questions at the time of this interview and wanted to take a nap. On 3/16/22, Surveyor reviewed R59's Kardex. Surveyor could not identify which day R59 was scheduled for a shower or tub bath. Surveyor requested a copy of R59's bathing documentation for the last 30 days. On 3/17/22, Surveyor reviewed R59's bathing documentation for the last 30 days. R59's bathing documentation indicates that R59 has not received a shower or tub bath in the last 30 days On 3/22/22 at 10:37 AM, Surveyor conducted interview with ADON (Assistant Director of Nursing)-D. ADON-D told Surveyor that residents should be receiving a shower or tub bath on at least a weekly basis. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/22/22 at 1:20 PM, Surveyor conducted interview with NHA-A. Surveyor asked how staff would be aware of how often a resident should be receiving a shower or tub bath. NHA-A told Surveyor that residents should receive a shower or tub bath at least weekly and that information should be in their medical record. Surveyor informed NHA-A of concerns related to R59 not receiving a documented shower in the last 30 days. No additional information was provided at this time. 36161 4. R10 was admitted to the facility on [DATE] with a diagnosis that included Quadriplegic Cerebral Palsy, Contracture, Chronic Respiratory Failure, Tracheostomy and Cognitive Communication Deficit. R10's Quarterly MDS (Minimum Data Set) dated 12/17/21 documents short and long term memory problems. Section C1000 (Cognitive Skills for Daily Decision Making) documents that R10 has severely impaired skills for daily decision making. Due to R10's mental status, Surveyor was unable to interview R10 regarding the ADL (Activities of Daily Living) care she received from staff at the facility. Section G (Functional Status) documents that R10 requires total assistance and two person physical assist for her bed mobility, transfer, personal hygiene and bathing needs. R10 did not trigger for a ADL (Activities of Daily Living) CAA (Care Area Assessment). R10's ADL (Activities of Daily Living) care plan dated as initiated on 3/18/20 documents under the Focus section, Resident has Impaired Mobility r/t (related to) spastic quadriplegia, cerebral palsy, bilateral upper and lower extremity contractures. Under the Interventions section it documents, Personal Hygiene- A1 (assist of 1); Bathing- A1 (assist of 1). On 3/15/22 at 10:22 a.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed R10 to have a white dry substance, believed to be respiratory phlegm and sputum, on her chest, down the sides of her neck and on her jaw and face. On 3/15/22 at 1:01 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed R10 to have a white wet substance, believed to be respiratory phlegm and sputum, on the top of her chest, down sides of her neck and on her jaw and face. On 3/16/22 at 7:56 a.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed R10 to continue have a white wet substance, believed to be respiratory phlegm and sputum, on the top of her chest, down sides of her neck and on her jaw and face. On 3/16/22 at 12:26 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed R10 to continue have a white wet substance, believed to be respiratory phlegm and sputum, on the top of her chest, down sides of her neck and on her jaw and face. On 3/16/22 at 2:08 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed R10 to continue have a white substance, believed to be respiratory phlegm and sputum, on the top of her chest, down sides of her neck and on her jaw and face. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/16/22 at 3:20 p.m., during the daily exit meeting, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. At the time no additional information was provided. On 3/17/22 at 8:31 a.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed R10 to continue have a wet white substance, believed to be respiratory phlegm and sputum, on the top of her chest, down sides of her neck and on her jaw and face. On on 3/17/22 at 1:41 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed R10 to continue have a white substance, believed to be respiratory phlegm and sputum, on the top of her chest, down sides of her neck and on her jaw and face. On 3/21/22 at 3:31 p.m., Surveyor asked DON-B why R10 did not have her tracheostomy stoma covered and why R10 had wet phlegm on her chest, neck, jaw and face. DON-B informed Surveyor that R10 had decannulated her self and that she had declined to have her tracheostomy tube placed again. DON-B informed Surveyor that he had had spoken to staff about having R10's tracheostomy stoma covered to prevent the sputum and phlegm from getting on R10's body. No additional information was provided as to why staff did not ensure R10 received necessary services to maintain good groom and personal hygiene.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure that 1 (R3) of 5 Residents reviewed for pain management received pain management consistent with professional standards of practice and Resident choice related to pain management. R3 was admitted to hospice on 10/23/21. On 3/11/22 R3 pain medication was increased. R3 did not receive requested and prescribed pain medication until 3/18/22. Findings Include: The facility policy, entitled Pain Assessment and Management dated as revised March 2015, states: Purpose The purpose of this procedure are to help the staff identify pain in the Resident, and to develop interventions that are consistent with the Resident's goals and needs and that address the underlying causes of pain . Defining Goals and Appropriate Interventions: 1. The pain management interventions shall be consistent with the Resident's goals for treatment. Such goals will be specifically defined and documented. 2. Pain management interventions shall reflect the sources, type, and severity of pain. 3. Pain management interventions shall address the underlying causes of the Resident's pain. Implementing Pain Management Strategies: 6. Implement the medication regimen as ordered, carefully documenting the results of the interventions. Monitoring and Modifying Approaches: 1. Re-assess the Resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. 2. Monitor the following factors to determine if the Resident's pain is being adequately controlled: a. The Resident's response to interventions and level of comfort over time b. The status of underlying cause(s) of pain c. The presence of adverse consequences to treatment (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Documentation 1. Document the Resident's reported level of pain with adequate detail (enough information to gauge the status of pain and effectiveness of interventions for pain) as necessary and in accordance with the pain management program . Reporting 1. Significant change in the level of the Resident's pain . 3. Prolonged, unrelieved pain despite care plan interventions . R3 was admitted to the facility on [DATE], with diagnoses of Hereditary and Idiopathic Neuropathy, Chronic Obstructive Pulmonary Disease (COPD), Adult Failure to Thrive, Dyspagia, and Anxiety Disorder. R3 is her own person. R3's Interim Care Plan dated 10/8/21, documents R3 has pain and is taking pain medications. Surveyor notes that R3's comprehensive care plan reflects a focused problem that R3 is at risk/potential for pain due to generalized discomfort, neuropathy initiated: on 10/18/21, along with all interventions put in place on 10/18/21. Surveyor notes this focused problem along with interventions for R3 has not been revised since 10/18/21. Surveyor notes that R3 elected to accept hospice care on 10/23/21. R3's Significant Change Minimum Data Set (MDS), dated [DATE], documents R3's short and long term memory is impaired, and R3 demonstrates severely impaired skills for daily decision making. Surveyor notes that R3's MDS documents R3 is receiving hospice care. The MDS also documents that R3 requires total dependence for bed mobility, transfers, dressing, toileting, and bathing. The MDS also documents that R3's PHQ-9 (Mood Score for the Patient Health Questionnaire) is 14 indicating that R3 has moderate depressive symptoms. R3's MDS documents R3 is receiving scheduled pain medication regimen. R3's pain assessment dated [DATE], documents R3 has vocal complaints of pain. Surveyor notes R3's pain in February ranged from 2-8 on a scale of 1-10, 10 being high pain. Surveyor notes R3's pain in March, prior to the increase in pain medication, ranged from 2-10. Surveyor noted R3 was receiving the ordered Norco Tablet 5-325 MG two times per day for pain. Surveyor notes per R3's MARs, R3 had Acetaminophen Tablet and Ibuprofen Tablet ordered as needed. On 3/10/2022, the following was documented by R3's physician: PATIENT ENCOUNTER History of Present Illness: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Patient is a [AGE] year-old status post COVID-19 who has become increasingly weak, is now on hospice. COPD , HTN (Hypertension) , depression. Her oral intake is poor hardly eating or drinking. She states that she has pain all over unable to localize it denies shortness of breath does have a cough. She is sleeping a lot on and and off all day and at night. Looks uncomfortable and is reluctant to engage in conversation. REVIEW OF SYSTEMS Constitutional Displays Fatigue, Displays Poor Appetite, Displays Weight Loss, Displays Weakness Extrem, Psychiatric Displays Anxiety, Displays Depression, Displays Memory Loss, Displays Mood Changes, Pain 5 Physical Exam: Constitutional: thin, alert not cooperative, uncomfortable Psychiatric: Oriented x 3, cognition intact, mood sad CARE PLAN / ASSESSMENT ICD 10 or DX: Chronic obstructive pulmonary disease, unspecified, Adult failure to thrive, Essential, primary hypertension, major depressive disorder, recurrent severe w/o (without) psych (psychotic) features, generalized anxiety disorder, Polyosteoarthritis, unspecified, other specified polyneuropathies, COVID-19. Patient is a [AGE] year-old status post Covid who has become increasingly weak poor appetite and is on hospice just wants comfort oriented care. Is very uncomfortable at this time has generalized pain. On 3/11/22, R3 transferred to a new hospice provider. Surveyor reviewed R3's hospice progress notes and noted the following: On 3/14/22, R3's medical record documents: Chaplain visit for assessment. R3 is bed, states that R3 hurts all over. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that there is a fax communication in R3's hospice binder dated 3/13/22, documenting R3's Norco Tablet 5-325 MG (milligrams) two times daily to be discontinued and changed to Norco Tablet 5-325 MG four times daily for pain and a new order for Morphine oral concentrate 20 MG/1 mL (milliliter). Give 10 MG (0.5mL) every 2 hours as needed sublingual. Surveyor reviewed R3's current MARs (Medication Administration Records) and physician orders as of 3/16/22 and notes, R3's medication changes ordered on 3/13/22 were not reflected on the MARs or current physician orders. On 3/16/22, at 1:17 PM, Surveyor spoke to R3 who stated that R3 was having pain. On 3/16/22, at 1:19 PM, Surveyor spoke to Certified Nursing Assistant (CNA-M) who stated that R3 often complains of pain. On 3/16/22, at 1:42 PM, Surveyor confirmed with Medication Technician (MT-N) that R3's Medication Administration Record (MAR) documented R3 was to receive Norco Tablet 5-325 MG two times a day for pain. On 3/17/22, at 8:55 AM, Surveyor spoke to R3 who stated R3's pain is constant and Surveyor observed grimacing by R3. On 3/17/22, at 12:50 PM, Surveyor interviewed hospice nurse (RN-J) who confirmed that on 3/11/22 RN-J initiated the change of R3's pain medication. RN-J stated RN-J verbally informed DON-B of the medication change on 3/11/22. RN-J stated that RN-J always faxes the medication changes to the pharmacy and the facility and that is what RN-J did with R3's medication changes on 3/11/22. RN-J states that RN-J visited R3 on 3/13/22 and checked to make sure the facility's MAR for R3 reflected the medication change. RN-J stated RN-J was informed by the 2nd shift agency nurse that the change in pain medication had been done. Surveyor notes the fax communicating the change in R3's medication was sent on 3/13/22 to the attention of DON-B. Surveyor notes there is no documentation of the conversation between RN-J and the 2nd shift agency nurse. On 3/17/22, at 1:15 PM, Surveyor shared with Administrator (NHA-A) and Corporate Registered Nurse (RN-O) that R3's pain medication had been changed significantly on 3/11/22 and the facility had not made the change as reflected in R3's current MAR and physician orders, thus R3 had not been receiving pain medication as prescribed by hospice. Surveyor shared the concern at this time of the break down in communication between hospice and the facility. On 3/17/22, at 1:39 PM, DON-B brought to Surveyor, R3's 'Medication Profile' and stated to Surveyor, I am telling you the morphine is not on there. Surveyor showed DON-B the fax dated 3/13/22, at 3:57 PM from hospice to DON-B reflecting the requested medication changes for R3 . DON-B stated, well it must be still up on the fax machine. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Surveyor notes that R3's electronic medical record (EMR) contains a note dated 3/17/2022, at 7:00 PM stating the following: Spoke with Hospice RN-J, discussed current regimen, made aware of Medication Error with no adverse effects. Son was called with message left to update, [name of nurse] RN to also attempt to call Son [name of son] to discuss. All medications reviewed for accuracy with no new changes at this time. R3's pain assessment dated [DATE], documents R3 has been in pain or hurting in the last 5 days and movement causes pain, lying on either side and R3 winces when turned. R3's hospice progress notes note dated 3/17/22 noted R3 was in a lot of pain. On 3/21/22, at 9:29 AM, Surveyor observed R3 in bed with eyes closed. Surveyor observed R3 to be restless and had facial grimacing. On 3/21/22, at 11:15 AM, Surveyor interviewed R3. R3 stated the following to Surveyor: I am so upset. I haven't been out of bed in 3 months and I wish I could get up. Its probably too late now. I have pain all the time no matter what time of the day. It bothers me all through my body, all day. I have a bedsore that hurts. They don't give me meds before they put the bandage on, before they put the pads on. Surveyor asked R3 on a scale of of 1-10 where is your pain at this time. I know all about those pain scales. I am at between a 9 and 10. Everything is so painful. I'm so alone, the grief is so bad. I can't see my TV, I'm losing my eyesight, but it's not even plugged in for me to listen to. I feel like suicide, I know I can't do anything. I will be 98 in 2 days. I know people have it worse than me, but I am miserable. Every morning I don't want to get up and face another day. On 3/21/22, at 11:40 AM, Surveyor interviewed CNA-L who stated that R3 complains of a lot of pain, especially with repositioning. On 3/21/22, at 1:48 PM, Surveyor spoke to RN-J again. RN-J stated RN-J sent the morphine order on 3/11/22, and called the pharmacy about 6:30 PM. RN-J stated RN-J wanted the medications sent out that night. RN-J was informed the facility got the medications. RN-J recalls talking to the floor nurse, and talked to DON-B who was in the building on 3/11/22 regarding the pain medication changes with follow up by fax on 3/13/22. RN-J stated DON-B acknowledged understanding. RN-J stated RN-J informed DON-B the medications were coming for R3. RN-J felt comfortable R3 would be getting the medications right away. RN-J is not sure why it did not happen. RN-J stated the family had expressed concerns with R3's pain. R3 is alert and oriented and had expressed that R3 was having pain with R3's wound. R3 is able to express what R3 wants and needs. R3 wanted to keep the Norco because R3 felt R3 was getting some relief and didn't want to change the pain medication so RN-J increased the dosage. RN-J stated R3 was clearly in pain when RN-J assessed R3. RN-J stated the morphine was ordered for R3's breakthrough pain and is part of the comfort package. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 3/21/22, at 3:14 PM, Surveyor shared the concern with NHA-A and DON-B that R3's pain had not been managed by the facility as evidenced by verbal and physical signs that R3 was in pain frequently throughout the day. Surveyor shared the concern that hospice had ordered for an increase in R3's pain medication along with morphine added as needed for breakthrough pain on 3/11/22 with follow up fax on 3/13/22 and the facility did not make the change until 3/17/22 when Surveyor brought it to the facility's attention. Surveyor shared that R3 has verbalized being in constant pain, evident during the survey process and as a result R3 is expressing emotional and psychosocial distress.