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	02/22/2023

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 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. 14305 Based on record review and staff interview, the facility did not ensure 1 of 22 sampled resident's representative was notified of a change in condition. Resident (R) 9 had a change in condition and the interested representative was not notified. Findings: According to the Electronic Medical Record (EMR), R9 was admitted to the facility with diagnoses of Blastomycosis and Chronic Obstructive Pulmonary Disease. R9 had a family member listed as the responsible party on the EMR profile. The Progress Notes dated 11/27/22, indicated R9 presented with an oxygen saturation of 74%. The Nurse Practitioner was notified and orders received to send R9 to the hospital. R9 refused transfer. The documentation does not indicate R9's interested representative was notified of the change in condition nor was there documentation that R9 did not want the representative notified. The Progress Notes dated 11/27/22 at 12:49 AM, indicated R9 continued with an oxygen saturation of 70 -71%. R9 was short of breath and has rapid breathing. No documentation the interested representative was notified. The Progress Notes dated 11/27/22 at 5:44 AM, indicated R9 was transferred to the hospital for evaluation. The documentation does not indicate R9's interested representative was notified of the change in condition nor was there documentation that R9 did not want the representative notified. On 02/08/22 at 8:20 AM, the Surveyor interviewed Licensed Practical Nurse Unit Manager (LPN UM) G. LPN UM G verified there is no documentation indicating R9's representative was informed of R9's change in condition and the nurse that documented the change of condition is no longer employed at the facility.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14305 Based on observation, staff and resident interviews, the facility did not ensure that 5 of 8 residents had the right to a safe, clean and comfortable environment. This deficient practice has the potential to affect 37 residents who resided on the North unit. * The shower room on the North unit was observed to have rusty pipes and wall heater. An old wound dressing dated 1/26/23 was on the floor. There was missing floor tile. The shower drain had hair in it. There was a cracked cover exposing wiring. The shower room was cluttered with equipment such as shower chairs. 3 bags of soiled linen was observed on the floor. Resident rooms and bathrooms (R2, R15, Resident rooms: 119, 121, 124, 125, 127, 127) were not clean and sanitary with urinal equipment observed on the floor, feces noted on front of the toilet bowel, water faucet not turning off etc. Resident rooms had door protective panels that were broken and torn away from the door. Vents were extremely dusty and bathrooms were in need of deep cleaning. Findings: On 02/07/23 at 9:30: AM, the Surveyor observed Certified Nursing Assistant (CNA) C take R18 into the shower room. CNA C was moving shower chairs around in the room to get R18 in. On 02/07/23 at 10:35 AM, the Surveyor observed the North unit shower room. The shower room contained 2 shower chairs with 2 bariatric shower chairs. A wound dressing was observed on the floor in the shower area. The dressing had a date of 01/26/23. The floor had a crescent shaped area with an irregular measurement of 12 inches by 3 inches of missing tiles exposing a bare concrete floor. The shower drain on the floor which is approximately 6 inches in diameter is about 1/3 plugged with dirty hair. The heater box located on the wall is very rusty and dust is observed on the fan blades inside the unit. The pipes in the shower room are very rusty. There is a cracked area approximately 3 inches in length observed on a wire covering. 3 bags of soiled linens were observed on the floor. On 02/07/23 at 10:45 AM, the Surveyor interviewed CNA C. CNA C stated the shower room is always used as a storage room and have to move shower chairs around to get residents in the room. CNA C indicated housekeeping staff clean the shower room. On 02/07/23 at 10:20 AM, the Surveyor observed R2's bathroom. A large amount of fecal matter was observed dried onto the front of the toilet bowl. A urine collection cap was noticed tipped on its side on the floor under the sink. A moderate amount of dried yellow, brown substance was observed on the floor in the bathroom. The faucet on the sink was corroded and covered in a bluish green covering. The water faucet does not turn off so water runs continuously. Dirt and debris observed on the edge of the floor. A large amount of dust was observed on the heat register in R2's room. On 02/02/23 at 10:30 AM, the Surveyor interviewed Housekeeper (Hskg) H. Hskg H verified she had already finished cleaning R2's room. Hskg H and the Surveyor observed the room. Hskg H stated she was unable to remove the dried fecal matter in the toilet. Hskg H stated she tries to clean the rooms the best of she can. At 10:50 AM, Hskg H was able to remove the dried fecal matter from the toilet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/23 at 11:05 AM, the Surveyor observed the door of room [ROOM NUMBER] has a bottom panel in place as a door protector. The left side of the panel is cracked and a bare wood appearance is showing along the edge. The door panel is pulled away from the door and some areas of the left side of the panel has broken off. On 02/07/23 at 11:10 AM, the Surveyor observed the door of room [ROOM NUMBER] has a bottom door panel. The right side of the panel has peeled away. The panel has pulled away from the door at the bottom right side approximately 1 1/2 feet. Bare wood on the door is exposed. On 02/07/23 at 3:55 PM, the Surveyor observed the bathroom in room [ROOM NUMBER]. A urinal is observed laying on its side behind the toilet. The bottom of the urinal has a dried yellow substance that was visible. There is ground in dirt at the edge of the bathroom floor. On 02/08/23 at 8:10 AM, the Surveyor observed the following rooms: ~ room [ROOM NUMBER]- Faucet corroded on the bathroom sink. Heat vent in the room had an accumulation of dust. ~ room [ROOM NUMBER]- Room heat vent was very dusty. ~ room [ROOM NUMBER]- Heat register in room is very rusty and the front of the register is pulled away from the unit exposing a rusty appliance. A large amount of dirt and debris located on top of the register. ~ room [ROOM NUMBER]- Floor coving to the right of the bathroom door has pulled away from the wall and flopped forward. The area that has pulled away is approximately 1 foot. On 02/08/23 at 10:30 AM, after the housekeeper has cleaned the above areas. Rooms remained in the condition as initially observed. On 02/08/23 at 10:00 AM, the Surveyor observed R15's room. The bottom of the door panel is chipped and pulled away from the door. The Surveyor interviewed R15. R15 stated the door has always been that way and needs to be fixed. R15 indicated she feels the facility is dirty. On 02/08/23 at 10:10 AM, the Surveyor interviewed R16. R16 indicated she felt the facility is dirty and in need of a deep cleaning. On 02/08/23 at 10:20 AM, the Surveyor interviewed R17. R17 stated the shower room is always cluttered and staff have to move items around just so she can get to the shower area. R17 indicated the shower room is always dirty and items left on the floor. On 02/08/23 at 10:55 AM, the Surveyor and Licensed Practical Nurse Unit Manager (LPN UM) G reviewed all the above areas. LPN UM G stated the areas do need some cleaning and maintenance needs to be done.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not ensure at least 4 of 4 residents (R6, R21, R22, and R1) reviewed involving resident to resident altercations with R6, were free from abuse. R6 was the aggressor in at least 4 resident to resident altercations on 11/18/22, 11/25/22, 12/1/20, & 12/20/22, along with multiple incidents of R6 grabbing &/or hitting staff and residents. The Facility did not initiate a behavior care plan until 11/28/22, ten days after the initial resident to resident altercation occurred, did not revise the care plan timely, did not consistently investigate R6's resident to resident altercations and did not evaluate the effectiveness of the interventions once implement to help prevent potential abuse to R6, R21, R22, R1. Findings include: The Resident-to-Resident Altercations policy 2001 Med-Pass, Inc. (Revised December 2016) under Policy Interpretation and Implementation documents; 1. Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents, family members, visitors, or to the staff. Occurrences of such incidents shall be promptly reported to the Nurse Supervisor, Director of Nursing Services, and to the Administrator. 1. If two residents are involved in an altercation, staff will: a. Separate the residents, and institute measures to calm the situation; b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; c. Notify each resident's representative and Attending Physician of the incident; d. Review the events with the Nursing Supervisor and Director of Nursing, add possible measures to try to prevent additional incidents; e. Consult with the Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem; f. Make any necessary changes in the care plan approaches to any or all of the involved individuals; g. Document in the resident's clinical record all interventions and their effectiveness; h. Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the Attending Physician or Interdisciplinary Care Planning Team; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record; j. If, after carefully evaluating the situation, it is determined that care cannot be readily given within the facility, transfer the resident; and k. Report incidents, findings, and corrective measures to appropriate agencies as outlined in our facility's abuse reporting policy. R6's diagnoses includes developmental disorder of speech and language, schizoaffective disorder, and bipolar depression. R6's nurses note dated 11/18/22 documents Resident grabbing at staff and residents aggressively. Difficult to redirect. Resident reportedly grabbed another resident and pinched her face. On 2/14/23 at 10:49 a.m. Surveyor inquired if there is an investigation regarding R6's resident to resident altercation on 11/18/22. RN Regional Educator-V informed Surveyor they have nothing. The Facility did not assess R6, did not investigate this resident to resident altercation or the behavior of grabbing staff & residents, and did not initiate a behavior care plan until 11/28/22, 10 days after this incident to help prevent potential abuse to R6 and to other Residents R6 may have contact with. R6's nurses note dated 11/25/22 documents Resident is agitated, noted presence of hair, pulling, slapping, pinching, and grabbing other residents and staff. Writer included at this time. hall nurse notified nurse practitioner and received order for Buspar 10 mg daily as needed for agitation and restlessness. Attempts made to contact guardian and call went straight to voicemail on both home and mobile numbers. The incident report dated 11/25/22 under Nursing Description documents Resident was observed grabbing other resident's arms and pulling hair of other resident and then slapping him. This was stopped immediately and residents were separated by writer. No apparent injury to this resident and the male resident denied any injury also. Resident then approached another male resident and grabbed his arm. This resident began vocalizing his discontent and asked resident to stop. He then grabbed her arm on her wrist stating I am stronger than you? These residents were also separated and no apparent injury to this resident either. Resident continued to self propel wc (wheelchair) and follow other staff through facility. She grabbed this writer wrists, pinched and slapped writer body also. Resident was verbally asked to stop and does not adjust her behaviors. This incident involved R6 with R21 & R22. Under Resident Description documents Resident is Developmentally disabled and has a dx (diagnosis) also of schizo. Unable to verbalize many words and grunts. Does say coffee? (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under immediate action taken documents Resident was immediately separated from other residents, continued to be physically aggressive with staff. No PRN (as needed) was available for agitation and restlessness. NP (nurse practitioner) notified and gave orders for Buspar (buspirone) 10 mg (milligrams) po (by mouth) qd (every day) daily PRN. No apparent injury to resident, monitoring 72 hours for behavior and to monitor wrists for potential bruising r/t (related to) altercation with second resident. Under other information documents Frequent wandering, baseline is grabbing or reaching for staff and other residents when passing in hallway. The facility self reported the 11/25/22 resident to resident altercation, a behavior care plan was initiated on 11/28/22, and R6 was placed on one to one on 11/29/22. Surveyor noted the Facility has not addressed the behavior of grabbing other Residents. The nurses note dated 11/27/22 at 1:09 p.m. documents Very agitated. Pacing around facility grabbing on to fell ow residents. Has been noted to be slapping staff. She intentionally threw a facility computer to the ground. Staff is being 1:1 with the resident as much as possible. Recently started on Buspar. No adverse medication reactions. Mentation and neuro status remain at resident's baseline. The nurses note dated 11/27/22 at 5:30 p.m. documents Resident's behavior is escalating. She is constantly grabbing and hitting staff and fell ow residents. NP (Nurse Practitioner) [name] notified, DON (Director of Nursing) notified, guardian notified. Orders received to send resident to ER (emergency room) for eval and treatment. 911 was called. She has been transferred to ER at [hospital name]. The nurses note dated 11/28/22 at 4:21 a.m. documents Resident returned to facility per [name] service. N. O. (new order) Keflex to start. Resident alert and requesting breakfast and coffee. The resident is/has potential to demonstrate physical behaviors care plan initiated 11/28/22 and revised on 11/29/22 has the following interventions: * Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc. Initiated 11/28/22 & revised 12/10/22. * Evaluate for side effects of medications. Initiated 11/28/22. * Resident may require a firm no when she needs to disengage or let go of others. Initiated 11/28/22. * When I become/the resident becomes/resident becomes) agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Initiated 11/28/22 & revised 11/29/22. * 1:1 monitoring or safety. Initiated 11/29/22. * Keep away from high traffic areas when able. Initiated 1/11/23. * Redirect traffic around resident when unable to redirect resident. Initiated 1/11/23. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurses note dated 11/29/22 at 12:22 p.m. documents Call placed to [name] NP from psych services and [name] NP regarding resident's continued and un redirectable behaviors towards staff. Resident presents as a risk to self and to others. Awaiting return call back. The nurses note dated 11/29/22 at 1:38 p.m. documents Spoke with [name] NP with psych services, her recommendation is to send resident out for evaluation. Spoke with [name] NP and gave orders to send resident out due to resident's harm to self and others, attempting to stab staff member with pencil, throwing self against wall, combative, hitting, kicking, and biting staff members. The nurses note dated 11/29/22 at 3:31 p.m. documents Resident transported via 911 to [hospital name] due to resident being a risk of harming self and others. Hospital notified by [name] NP of psych services on resident's current condition. POA (power of attorney) called and left message to call facility. The nurses note dated 11/30/22 at 12:50 a.m. documents Returned from ER in stable condition. She was given fluids in the ER. Arrived with NNO (no new orders). She willingly went to bed and rapidly fell asleep. Will monitor. The facility did not evaluate the effectiveness of their interventions and did not revise R6's behavior care plan until 12/10/22 to prevent potential abuse to R6. R6's nurses note dated 12/1/22 documents Resident agitated and combative. Hit a fell ow resident (R1) in the face. Hitting staff. Sent to [name of hospital] ER (emergency room) for an eval. (evaluation) and treat. She was sent back after receiving Ativan. Is presently asleep. Will monitor. The Facility self reported this resident to resident altercation, conducted an investigation although the investigation does not indicate what R6 was doing prior to the incident and did not evaluate the effectiveness of their interventions already in place. Also according to R6's behavior care plan, on one to one began on 11/29/22, the Facility's investigation does not include why R6 was not provided with a one to one and after this altercation, R6 was placed back on 1 to 1. R6's behavior care plan was not revised until 12/10/22. The social service note dated 12/6/22 documents SSC (Social Service Coordinator) spoke with guardian giving updates. Guardian stated she has had these bouts of increased behaviors throughout the years and after a few weeks she returns to non behavioral baseline. The nurses note dated 12/18/22 at 7:49 a.m. documents Res (resident) restless and yelling, grabbing and pulling on any and every object. Writer attempted to escort res to her room res slapped writer across the face. Res not easily consoled or redirected at this time. [name] NP aware. The nurses note dated 12/18/22 at 8:55 a.m. documents Res combative. Pulled writer's hair. Took several staff members to detach her hand from the back of my head. Res climbing on and over nurses station. [name] NP aware. Rest sent to [hospital name] ER for eval and treatment. [Name] the guardian has been updated. She is very apologetic. Stating those behaviors are why she was not able to care of her at home anymore. [Name] Unit Manager on-call made aware. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurses note dated 12/18/22 at 11:26 a.m. documents [Hospital name] called. Stated they will be sending res back with NNO. This is her baseline and there is nothing they can do for her. Awaiting on res to arrive back. The nurses note dated 12/18/22 at 2:20 p.m. documents Resident returned to the Facility. The medication administration note on 12/18/22 at 4:49 p.m. documents Resident continues to have behaviors grabbing, pulling, and hitting on staff. Resident standing up in w/c (wheelchair) and throwing herself back almost knocking over w/c. Resident grabbing writers arm and standing up trying to bite. Staff unable to redirect staff sic (resident). No 1:1. The nurses note on 12/18/22 at 6:01 p.m. documents Resident continue to be combative with staff. Resident smacked CNA (Certified Nursing Assistant) across her face. Hitting writer numerous times across back and closing hand in med cart. Resident continue to try and tip chair over by standing and throwing herself back. Resident grabbing on staff clothing as they pass by. Resident unable to be redirected. Behaviors continue. The Facility did not evaluate the effectiveness of their interventions, did not implement their intervention of one to one as evidenced by the nurses note at 4:49 p.m. and R6's behavior care plan was not revised until 1/11/23 to help prevent potential abuse to R6 and others. The nurses note dated 12/19/22 at 10:24 a.m. documents At 0900 (9:00 a.m.) as needed Ativan was administered due to increased agitation and aggressive behaviors. Medication was ineffective. Resident continues lashing out at 1 on 1 caregiver. Resident choked, hit and scratched at caregiver. Will continue to maintain 1:1 intervention as well as continue to attempt as needed medication. The nurses note dated 12/19/22 at 2:28 p.m. documents Despite interventions, including redirection, distraction, speaking in low calm voice, providing snacks and drinks and as needed anxiety medication, resident continued to be agitated and aggressive. Continued to unsafely attempt to self transfer, hit staff, yell out and grab at other residents and visitors as the sic (they) walked by her. Will continue to attempt interventions and monitor. The Facility did not evaluate the effectiveness of their interventions and R6's behavior care plan was not revised until 1/11/23 to help prevent potential abuse to R6 and other Residents R6 may have contact with. The nurses note dated 12/20/22 documents Resident pushed against [R21's initials] w/c (wheelchair) and attack resident pulling back of his hair and then injured right hand between w.c. causing very small scratch right hand 3rd digit redness and minimal swelling. Lorazepam 0.5 was given hour before incident not effective. Noted grabbing on writer clothes pushing against nursing station and attempting to get out of w/c several times. Resident then became drowsy around 02:30 (2:30 a.m.). 0520 (5:20 a.m.) asleep in bed. RN (Registered Nurse) present time of incident. On 2/14/23 at 10:49 a.m. Surveyor inquired if there is an investigation regarding R6's resident to resident altercation with R21 on 12/20/22. RN Regional Educator-V informed Surveyor they have nothing. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility did not investigate R6's resident to resident altercation with R21, they did not evaluate the effectiveness of their interventions, and R6's behavior care plan was not revised until 1/11/23 to help prevent potential abuse to R6 and Residents R6 may have contact with. The medication administration note dated 12/24/22 at 2:53 p.m. documents non-compliant with cares, grabbing staff and other residents, throwing beverages on floor. The nurses note dated 12/24/22 at 4:31 p.m. documents Remains on 24 hoard while continuing on 1:1. 1:1 in place. Behaviors exhibited during start of shift. Resident grabbing staff/other residents, walking without w/c, throwing water on the floor, yelling out. Writer administered prn Lorazepam. Effective. Continues to be monitored. The Facility did not evaluate the effectiveness of their interventions and R6's behavior care plan was not revised until 1/11/23 to help prevent potential abuse to R6 and other Residents R6 may have contact with. On 2/13/23 at 8:56 a.m. Surveyor met with SSC (Social Service Coordinator)-BB to discuss R6. SSC-BB informed Surveyor R6 used to live in a group home and when admitted R6 was lethargic, not very engaged, is getting better and more active. SSC-BB informed Surveyor there were some issues and R6 had to be put on a one to one. Surveyor inquired when R6 was placed on the one to one. SSC-BB informed Surveyor off the top of her head she doesn't know but will get the date for Surveyor. Surveyor asked once R6 was placed on one to one did the one to one ever stop. SSC-BB replied no. SSC-BB informed Surveyor R6's guardian offered some insight as R6 had behavior when she lived with the guardian but the behavior lasted for a shorter period of time and then went back to her baseline. SSC-BB informed Surveyor they have not seen this yet. Surveyor asked SSC-BB when staff are doing one to one is staff at arm's length from R6. SSC-BB replied yes, they are next to R6. Surveyor inquired if SSC-BB is involved with care plans. SSC-BB replied yes. SSC-BB explained she also updates the care plans and they have discussions regarding the care plans. Surveyor informed SSC-BB R6 was involved in a resident to resident altercation on 12/1/22 & 12/20/22 and inquired if the one to one staff was with R6 when these incidents occurred. SSC-BB informed Surveyor she would have to look into this. On 2/13/23 at 9:57 a.m. Surveyor met with LPN/UM-G to discuss R6. Surveyor went over the nurses notes which discussed R6 grabbing or hitting staff and residents and inquired what was done to prevent this further behavior. LPN/UM-G explained the one to one was implemented on 11/29/22 for the first and second shift and on 12/19/22 the third shift was added. LPN/UM-G informed Surveyor she wasn't here when R6 was first admitted but understands she was in bed and then gradually her behavior started. Surveyor inquired if the one to one every stopped. LPN/UM-G replied no. Surveyor asked if there was a one to one how was R6 able to grab & or hit other residents and staff. LPN/UM-G informed Surveyor even with a one to one she will grab staff & residents, they can't stop her and the only way to prevent this is to keep R6 in her room all the time which they can't do. LPN/UM-G informed Surveyor she will look into the dates Surveyor provided to see if there was one to one staff assigned and get back to Surveyor. Surveyor informed LPN/UM-G Surveyor noted a behavior care plan was initiated on 11/28/22 and inquired if there was a previous care plan. LPN/UM-G informed Surveyor she would find out. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/23 at 12:59 p.m. SSC-BB informed Surveyor R6 started having a one to one for the first and second shifts as this is when the behavior was occurring. Something happened on third shift and one to one was started. Surveyor asked when the third shift one to one started. SSC-BB informed Surveyor she's not sure of the exact date and LPN (Licensed Practical Nurse)/UM (Unit Manager)-G is going through this. SSC-BB informed Surveyor they did specific education on R6 being impulsive, keeping R6 out of high traffic areas. Surveyor inquired when this education was done. SSC-BB indicated 1/20/23. On 2/14/23 at 9:27 a.m. Surveyor met with LPN/UM-G to discuss R6. Surveyor inquired if there was a behavior care plan prior to 11/28/22. LPN/UM-G replied no. LPN/UM-G explained there was no behavior when R6 was admitted , R6 was basically bed bound, gradually R6 would have a day with an episode but there was no behavior care plan in place until the behaviors started to be constant. Surveyor informed LPN/UM-G R6's first resident to resident altercation was on 11/18/22 and a care plan was not implemented until 10 days later which placed R6 and other residents at risk for potential abuse. Surveyor inquired if LPN/UM-G was able to determine whether according their plan of care a one to one was present. LPN/UM-G provided Surveyor with a list of dates Surveyor had questioned with staff assigned. LPN/UM-G explained if there was not a name on a particular date she (LPN/UM-G) wasn't able to determine who was the one to one staff member and if it was rotation there wasn't one particular staff member assigned but staff took turns during their shift. Surveyor noted according to the information LPN/UM-G provided Surveyor there was no one to one staff member on 12/1/22 when R6 was involved in a resident to resident altercation with R1. 12/14/22 no staff listed for first & third shift, 12/17/22 & 12/18/22 no staff assigned during any of the three shifts, 12/19/22 no staff listed for 1st & 2nd shift, 12/20/22 when R6 had a resident to resident altercation with R21 staff rotated on first & third shift and there was no staff listed for 2nd shift.

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	525318	A. Building B. Wing	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not self report to the State agency and/or report allegations of abuse within the required time frame for 6 (R6, R21, R22, R1, R4, & R20) of 7 Resdents. * R6's resident to resident altercation on 11/18/22 was not reported to the State agency. R6's resident to resident altercation with R21 & R22 on 11/25/22 was not reported to the State agency within the required time frame for the 5 day report. R6's resident to resident altercation with R1 on 12/1/22 was not reported to the State agency within the required time frame for the 5 day report. R6's resident to resident altercation with R21 on 12/20/22 was not reported to the State agency. * R4 and R20 had a resident-to-resident altercation on 2/14/2023 at approximately 12:30 AM when R4 allegedly hit R20 and R20 made homicidal threats to R4. The facility did not report the allegation of abuse to the State Agency within the required two-hour time frame. Findings include: The Abuse Investigating and Reporting policy 2001 Med Pass, Inc (Revised July 2017) under Policy Statement documents All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Under the section Reporting includes documentation of: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman' c. The Resident's Representative (Sponsor) of Record; d. Adult Protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 5. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. 1. R6's diagnoses includes developmental disorder of speech and language, schizoaffective disorder, and bipolar depression. * R6's nurses note dated 11/18/22 documents Resident grabbing at staff and residents aggressively. Difficult to redirect. Resident reportedly grabbed another resident and pinched her face. On 2/8/23 at 2:55 p.m. during the end of the day meeting with Current Administrator-P, LPN (Licensed Practical Nurse)/(Unit Manager)-G, RDO (Regional Director of Operations)-U and RN (Registered Nurse)/Regional Educator-V Surveyor asked for any self reports involving R6. On 2/14/23 at 10:49 a.m. Surveyor inquired about a self report regarding R6's resident to resident altercation. RN Regional Educator-V informed Surveyor they have nothing. This resident to resident altercation was not reported to the State agency. * R6's nurses note dated 11/25/22 documents Resident is agitated, noted presence of hair, pulling, slapping, pinching, and grabbing other residents and staff. Writer included at this time. hall nurse notified nurse practitioner and received order for Buspar 10 mg daily as needed for agitation and restlessness. Attempts made to contact guardian and call went straight to voicemail on both home and mobile numbers. The incident report dated 11/25/22 under nursing description documents Resident was observed grabbing other resident's arms and pulling hair of other resident and then slapping him. This was stopped immediately and residents were separated by writer. No apparent injury to this resident and the male resident denied any injury also. Resident then approached another male resident and grabbed his arm. This resident began vocalizing his discontent and asked resident to stop. He then grabbed her arm on her wrist stating I am stronger than you?. These residents were also separated and no apparent injury to this resident either. Resident continued to self propel wc (wheelchair) and follow other staff through facility. She grabbed this writer wrists, pinched and slapped writer body also. Resident was verbally asked to stop and does not adjust her behaviors. This incident involved R6 with R21 & R22. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed the Facility's self report and noted the initial reporting was submitted within the required time frame but the 5 day (F-62447) was not submitted until 12/13/22. This report should have been submitted by 12/2/22. On 2/14/23 at approximately 10:50 a.m. Surveyor inquired why the 5 day for R6 was not submitted until 12/13/22. RN (Registered Nurse) Regional Educator-V informed Surveyor Prior Administrator-AA is no longer with the company and is unable to explain why the 5 days was submitted after the required time. * R6's nurses note dated 12/1/22 documents Resident agitated and combative. Hit a fell ow resident (R1) in the face. Hitting staff. Sent to [name of hospital] ER (emergency room) for an eval. (evaluation) and treat. She was sent back after receiving Ativan. Is presently asleep. Will monitor. Surveyor reviewed the Facility's self report and noted the 5 day (F62447) was not submitted until 1/23/23. This should have been submitted by 12/9/22. On 2/14/23 at approximately 10:50 a.m. Surveyor inquired why the 5 day for R6 was not submitted until 1/23/23. RN (Registered Nurse) Regional Educator-V informed Surveyor Prior Administrator-AA is no longer with the company and is unable to explain why the 5 days was submitted after the required time. * R6's nurses note dated 12/20/22 documents Resident pushed against [R21's initials] w/c (wheelchair) and attack resident pulling back of his hair and then injured right hand between w.c. causing very small scratch right hand 3rd digit redness and minimal swelling. Lorazepam 0.5 was given hour before incident not effective. Noted grabbing on writer clothes pushing against nursing station and attempting to get out of w/c several times. Resident then became drowsy around 02:30 (2:30 a.m.). 0520 (5:20 a.m.) asleep in bed. RN (Registered Nurse) present time of incident. On 2/8/23 at 2:55 p.m. during the end of the day meeting with Current Administrator-P, LPN (Licensed Practical Nurse)/(Unit Manager)-G, RDO (Regional Director of Operations)-U and RN (Registered Nurse)/Regional Educator-V Surveyor asked for any self reports involving R6. Surveyor was not provided with a self report for R6's resident to resident altercation with R21 on 12/20/22. On 2/14/23 at 10:49 a.m. Surveyor inquired about a self report regarding R6's resident to resident altercation with R21 on 12/20/22. RN Regional Educator-V informed Surveyor they have nothing. This resident to resident altercation was not reported to the State agency. 38253 2. R4 was admitted to the facility on [DATE] with diagnoses of anxiety and adjustment disorder with depressed mood. R4's Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R4 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 03 and coded R4 as having hallucinations, delusions, verbal behaviors toward others, and wandering. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/2023 at 1:24 AM in the progress notes, nursing charted R4 had a resident-to-resident altercation with R20. Nursing charted R4 did not appear agitated prior to the incident and sustained no injury; R4 was able to be redirected and was currently resting in a chair in the dining room. On 2/14/2023 at 1:26 AM, in the progress notes, nursing charted the Assistant Director of Nursing (ADON) was made aware of the incident via voicemail. R20 was admitted to the facility on [DATE] with diagnoses of attention-deficit hyperactivity disorder, morbid obesity, depression, anxiety, and bipolar disorder. R20's Quarterly MDS assessment dated [DATE] indicated R20 was cognitively intact with a BIMS score of 13 and coded R20 as having delusions. On 2/14/2023 at 1:20 AM in the progress notes, nursing charted R20 had an altercation with R4 where R20 alleged physical assault by R4. Nursing charted R20 called the police department and when the police arrived, the police took a statement from R20. R20 made homicidal statements and R20 was educated by the police about making homicidal statements. Nursing charted R20 was currently sitting in their room in a wheelchair, eating pizza. Nursing charted R20 did not show any signs of injury. On 2/14/2023 at 1:26 AM in the progress notes, nursing charted the ADON was made aware of the incident via voicemail. In an interview on 2/14/2023, at 9:24 AM, Surveyor asked Nursing Home Administrator (NHA)-P if there had been any reports of resident-to-resident altercations in the last couple of days. NHA-P stated there was an altercation early that morning and was submitting a report to the State Agency at that very moment. Surveyor asked NHA-P how NHA-P became aware of the incident. NHA-P stated the ADON Licensed Practical Nurse Unit Manager (LPN UM)-G told NHA-P that LPN UM-G had a voicemail and they listened to the voicemail together this morning. Surveyor asked NHA-P who was the manager on call last night. NHA-P stated LPN UM-G was on call. Surveyor asked Director of Nursing (DON)-B if DON-B was notified of the incident last night. DON-B stated DON-B got a call from a nurse in the middle of the night, but it was in regards to a resident that fell and was not notified of the resident-to-resident altercation. NHA-P stated NHA-P has called the nurse that documented the incident to get a detailed statement of what happened and then will get a statement from the residents involved. Surveyor asked NHA-P what time the incident happened. NHA-P stated the incident occurred at approximately 12:30 AM. Surveyor shared with NHA-P the concern the allegation of abuse was not reported within the two hours of the incident occurring. NHA-P agreed the report was not done timely. No further information was provided at that time.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 20483 Based on interview and record review the Facility did not have evidence allegations of abuse were thoroughly investigated for 1 (R6) of 7 Residents reviewed for abuse. R6's resident to resident altercation on 11/18/22 and 12/20/22 were not investigated. Findings include: The Abuse Investigating and Reporting policy 2001 Med Pass, Inc (Revised July 2017) under Policy Statement documents All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Under the Role of the Investigator documents The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident. R6's diagnoses includes developmental disorder of speech and language, schizoaffective disorder, and bipolar depression. R6's nurses note dated 11/18/22 documents Resident grabbing at staff and residents aggressively. Difficult to redirect. Resident reportedly grabbed another resident and pinched her face. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/8/23 at 2:55 p.m. during the end of the day meeting with Current Administrator-P, LPN (Licensed Practical Nurse)/(Unit Manager)-G, RDO (Regional Director of Operations)-U and RN (Registered Nurse)/Regional Educator-V Surveyor asked for any self reports involving R6. On 2/14/23 at 10:49 a.m. Surveyor inquired if there is an investigation regarding R6's resident to resident altercation on 11/18/22. RN Regional Educator-V informed Surveyor they have nothing. * R6's nurses note dated 12/20/22 documents Resident pushed against [R21's initials] w/c (wheelchair) and attack resident pulling back of his hair and then injured right hand between w.c. causing very small scratch right hand 3rd digit redness and minimal swelling. Lorazepam 0.5 was given hour before incident not effective. Noted grabbing on writer clothes pushing against nursing station and attempting to get out of w/c several times. Resident then became drowsy around 02:30 (2:30 a.m.). 0520 (5:20 a.m.) asleep in bed. RN (Registered Nurse) present time of incident. On 2/8/23 at 2:55 p.m. during the end of the day meeting with Current Administrator-P, LPN (Licensed Practical Nurse)/(Unit Manager)-G, RDO (Regional Director of Operations)-U and RN (Registered Nurse)/Regional Educator-V Surveyor asked for any self reports involving R6. Surveyor was not provided with a self report for R6's resident to resident altercation with R21 on 12/20/22. On 2/14/23 at 10:49 a.m. Surveyor inquired if there is an investigation regarding R6's resident to resident altercation with R21 on 12/20/22. RN Regional Educator-V informed Surveyor they have nothing.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 interview and record review, the facility did not ensure residents received treatment and care based on a comprehensive assessment in accordance with professional standards of practice for residents experiencing changes in condition and for diabetic care for 4 of 14 sampled residents (R8, R9, R19, and R1.) There were no Registered Nurse (RN) assessments and there was a lack of monitoring by a competent licensed nursing staff for residents (R8, R9, R19) who experienced a change in condition requiring hospitalization . Additionally, the facility was not monitoring R1's blood sugars closely and was not conducting diabetic foot checks. R1 was hospitalized and was found to have gangrene on the toes of his left foot extending onto the dorsum of the foot as well as plantar surface. *R8 was sent to the hospital on 11/27/2022 via 911 for shortness of breath and low oxygenation. A timeline of events leading up to R8's hospitalization could not be determined due to lack of documentation. The last vital sign assessment of R8 was on 11/22/22. A physician order was in place to monitor temperature and oxygen saturation every shift and notify the physician and Director of Nursing (DON) immediately if any symptoms were present such as cough, fever greater than 100.0, and/or decreased oxygen saturation. Checkmarks were placed on the Medication Administration Record/Treatment Administration Record (MAR/TAR) with no values documented of the temperature or oxygen saturation levels. R8 was not comprehensively assessed by a licensed professional prior to hospitalization on [DATE] and at the time of the change of condition, no vital signs were documented, and no circumstances around the change of condition were documented. A non-nurse (Staff Member F) was working as a Licensed Practical Nurse (LPN) from 11/22/2022 through 11/27/2022 and was assigned to R8 on 11/27/22 during R8's change in condition. R8 passed away in the hospital on 11/28/2022. *R9 had a change in condition on 11/27/2022 with an oxygen saturation level of 74%. R9 was not comprehensively assessed by a licensed professional at the time of the change in condition. A non-nurse (Staff Member F) was assigned to R9 on 11/27/2023. Staff Member F did not get a Registered Nurse (RN) to assess R9 during this change in condition. Staff Member F contacted the Nurse Practitioner who ordered R9 to be sent to the hospital for evaluation and treatment. R9 refused to go to the hospital at that time. Staff Member F did not notify the Nurse Practitioner of R9's refusal. R9 was sent out to the hospital on 11/28/2022 at 1:45 AM with an oxygen saturation level of 70-71%. Complete vital signs were not documented at the time when the change of condition was first noted on 11/27/2022 or prior to leaving the facility on 11/28/2022 and no documentation was found describing the circumstances around the change of condition or between the time the change of condition was first noted and when R9 was sent to the hospital. A timeline of events could not be determined due to lack of documentation. R9 did not return to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* R19 was sent to the hospital on 10/25/2022 for a change in condition. A non-nurse (Staff Member F) was assigned to R19's unit on 10/25/2022. The medication administration record for 10/25/2022 indicates Staff Member F administered some of R19's morning medication. On 10/25/2023 R19's oxygen saturation level was 63%. R19's medical record did not have any documentation on 10/25/2022 indicating R19 had a change in condition that would require hospitalization : no progress note, no change of condition evaluation documentation, and no vital signs. A timeline of events could not be determined due to lack of documentation. R19 was admitted into the hospital on 10/25/2022. Cross-reference F726 for Competent Nursing Staff. Staff Member-F was not a licensed nurse or a Certified Nursing Assistant. *R1 was admitted to the facility on [DATE] without any skin concerns. The hospital discharge summary dated 11/23/22 under the section Follow Up Items for PCP (Primary Care Physician)/Outpatient Providers includes documentation of - Patient should have his DM (diabetes mellitus) meds (medications) optimized, he is noted to have diarrhea from Metformin, recommend PCP to consider alternate PO (by mouth) meds. There is no evidence the facility discussed this recommendation with R1's physician or physician extender to monitor R1's blood sugars closely. This physician's note was not scanned into the electronic medical record and the facility only obtained blood sugar for R1 one time which was on 12/4/22. Diabetic foot checks were not being completed, staff were not removing R1's gripper socks during cares and weekly skin assessments were not consistently being completed. On 1/7/23, R1 was transferred to the hospital. The emergency department note dated 1/7/23 documents - Left foot with toes 3 through 5 completely gangrenous and the distal portion of 2nd toe gangrenous. This extends little bit onto the dorsum of the foot as well as plantar surface. Proximal redness. The facility was unaware of R1's left foot gangrene until the hospital notified facility staff of this. The facility failure to have a licensed professional (RN) comprehensively assess residents (R8, R9, and R19) who were having a change in condition, the failure of the facility to have licensed professional staff monitoring residents with changes in condition, the failure to closely monitor R1's diabetic status to include the monitoring of blood sugars, and the failure to conduct diabetic foot checks and the monitoring of pain, created a finding of immediate jeopardy that began on 11/22/2022. Surveyor notified Nursing Home Administrator (NHA)-P and Director of Nursing (DON)-B of the immediate jeopardy on 2/13/2023 at 4:35 PM. The immediate jeopardy was removed on 2/21/23. The deficient practice continues at a scope/severity of E (potential for harm/pattern) as the facility continues to implement and monitor the effectiveness of their removal plan. Findings: The facility policy and procedure entitled Change in a Resident's Condition or Status dated with revision 5/2017 states: Policy Interpretation and Implementation: 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; . g. need to transfer the resident to a hospital/treatment center; . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. A 'significant change' of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting'); b. Impacts more than one area of the resident's health status; c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 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 Communication Form. 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. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 1. R8 was admitted to the facility on [DATE] with diagnoses of spastic quadriplegic cerebral palsy, anxiety, schizophrenia, intellectual disabilities, scoliosis, gastro-esophageal reflux disease, and dysphagia requiring a gastrostomy feeding tube for nutrition. R8's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R8 was severely cognitively impaired per staff assessment and was dependent for all activities of daily living. On 11/22/2022 at 12:23 PM in the progress notes, nursing charted R8 was visited by a community Case Manager and R8's Guardian. Nursing charted R8 was placed in a Broda chair with a Hoyer lift and positioned with pillows. Nursing charted R8 was able to tolerate being reclined and upright in the Broda chair for approximately one hour before being transferred back to bed. On 11/22/2022 (pm shift,) R8's vital signs were as follows: blood pressure 129/67, temperature 97.6, pulse 71, respirations 18, and oxygen saturation 97%. Surveyor noted the vital signs were obtained on 11/22/2022 because there was a physician order to obtain vital signs and monitor edema weekly on Tuesday PM shift. Surveyor noted a physician order was in place to monitor temperature and oxygen saturation every shift and notify the physician and Director of Nursing (DON) immediately if any symptoms were present such as cough, fever greater than 100.0, and/or decreased oxygen saturation. Surveyor noted checkmarks were placed on the Medication Administration Record/Treatment Administration Record (MAR/TAR) and no values were documented of the temperature or oxygen saturation level. R8 was not comprehensively assessed by a licensed professional prior to hospitalization on [DATE] and at the time of the change of condition, no vital signs were documented, and no circumstances around the change of condition were documented. A non-nurse was working as a Licensed Practical Nurse (LPN) from 11/22/2022 through 11/27/2022 and was assigned to R8's unit during this timeframe. There was no documentation in the progress notes between 11/22/2022 and 11/26/2022. No vital signs were documented after 11/22/2022. (continued on next page)

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Sheridan Health and Rehabilitation Center	8400 Sheridan Rd Kenosha, WI 53143

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/27/2022 at 11:34 AM in the progress notes, Staff Member-F, an unlicensed employee, charted R8 was sent out 911 at 11:00 AM for shortness of breath and low oxygen saturation. Staff Member-F charted the community Case Manager was unavailable and a message was left for them to call the facility for an update on the changes in R8. Staff Member-F charted R8's guardian was called and notified of changes, the Nurse Practitioner was updated, and the DON was aware. Surveyor did not find any documentation of Staff Member-F contacting a Registered Nurse to do an assessment of R8 for the change in status. No vital signs were documented. No details surrounding the change in condition were documented. Surveyor requested and received the Emergency Medical Service (EMS) report of R8's change of condition on 11/27/2022. The report states the following: EMS received the 911 call on 11/27/2022 at 11:11 AM and an ambulance unit and fire engine were dispatched to the scene for a call regarding a resident with complaints of difficulty breathing. On arrival, R8 was lying in bed in the care of staff. R8 was noted to have an altered mental status with the last known well time being 30 minutes ago. Staff stated R8 was not verbal and normally with an altered mentation, but this morning when giving R8 a bath, R8 became more altered than normal and was gasping for air. Staff stated R8's oxygen saturation was in the 70's and they applied oxygen via nasal cannula with no relief. R8's past medical history of cerebral palsy and scoliosis was noted. At 11:25 AM, R8's vital signs were assessed: blood pressure 98/58, oxygen saturation 71%, pulse 140 and regular, respirations 24 and rapid, blood glucose over 500, and temperature 98.0. (Surveyor noted R8's blood pressure and oxygen saturation were low and R8's pulse, respirations, and blood glucose were high.) R8's lungs were noted with rhonchi bilaterally, and R8 was placed on a mask with high flow oxygen. R8 was then moved to the ambulance for a further assessment. Once in the ambulance, vital signs were noted again, and R8's blood glucose read high on the glucose monitor. Intravenous (IV) access was attempted twice but was unsuccessful. R8's Glasgow Coma Scale was 8 and inconclusive on the stroke scale. R8 was placed on a heart monitor that showed sinus tachycardia (fast heart rate.) R8's oxygen saturation was 96% with the high flow oxygen. During the secondary assessment, no new issues were found. R8 was placed in a position of comfort and transported to the hospital at 11:34 AM. Surveyor requested and received the hospital record of R8's change of condition on 11/27/2022. The hospital medical record states the following: -The Emergency Department (ED) Triage note on 11/27/2022 at 12:04 PM states: R8 presented to the ED for shortness of breath. Staff stated R8 was having shortness of breath and was turning blue and they put oxygen at 2 liters per nasal cannula on R8 with no increase in oxygen saturations. R8 was placed on a non-rebreather oxygen mask in the rescue squad and the oxygen saturation increased to 96%. R8 was alert and oriented times two which was baseline for R8 per nursing home staff. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The Death Summary Note on 11/28/2022 at 7:16 PM describes R8's hospital course and states: R8 was a [AGE] year-old patient with a history of mental retardation, cerebral palsy, seizure disorder, anxiety, spastic quadriplegia, and scoliosis that presented with shortness of breath and hypoxia. R8 was noted to be turning blue at the nursing home. R8 did not improve with oxygen at 2 liters per nasal cannula and EMS was called. R8 was placed on BiPAP, tested negative for influenza and COVID, and was found to be febrile with a temperature of 100.8. R8 was started on empiric Rocephin. R8 coded and was intubated. R8 responded to epinephrine and then coded a second time. An epinephrine drip was started. Dark drainage was noted around the gastrostomy tube site and tested positive for occult blood. R8 was started on a Protonix drip. R8 was too unstable for any type of procedure and due to renal function and instability, they were unable to proceed with a CT scan. R8 was able to be weaned off the insulin drip and started on Lantus insulin and sliding scale insulin. R8 remained acidotic with worsening lactic acid. R8 was started on a Bicarb drip and nephrology was consulted. A conversation was had with R8's family about R8's poor prognosis and multiorgan failure with R8 requiring to be on four full dose pressors. R8 coded again on 11/28/2022; the ED was the first to respond to the room. LUCAS (an external automated chest compression device) was placed for compressions. R8 began to lose a large amount of blood from the mouth from compressions. R8 was already on multiple pressors, and no shockable rhythm was detected. Time of death was called at 4:44 PM (on 11/28/2022). Surveyor reviewed the 24-hour board that lists the residents in the facility that were being monitored for a change in condition, new medication, new skin area of concern, or any other focused monitoring for 11/22/2022 through 11/27/2022. R8 was not on the 24-hour board for monitoring of any condition. Surveyor requested the staff schedule for 11/27/2022. DON-B was the manager on call that day. Staff Member-F was listed as working day shift and was listed as the Charge Nurse for the day shift. Registered Nurse (RN)-X and two Licensed Practical Nurses (LPNs) from an agency were on the staff schedule on day shift. Certified Nursing Assistant (CNA)-W, CNA-Y, and CNA-Z were listed as the CNA staff on the unit Staff Member-F was working on day shift. In an interview on 2/2/2023 at 1:52 PM, Surveyor asked DON-B if DON-B recalled R8. DON-B stated R8 was on continuous tube feeding and needed to have everything done for R8. DON-B stated R8 liked to be in the fetal position and was non-verbal but moaned when uncomfortable. Surveyor noted DON-B was the manager on call for that day. Surveyor asked DON-B if DON-B recalled R8's change of condition on 11/27/2022. DON-B did not remember R8's change of condition. Surveyor asked DON-B if DON-B was called by Staff Member-F on 11/27/2022 either before, during, or after R8 was transferred to the hospital. DON-B did not remember being called on 11/27/2022. Surveyor asked DON-B if Staff Member-F was available for an interview. DON-B stated Staff Member-F no longer worked at the facility. DON-B stated Staff Member-F did not pass the Practical Nursing boards exam and did not return to work at the facility after failing the boards. Surveyor shared with DON-B the concerns that when R8 had difficulty breathing with low oxygen saturations, no RN was notified of R8's change in condition and R8 was not assessed by an RN, no vital signs were documented, and no documentation was found describing the events prior to the change in condition or the change in condition itself. DON-B stated DON-B would see if more information could be found regarding that incident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 2/8/2023 at 1:17 PM, Surveyor asked CNA-W if CNA-W recalled R8. CNA-W stated R8 was very contracted and needed to be repositioned every two hours to make R8 comfortable. Surveyor asked CNA-W if CNA-W could recall what happened with R8 on 11/27/2022. CNA-W stated R8 was fine on first shift and R8 was sent out on second shift. Surveyor clarified with CNA-W that R8 was sent out 911 on day shift. CNA-W agreed R8 was a full code but could not really remember that day. CNA-W stated R8 was not verbal and could not track with the eyes; R8 would moan sometimes but really did not have any communication. Surveyor asked CNA-W if CNA-W could recall working with Staff Member-F. CNA-W stated Staff Member-F would float between the two units. CNA-W remembered on 11/27/2022 an oxygen mask was placed on R8 because the oxygen levels were low. Surveyor asked CNA-W if R8 looked blue or distressed. CNA-W could not remember R8 looking blue or having difficulty breathing. Surveyor asked CNA-W if Staff Member-F called any other nurses to come and assess R8. CNA-W could not recall any other nurses being called to assess R8. In an interview on 2/8/2023 at 1:28 PM, Surveyor asked RN-X if RN-X recalled R8. RN-X recalled R8 had tube feeding for nutrition and would not really respond to staff because R8 was non-verbal. RN-X stated R8 resided on the unit RN-X did not work on. Surveyor asked RN-X if RN-X was called to assess R8 when R8 had a change in condition on 11/27/2022. RN-X stated RN-X did not get a call to assess R8 but heard R8 had desaturated. RN-X stated usually an LPN would call an RN before calling 911, but RN-X did not assess R8 before R8 left the building. RN-X stated RN-X was the only RN in the building at that time. Surveyor reviewed the time clock punches for 11/27/2022. RN-X was not working day shift on 11/27/2022 as was stated on the staffing schedule provided to Surveyor by the facility and was not in the building when R8 had a change in condition. During the daily meeting with the facility on 2/8/2023 at 2:49 PM, Surveyor shared with Nursing Home Administrator-P, Licensed Practical Nurse Unit Manager (LPN UM)-G, Regional Director of Operations (RDO)-U, and RN Regional Educator-V the concerns regarding R8's change of condition on 11/27/2022. On 11/27/2022, R8 had a change in condition with respiratory status. Staff Member-F did not have R8 assessed by an RN or any licensed staff with that change in condition, no vital signs were documented, and nothing was documented as to the circumstances prior to or during the change of condition. Surveyor shared DON-B did not recall being notified of the change of condition and was the manager on call that day. In an interview on 2/9/2023 at 9:24 AM, CNA-Y and CNA-Z talked to Surveyor together and had the same recollection of R8 and the events on 11/27/2022. CNA-Y and CNA-Z stated all R8 did was lie in bed in the fetal position and they would reposition R8 every two hours. CNA-Y stated R8 was usually a screamer when cares were being provided and CNA-Y recalled R8 was not screaming out like normal. CNA-Z stated it was like R8 had a cold, like R8 had nasal congestion. CNA-Y stated they noticed that R8 was different than normal and told Staff Member-F. CNA-Y stated Staff Member-F went in to do vital signs and R8's oxygen level was low, so they gave R8 oxygen and then Staff Member-F called the doctor and 911. Surveyor asked CNA-Y and CNA-Z if they remember R8 turning blue or gasping for air. CNA-Y and CNA-Z stated R8 was having a hard time breathing, but R8 was not blue. In an interview on 2/13/2023 at 10:18 AM, Surveyor asked Nurse Practitioner (NP)-M if NP-M was called on 11/27/2022 when R8 was having a change of condition. NP-M stated NP-M did not recall being notified of R8 being sent out and did not know any details of the transfer. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/13/2023 at 11:52 AM, Surveyor shared with NHA-P and RN Educator-V the serious concerns regarding R8's change of condition on 11/27/2022 with the lack of assessment by any licensed professional, the lack of documentation at that time with no vital signs or description of preceding events, and R8 passing away in the hospital on 11/28/2022. No further information was provided at that time. 2. R9 was admitted to the facility on [DATE] with diagnoses of blastomycosis and chronic obstructive pulmonary disease. On 11/25/2022 at 7:56 PM, R9's temperature was 98.1 and respirations were 19. On 11/26/2022 at 8:42 PM in the progress notes, Registered Nurse (RN)-X charted R9 visited with family and had issues with anxiety. R9 refused medications and refused to eat dinner but took sips of fluids. R9 verbalized wanting to be Hospice. On 11/27/2022 at 4:44 AM, R9's oxygen saturation was 93%. On 11/27/2022 at 9:15 AM, R9's blood pressure was 144/87 and pulse was 73. On 11/27/2022 at 10:48 AM, R9's oxygen saturation was 97%. On 11/27/2022 at 4:22 PM, R9's oxygen saturation was 92%. Surveyor noted a complete set of vital signs was not obtained at any one time from 11/25/2022 through 11/27/2022. On 11/27/2022 at 4:24 PM in the progress notes, Staff Member-F, an unlicensed employee, charted R9's oxygen saturation was 74% and R9 was positioned in high [NAME] (sitting upright). Staff Member-F charted an albuterol inhaler was administered and the oxygen saturation did not increase. (Surveyor noted the albuterol inhaler on the Medication Administration Record was not signed out as being administered.) Staff Member-F charted the Nurse Practitioner (NP) was contacted and the NP requested R9 be sent to the hospital. Staff Member-F charted R9 refused to go to the hospital and the NP was notified of the refusal. Surveyor noted no Registered Nurse (RN) was contacted to do an assessment of R9 at the time of the change of condition and no vital signs were documented. Per the staffing schedule, RN-X was in the building at the time of R9's change of condition. On 11/28/2022 at 12:49 AM in the progress notes, Licensed Practical Nurse (LPN)-E charted R9 had an oxygen saturation of 70-71% on 4 liters of oxygen per nasal cannula and R9 was tachypneic (fast heart rate). On 11/28/2022 at 12:54 AM, R9's oxygen saturation was 71%. Surveyor noted no other vital signs were documented. On 11/28/2022 at 5:44 AM in the progress notes, LPN-E charted R9 was transported to the hospital for evaluation at 1:45 AM. The LPN charted the NP had instructed R9 to be sent out during the previous shift due to shortness of breath, but R9 refused to go at that time. The LPN charted a message was left for the NP and the Director of Nursing of R9's transfer to the hospital. Surveyor noted per the staffing schedule, no RN was in the building at the time R9 was sent out to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R9 did not return to the facility. On 2/8/2023 at 7:50 AM, Surveyor conducted a telephone interview with LPN-E, who completed the documentation on 11/28/22 at 12:49 AM and 5:44 AM. LPN-E stated LPN-E could not recall R9 or the incident. LPN-E stated there is not an RN in the facility at all times, but the Director of Nursing (DON) can be called if needed. On 2/8/2023 at 8:20 AM, Surveyor interviewed Licensed Practical Nurse Unit Manager (LPN UM)-G. LPN UM-G indicated when a resident presents with a change in condition the facility does not call a resident assessment an assessment. LPN UM-G stated the facility uses the term an evaluation and LPNs can complete evaluations. LPN UM-G did indicate a head-to-toe evaluation should have been completed. LPN UM-G reviewed R9's medical record and verified an evaluation had not been completed. In an interview on 2/13/2023 at 10:18 AM, Surveyor asked NP-M if NP-M was notified on 11/27/2022 of R9 refusing to go to the hospital. NP-M stated NP-M did not recall R9 refusing. Surveyor shared with NP-M that R9 was sent out a few hours later with oxygen saturations in the low 70's. NP-M stated NP-M was glad someone sent R9 out with oxygen saturation levels that low. On 2/13/2023 at 4:35 PM, Surveyor shared with Nursing Home Administrator (NHA)-P, DON-B, RN Regional Educator-V, and LPN Unit Manager-G the concern with R9 not being comprehensively assessed by an RN with a change in condition on 11/27/2022 when Staff Member-F, an unlicensed employee, was caring for R9, no vital signs were obtained on 11/27/2022 and 11/28/2022 when R9 was in distress, and NP-M was not notified R9 had refused transfer to the hospital on 11/27/2022. No further information was provided at that time. 3. R19 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), diabetes, emphysema, alcoholic cirrhosis of the liver, metabolic encephalopathy, bipolar disorder, anxiety, alcohol abuse, nicotine dependence, and depression. On 10/21/2022 at 12:13 AM in the progress notes, Registered Nurse (RN)-X charted R19 went outside to smoke and had been following the safety rules to remove oxygen when smoking. On 10/23/2022 at 7:46 AM in the progress notes, a Licensed Practical Nurse (LPN) charted R19 had removed oxygen multiple times throughout the night shift to smoke cigarettes; R19 was educated on what occurs when not having oxygen on for periods of time while smoking. The LPN charted R19 would continue to be monitored for oxygen saturation levels and document as necessary. On 10/23/2022 at 8:18 AM in the electronic Medication Administration note, an LPN charted oxygen was on at that time and the LPN had to consistently remind R19 to keep the oxygen on due to R19 taking the oxygen off multiple times to smoke. No documentation was found in R19's progress notes from 10/23/2022 until 10/28/2022. On 10/25/2022 at 8:50 AM, R19's oxygen saturation was 63%. No other vital signs were noted. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor noted R19 had a Discharge Return Anticipated Minimum Data Set (MDS) assessment completed with a date of 10/25/2022. Surveyor could not find any documentation in R19's medical record on 10/25/2022: no progress note, no vital signs other than low oxygenation at 8:50 AM, and no change of condition SBAR (Situation-Background-Assessment-Recommendation) form showing the details of the change in status or notification to the physician, Nurse Practitioner, or family member. Surveyor reviewed R19's Medication Administration Record (MAR). R19 received medication on the night shift of 10/24/2022 and did not receive all the morning medications on 10/25/2022. The medication documentation for the morning of 10/25/2022 was written by Staff Member-F, an unlicensed employee. Surveyor asked for the nursing schedule for 10/25/2022. Staff Member-F was assigned to R19's unit on that date. Surveyor reviewed R19's Hospital Discharge Summary dated 10/27/2022. R19 was admitted to the hospital on 10/25/2022 with hypoxemia and increased respiratory distress. R19 was placed on BiPAP in the emergency room and had slow progressive improvement. R19 was weaned off to an oxygen mask followed by nasal cannula and required an average of 2 to 5 liters per minute by nasal cannula. R19 was placed on intravenous (IV) antibiotics to cover HCAP (healthcare associated pneumonia) due to recent hospitalization for pneumonia and COPD exacerbation as well as respiratory failure that required mechanical ventilation as well as residing at a nursing home facility. R19 had significant improvement in respiratory status. On 10/27/2022, R19 was clinically stable and at baseline and was discharged back to the nursing home. On 2/13/2023 at 4:35 PM, Surveyor shared with Nursing Home Administrator (NHA)-P, DON-B, RN Regional Educator-V, and LPN Unit Manager-G the concern with R19 not having any documentation of a change of condition on 10/25/2022 that required hospitalization . Surveyor was not able to find any progress notes, vital signs other than low oxygenation, or change of condition SBAR form indicating what had occurred requiring hospitalization and lack of documentation of who was notified. Surveyor shared the concern Staff Member-F was the employee listed on the schedule to care for R19 and Staff Member-F was not licensed as a nurse. No further information was provided at that time. 20483 The Nursing Care of the Resident with Diabetes Mellitus 2001 Med-Pass, Inc. (Revised December 2015) under Glucose Monitoring includes documentation of; 1. The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. 2. The physician will order the frequency of glucose monitoring. Under Medication Management documents; 1. Insulin (injectable or inhaled) is required for individuals with type I diabetes. 2. Insulin (injectable) can be administered via syringe, pump, or pen. 3. Medication management of type II diabetes may include oral hypoglycemic agents with or without insulin. Under documentation includes; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on observation, interview and record review, the facility did not ensure residents with pressure injuries received appropriate care and treatment to promote healing, prevent infection and prevent new pressure injuries from developing for 2 (R13 and R7) of 6 residents reviewed for pressure injuries. 1. R13 was admitted to the facility 5/26/22 and assessed to be at high risk for pressure injuries. On 10/6/22, the facility documented R13 had a healed pressure injury to the sacrum. Between 10/6/22 and 10/20/22 there were no skin assessments documented for R13. R13 was hospitalized on [DATE] and the hospital identified a 6 cm (centimeter) abscess due to pressure ulceration on R13's right gluteal area. R13 required surgery including debridement of skin, subcutaneous tissue, muscle, fascia perineum, right buttocks, bilateral groin and bilateral scrotum. R13 required a colostomy for wound healing and was transferred back to the facility on [DATE]. Upon readmission the wound was not comprehensively assessed until 11/10/22. Multiple wound treatments were not documented as being completed in November. R13 was hospitalized again 11/28/22 for a dislodged G-tube but wounds were noted by the hospital to be deteriorating and R13 was diagnosed with osteomyelitis. A PICC line was placed and F13 was transferred back to the facility on [DATE] with orders for 4 weeks of antibiotics for the wound infection and weekly labs. Upon readmission the wound was not comprehensively assessed until 12/8/22 and a fourth wound, a Deep Tissue Injury (DTI) was identified to the left heel. Multiple wound treatments were not documented as being completed in December nor were the weekly labs requested by the Infectious Disease MD obtained. The facility identified wound treatments were not being completed but the problem continued. On 12/29/22, an additional wound was identified to the left upper buttocks. On 1/4/23 R13 went to the Infectious Disease MD who had to extend the use of the antibiotics for the wound infection for another 2 weeks. By 1/5/23 the wound to the left heel had deteriorated from DTI to Stage 3, the left upper buttocks wound from Stage 2 to unstageable and undermining to the sacral wound. The left heel wound was healed by February 2023 but all other wounds noted deterioration on 1/26/23 or 2/2/23. Multiple wound treatments were not documented as completed in January and the facility again identified that wound treatments were not being completed but the problem continued through February. On 2/4/23, R13 was again transferred to the hospital and admitted . At time of the onsite survey R13 remained in the hospital with plans for surgical debridement of the wounds again. 2. R7 was admitted to the facility in 2018 and had a history of pressure injuries. On 3/30/22 a wound was found to his right gluteal fold and assessed as trauma. On 4/20/22 the Wound MD(Medical Doctor) assessed the wound as an Unstageable pressure injury and then a Stage 4. The wound deteriorated needing debridement due to necrotic tissue, undermining and became infected. The infection needed to be treated with IV (intravenous) antibiotics and then a wound vac. The wound improved to the point that it was almost healed on 2/2/23 according to the Wound MD. On 2/7/23 Surveyor observed wound care completed to R7 and when the nurse went to remove the bandage it was dated 2/2/23, was completely saturated, malodorous and had been on for 5 days even though the treatment was scheduled for daily. The facility had been aware in previous months that wound treatments were not being completed. Although they implemented at PIP (Performance Improvement Plan), it was not effective noted by the current observations. On 2/9/23, Surveyor again observed the wound with the Wound MD and the wound had deteriorated, had a 20% increase in length and was again necrotic and needed to be chemically debrided. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to comprehensively assess the wounds and skin timely, complete wound treatments as ordered, prevent new wounds from forming, prevent deterioration of existing wounds and prevent infections for these wounds created a finding of Immediate Jeopardy (IJ) that began on 10/20/22. Surveyor notified Current Nursing Home Administrator (NHA)-P, Director of Nursing (DON)-B and RN (Registered Nurse) Regional Educator (RN)-V of the IJ on 2/13/22 at 4:35 PM. The IJ was removed on 2/21/23, however the deficient practice continues at a scope/severity level of E (Potential for Harm/pattern) as the facility continues to implement its action plan. The AMDA (American Medical Directors Association) clinical practice guideline entitled Pressure Ulcers and Other Wounds, dated 2017, states in part: .A pressure ulcer [Injury] is localized damage to the skin or underlying soft tissue, usually over a bony prominence or related to a medical or other device. The ulcer may present as intact skin or as an open ulcer and may be painful. The ulcer occurs as a result of intense or prolonged pressure or pressure in combination with shear. Recognition: Early recognition of pressure ulcers and of any risk associated with the development of pressure ulcers and other wounds is critical to their successful prevention and management. Assessment: The purpose of the assessment is to collect enough information to evaluate the patient's general condition, characterize a pressure ulcer; and identify related causes and complications. Step 2. Examine the patient's skin thoroughly to identify existing pressure ulcers. Examine the patient's skin upon admission or readmission. Step 3. Assess the patient's overall physical and psychosocial health and characterize the pressure ulcers. A pressure ulcer should be assessed along with the patient's overall clinical, functional, and cognitive status weekly reassessment and documentation of ulcer characteristics is recommended. More frequent assessment may be necessary for ulcers that are not responding to treatment or are worsening despite treatment. Step 4. Identify factors that can influence ulcer treatment and healing.functional status. Functional factors, including impaired mobility, a self-care deficit, and incontinence (especially fecal incontinence), may influence the severity, duration, and healing of a pressure ulcer. Step 5.Documentation should cover all pertinent characteristics of existing pressure ulcers, including location; size; depth; maceration; color of the ulcer and surrounding tissues; a description of any drainage, eschar, necrosis, odor, tunneling, or undermining; tissue types covering the wound bed; .and a description of the peri-wound skin .including type and amount of drainage. Step 6. Identifying priorities in managing the ulcer and the patient .Pain control related to the ulcer and any comorbid conditions.The same factors that increase a patient's susceptibility to developing pressure ulcers . may also impair the healing of an existing pressure ulcer . Surveyor reviewed facility's Pressure Ulcer/Skin Breakdown - Clinical Protocol policy with a revision date of April 2018. Documented was: Assessment and Recognition (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Healing or Prevention Likely: The resident's underlying physical condition, prognosis, personal goals and wishes, care instructions, and ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. b. Healing or Prevention Possible: Healing may be delayed or may occur only partially; wounds may occur despite appropriate preventive efforts. c. Healing or Prevention Unlikely: The resident is likely to decline or die because of his/her overall medical instability; wounds reflect the individual's overall medical instability; an existing wound is unlikely to improve significantly; additional wounds are likely to occur despite preventive efforts . Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healing especially for those with complicated, extensive, or poorly-healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. b. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker. 1. R13 was admitted to the facility on [DATE] with diagnoses that included Unspecified Cord Compression, Quadriplegia due to Motor Vehicle Accident, Type 2 Diabetes Mellitus (DM) with Diabetic Neuropathy, Chronic Obstructive Respiratory Failure (COPD), Congestive Heart Failure (CHF) and Chronic Kidney Disease (CKD). Surveyor reviewed R13's Braden Scale for Predicting Pressure Sore Risks with an effective date of 5/26/22, documented a score of 9 indicating R13 is at very high risk for the development of pressure injuries. Surveyor reviewed R13's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/1/22, which documents a Brief Interview for Mental Status (BIMS) score of 13 which indicates R13 is cognitively intact; requires total assist of 2 + staff for bed mobility and transfers; is at risk for the development of pressure ulcers/injuries. Surveyor reviewed R16's Care Area Assessment (CAA) related to Pressure Ulcer/Injury with an assessment date of 6/1/22. Documented under Nature of the Problem/Condition was Resident is at risk for impaired skin integrity [related to (R/T)] Quadriplegia [status post (s/p)] Spinal cord compression, CHF (Congestive Heart Failure), CKD (Chronic Kidney Disease), COPD (Chronic Obstructive Pulmonary Disease), DM (Diabetes Mellitus) type 2, Oxygen use, Medication use, Dependent on staff for all [activities of daily living (ADL's)], and Bowel incontinence. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R13's Comprehensive Care Plan with initiation date of 6/5/22. Documented was Focus: Resident has Actual impaired skin integrity R/T Quadriplegia s/p Spinal cord compression, CHF, CKD, COPD, DM type 2, Oxygen use, Medication use, Dependent on staff for all ADL's, and Bowel incontinence. History of pressure related skin breakdown. Resident prefers to lay on back. Refuses repositioning at times. Goal: Resident will have intact skin, free of redness, blisters or discoloration by/through review date [as evidenced by (AEB)] weekly skin audits. Interventions: - Air mattress set to 360 check functioning every shift - I need assistance to turn/reposition at least every 2-3 hours with rounds, more often as needed or requested. - Monitor nutritional status. Serve diet as ordered, monitor intake and record. - Monitor, document and report [signs and symptoms (s/s)] of skin breakdown/impairment. - Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Surveyor reviewed R13's wound documentation. In June, July, August and September of 2022, R13 is documented as having a Stage 3 pressure injury to sacrum. It was assessed, monitored and a treatment was in place. Surveyor reviewed MD (Medical Doctor) orders for R7 for prevention of pressure injuries's. Documented with a start date of 8/26/22 was Zinc Oxide Cream 15 % Apply to PERI-RECTAL AREA topically every 8 hours as needed for SKIN PROTECTION and Head to toe skin assessment weekly one time a day every Fri (Friday) for Skin Monitoring. On 9/29/22, Wound MD-J assessed R13's pressure injury on the sacrum. Wound MD-J reclassified it Wound Status: HEALED. Observations of the wound were documented by Wound MD-J as Woundbed assessment: Fully granulated. Surveyor reviewed R13's Weekly Wound Assessment with an assessment date of 9/29/22. Documented was .B. Wound Description. 1. Type of wound: Pressure. 2. Wound Description: Site: 53) Sacrum. Type: Pressure. Length: 2.9 cm. (centimeter) Width: 2.0 cm. Depth: 0.1 cm. Stage: III. 3a. Percentage of granulation: 70. 3b. Percentage of slough: 0. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 30 . Surveyor notes this contradicted the Wound MD's assessment on the same day that documented the wound was healed. Survyeor was unable to locate documentation the facility addressed the discrepancy in the two assessments. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R13's Weekly Wound Assessment with an assessment date of 10/6/22. Documented was .B. Wound Description. 1. Type of wound: Pressure. 2. Wound Description: Site: 53) Sacrum. Type: Pressure. Length: 0 cm. Width: 0 cm. Depth: 0 cm. Stage: III. 3a. Percentage of granulation: 100. Surveyor noted the facility stated the wound was healed on 10/6/22. Surveyor reviewed MD orders for R7 for prevention of the wound site. Documented with a start date of 10/8/22 was Apply foam dressing to Sacrum for protection. Every day shift every Tue (Tuesday), Thu (Thursday), Sat (Saturday). Surveyor reviewed R13's Treatment Administration Record (TAR) for October 2022. The sacrum dressing was signed out as completed 10/8/22, 10/11/22, 10/13/22, 10/15/22, 10/18/22, and 10/20/22. Surveyor reviewed R13's TAR for October 2022. The Head to Toe Skin Assessment was blank and not documented as completed 10/7/22 and 10/14/22. Surveyor reviewed Evaluations and Progress Notes for R13 and there were no skin assessments documented as completed between 10/7/22 and 10/20/22. Documented 10/20/2022, at 9:23 AM, in R13's Progress Notes was Patient is alert with acute confusion and lethargy noted. Vital signs 133/69, 99, 18, 91% 2l, 100.8. He is being treated for upper resp (respiratory) infection with oral [antibiotics (ABT) at this time. Upon observation patient is speaking incoherently. His mentation changes from acute confusion and yelling to lethargy and uneasily aroused within minutes. Stated Please get me off the mill. Lung sound adventitious no s/sx (signs/symptoms) of resp distress noted at this time. Writer placed a call to [Nurse Practitioner (NP)-M] with updates. New order placed to send him to the ER (emergency room) for eval (evaluation) and treat . Surveyor reviewed R13's Hospital Report from admission on 10/20/22. Documented by General Surgery on 10/20/22 was Impression . right buttocks abscess secondary to what appears to be a pressure ulceration. Assessment and Plan: Right buttocks abscess with what appears to be acute nonviable skin overlying this region. Recommend incision and drainage and debridement. Plan on incision and drainage and debridement right buttocks . Documented on 10/21/22 in Hospital Progress Notes was: Assessment/Diagnostic and Therapeutic Plan: Patient Active Hospital Problem List: [status post (s/p)] debridement of wound of perineum, scrotum, right buttock, Fournier's gangrene of perineum, Abscess of right-sided buttock, Leukocytosis, Fever, AMS (altered mental status). -Patient presents to the emergency department w/(with). Altered mental status -Fever, temp of 102F, tachycardia, AMS on admission. -Leukocytosis w/ left shift, elevated [creatine phosphate] and procalcitonin on admission. -Blood cultures w/ [no growth to date (NGTD)] on admission. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CT (Computerized Tomography) of [anterior/posterior (A/P)] w/ 6 cm partially imaged soft tissue abscess [within] right medial gluteal region, suspected acute proctocolitis, G-tube more anterior than expected in location relative to stomach (functioning properly thus far) on admission. -Underwent debridement of skin, subcutaneous tissue, muscle, fascia perineum, right buttocks, bilateral groin and bilateral scrotum by General surgery on 10/20 by [MD]. -Found to have extensive necrotizing infection of skin, subcutaneous tissues of perineum, scrotum, buttocks. -Noted to be spiking fevers this AM, temp of 101F and 102F, given Tylenol w/improvement -Continue Vancomycin, pharmacy to dose, Zosyn for antimicrobial coverage. -General surgery following, will abide by their recommendations . Documented on R13's Patient Discharge Summary with a date of 11/3/22 was Discharge Diagnoses: -Fournier's gangrene in male (10/20/2022) POA (Power of Attorney): Yes -Right buttock abscess s/p debridement -Fournier's gangrene of perineum -Coccyx pressure ulcer -S/p colostomy creation 10/25 -Probable sepsis -Acute blood loss anemia -Iron deficiency anemia -Thrombocytosis -Urinary tract infection -Altered mental status resolved . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R13 was readmitted to the facility on [DATE]. Documented in Progress Notes on 11/3/2022 at 2:13 PM was Patient is alert and able to make needs known. readmitted to facility from [hospital.] Arrived via stretcher and assisted to bed with 4 staff members. Readmission dx (diagnoses) include: Fournier gangrene of the perineum, UTI (urinary tract infection), Sepsis, colostomy, altered mental status, and acute blood loss . Wound observation and measurements performed . Coccyx wound 6 x 3.5 50% slough, 25% eschar Left buttocks: 3.0 x4.0 x 3.0 right buttocks: 6.0 x10.0 x 4.5, under scrotum 6.0 x3.1 x 0.4. moderate amounts of drainage noted with dressing change. No foul odor noted . Surveyor notes there were no assessments of the wound bed or any description of the type of wounds. Surveyor reviewed R13's Admission/Readmission Evaluation with a date of 11/3/22. Documented under the Skin Integrity section was an assessment date of 11/10/22. Surveyor notes this is 7 days after R13's readmission to the facility. Documented was Site: 32) Left buttocks. Type: Surgical Incision. Length: 5.0 cm. Width: 4.0 cm. Depth: 1.0 cm. Stage: N/A. Site: 53) Sacrum. Type: Pressure. Length: 6 cm. Width: 3.5 cm. Depth: 0.1 cm. Stage: Unstageable. Site: Other (specify): Rt (right) butt to Scrotum. Type: Surgical Incision. Length: 15.0 cm. Width: 10.0 cm. Depth: 4.5 cm. Stage: N/A. Surveyor notes there were no comprehensive assessments of the wound beds upon R13's readmission to the facility. MD orders documented Clean wound to coccyx, left buttocks, right buttocks, scrotum and perineum with normal saline wash. [followed by (F/B)] pat dry F/B wet to dry dressing with Vashe wash [twice daily (BID) and [as needed (PRN)] two times a day with a start date of 11/3/2022. Surveyor notes this order was not documented on R13's November TAR and there was no documentation that it was completed 11/3/22 through 11/10/22. Surveyor reviewed R13's Weekly Skin Check with a date of 11/4/22. Documented was Resident admitted with open areas to coccyx, left buttocks, right buttocks. and scrotum. Areas were surgically debrided at hospital. There were no assessments of the wounds on 11/4/22. MD orders documented Head to toe skin assessment weekly one time a day every Thu (Thursday) with a start date of 11/10/2022. Wound MD-J and the facility assessed the wounds and surgical incisions on 11/10/22. Survyeor notes this is 1 week after readmission. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R13's Weekly Wound Assessments dated 11/10/22. Documented was .B. Wound Description. 1. Type of wound: Non-Pressure. 2. Wound Description: Site: Other (specify): Rt buttocks-Scrotum. Type: Surgical Incision. Length: 14.7 cm. Width: 10.0 cm. Depth: 3.2 cm. Stage: N/A. 3a. Percentage of granulation, new connective tissue and small blood vessels that form on the surface of a wound during the healing process that presents as shiny red tissue: 75. 3b. Percentage of slough: A layer of yellow, gray or brown non-viable tissue: 25. 3c. Percentage of eschar: A crust of thick, hard black non-viable tissue: 0. 3d. Percentage of epithelialization: Pearly pink new tissue present over the wound bed: 0 . Documented was .B. Wound Description. 1. Type of wound: Pressure. 2. Wound Description: Site: 53) Sacrum. Type: Pressure. Length: 3.6 cm. Width: 4.0 cm. Depth: 0.1 cm. Stage: Unstageable. 3a. Percentage of granulation: 25. 3b. Percentage of slough: 75. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . Documented was .B. Wound Description. 1. Type of wound: Non-Pressure. 2. Wound Description: Site: Other (specify): Left buttocks. Type: Surgical Incision. Length: 5.0 cm. Width: 3.2 cm. Depth: 1.9 cm. Stage: N/A. 3a. Percentage of granulation: 75. 3b. Percentage of slough: 25. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . Wound MD-J changed the treatments and MD orders were placed in chart. Documented with a start date of 11/10/22 was Wash right buttocks-Scrotum wound with 1/2 strength Dakin's solution and pat dry. Pack wound with Alginate AG and cover with [abdominal dressing (ABD)] and secure with tape. Every day and evening shift for wound care, Santyl Ointment 250 UNIT/GM (gram) (Collagenase) Apply to Sacral wound topically every day shift for wound care Wash wound with 1/2 strength Dakin's solution and pat dry. Skin prep per wound. Apply Santyl to wound bed followed by Bordered Gauze and Santyl Ointment 250 UNIT/GM (Collagenase) Apply to Left buttocks wound topically every day shift for wound care Wash wound with 1/2 strength Dakin's solution and pat dry. Skin prep peri wound. Apply Santyl to wound bed followed by Calcium Alginate and cover with Bordered gauze. R13's Care Plan was updated on 11/10/22 to include: Focus: readmitted [DATE] with Surgical wounds to Left buttocks and right buttocks/Scrotum and an Unstageable pressure wound to Sacrum Interventions: - Administer medications as ordered. Monitor/document for side effects and effectiveness. - Administer treatments as ordered and monitor for effectiveness. - Assess/record/monitor wound healing (FREQ) (frequency). Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound MD-J and the facility assessed the wounds and surgical incisions on 11/17/22. Documented on R13's Weekly Wound Assessments dated 11/17/22 was .B. Wound Description. 1. Type of wound: Non-Pressure. 2. Wound Description: Site: Other (specify): Rt buttocks-Scrotum. Type: Surgical Incision. Length: 10.9 cm. Width: 8.7 cm. Depth: 3.7 cm. Stage: N/A. 3a. Percentage of granulation: 75. 3b. Percentage of slough: 25. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . Documented was .B. Wound Description. 1. Type of wound: Pressure. 2. Wound Description: Site: 53) Sacrum. Type: Pressure. Length: 3.4 cm. Width: 3.1 cm. Depth: 0.1 cm. Stage: Unstageable. 3a. Percentage of granulation: 25. 3b. Percentage of slough: 75. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . Documented was .B. Wound Description. 1. Type of wound: Non-Pressure. 2. Wound Description: Site: Other (specify): Left buttocks. Type: Surgical Incision. Length: 5.7 cm. Width: 2.9 cm. Depth: 1.7 cm. Stage: N/A. 3a. Percentage of granulation: 75. 3b. Percentage of slough: 25. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . Wound MD-J changed the treatment to the right buttocks - scrotum wound. Documented with a start date of 11/18/22 was Wash right buttocks-Scrotum wound with 1/2 strength Dakin's solution and pat dry. Pack wound with Moistened Dakin's Gauze and cover with ABD and secure with tape every day and evening shift for wound care. The facility assessed the wounds and surgical incisions on 11/23/22. Documented on R13's Weekly Wound Assessments dated 11/23/22 was .B. Wound Description. 1. Type of wound: Non-Pressure. 2. Wound Description: Site: Other (specify): Rt buttocks-Scrotum. Type: Surgical Incision. Length: 16 cm. Width: 6.0 cm. Depth: 2.2 cm. Stage: N/A. 3a. Percentage of granulation: 75. 3b. Percentage of slough: 25. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . Documented was .B. Wound Description. 1. Type of wound: Pressure. 2. Wound Description: Site: 53) Sacrum. Type: Pressure. Length: 3.5 cm. Width: 4. 0 cm. Depth: 0.1 cm. Stage: Unstageable. 3a. Percentage of granulation: 25. 3b. Percentage of slough: 75. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . Documented was .B. Wound Description. 1. Type of wound: Non-Pressure. 2. Wound Description: Site: Other (specify): Left buttocks. Type: Surgical Incision. Length: 6.0 cm. Width: 1.9 cm. Depth: 1.3 cm. Stage: N/A. 3a. Percentage of granulation: 75. 3b. Percentage of slough: 25. 3c. Percentage of eschar: 0. 3d. Percentage of epithelialization: 0 . R13 was sent out and admitted to the Hospital on 11/26/22 for a dislodged G-tube. Surveyor reviewed TAR for R13 from 11/11/22 when wound treatments started through 11/26/22. There were 13 dates blank and 1 documented refusal of 32 possible treatment dates for right buttocks-scrotum wound treatment noting only 17 wound treatments as documented completed. There were 10 dates blank and 1 documented refusal of 16 possible treatment dates for left buttocks wound treatment noting only 5 wound treatments as documented completed. The order for the sacral wound was not documented on November TAR. (continued on next page)

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	525318	A. Building B. Wing	02/22/2023

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R13 was hospitalized from 11/26/22 through 12/3/22. Documented in the Hospital Discharge Summary was . Discharge Diagnoses: Principle Problem: Dislodged gastronomy tube. Active Problems: . Sacral and ischial decubitus ulcers. Right ischial osteomyelitis .Hospital Course: . Patient also has known decubitus ulcers of his coccyx and left buttocks. Imaging was performed to the area, with concerns about osteomyelitis in the right ischium. It was previously debrided 1 month prior. After discussion with [infectious disease (ID)], patient will have a PICC (Peripherally Inserted Central Catheter) line placed today, will continue Zosyn upon discharge and it will be needed for 6 weeks. It has been requested that he has weekly [complete blood count lab (CBC)], [basic metabolic panel (BMP)] and [C-Reactive Protein lab (CRP)] checks, for results to be sent to [ID MD]. Also follow-up with [ID MD] will need to be coordinated with wound care as they have the ability to turn and position him for better examination . Documented in Progress Notes on 12/3/2022 was Resident returned from hospital via stretcher. Resident now has PICC line in R. (right) arm. Returning with order for IV antibiotic q. (every) 8 hours. Continue with soft diet, nectar thickened liquids. Wound clinic and Infectious Disease want appointment scheduled; papers left on reception desk for scheduling . Added to MD orders with a start date of 12/3/22 and end date of 1/3/22 was Piperacillin Sod-Tazobactam So Solution Reconstituted 3.375 (3-0.375) GM Use 3.375 gram intravenously every 8 hours related to OSTEOMYELITIS, UNSPECIFIED (M86.9) until 01/02/2023. Surveyor reviewed R13's Admission/Readmission Evaluation with a date of 12/3/22. Documented was Site: 32) Left buttocks. Type: Surgical Incision. Length: Blank. Width: Blank. Depth: Blank. Stage: Blank. Site: 53) Sacrum. Type: Pressure. Length: Blank. Width: Blank. Depth: Blank. Stage: Unstageable. Other (specify): Rt arm. Type: IV/Sub q/Implanted Port. Length: Blank. Width: Blank. Depth: Blank. Stage: Blank. Site: Other (specify): Rt butt to Scrotum. Type: Surgical Incision. Length: Blank. Width: Blank. Depth: Blank. Stage: Blank. There were no assessments of the wounds or measurements on the readmission assessment. Surveyor reviewed R13's Initial Wound Assessment with a date of 12/3/22. Documented was A. Onset. 1. Date wound was identified: 12/3/2022. 2. Where was the wound acquired? 2. Present upon admission/readmission to facility. B. Wound Description. 1. Type of wound: Pressure. 2. Wound Description: Site: 53) Sacrum. Type: Pressure. Length: 16 cm. Width: 5 cm. Depth: Blank. Stage: Unstageable. 3a. Percentage of granulation: Blank. 3b. Percentage of slough: Blank. 3c. Percentage of eschar: Blank. 3d. Percentage of epithelialization: Blank . There were no other assessments of the wounds or measurements on this assessment. The sacral wound was the only one mentioned and there was no assessment of the wound bed. Upon readmission the wound treatment orders were not changed. Documented with a start date of 11/18/22 and end date of 12/8/22 was Wash right buttocks-Scrotum wound with 1/2 strength Dakin's solution and pat dry. Pack wound with Moistened Dakin's Gauze and cover with ABD and secure with tape. Every day and evening shift for wound care. Documented with a start date of 11/10/22 and end date of 12/8/22 was Santyl Ointment 250 UNIT/GM (Collagenase) Apply to Left buttocks wound topically every day shift for wound care Wash wound with 1/2 strength Dakin's solution and pat dry. Skin prep peri wound. Apply Santyl to wound bed followed by Calcium Alginate and cover with Bordered gauze. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor notes there was no order for the sacral wound and was not documented on the December TAR. Antibiotic order was documented as Piperacillin Sod-Tazobactam So Solution Reconstituted 3.375 (3-0.375) GM Use 3.375 gram intravenously every 8 hours related to OSTEOMYELITIS, UNSPECIFIED (M86.9) until 01/03/2023. Also documented with a start date of 12/7/22 was CRP: one time a day every Wed (Wednesday) related to OSTEOMYELITIS, UNSPECIFIED (M86.9) until 01/02/2023. BMP: one time a day every Wed related to OSTEOMYELITIS, UNSPECIFIED (M86.9) until 01/02/2023. CBC: one time a day every Wed until 01/02/2023. Documented with a start date of 12/7/22 and end date of 1/4/23 was Please fax weekly lab results drawn on Wednesday (CBC, BMP CRP) to [ID MD] @ [phone number] one time a day every Wed, Thu. Surveyor reviewed TAR for R13 from 12/3/22 through 12/8/22. There were 3 dates blank and 2 documented other' of 11 possible treatment dates for right buttocks-scrotum wound treatment noting only 6 wound treatments documented as completed. There were 3 dates blank of 5 possible treatment dates for left buttocks wound treatment not [TRUNCATED]

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on interview and record review, the facility did not ensure 1 (R13) of 4 residents reviewed had care and treatment based upon current standards of practice for indwelling catheter care to prevent urinary tract infections (UTI's.) R13 had an indwelling foley catheter placed on 5/27/22 for urinary retention and was noted to have signs and symptoms of a UTI at that time. The facility did not put orders and preventative measures in place to prevent R13 from Urinary Tract Infections (UTIs). R13 was noted to have a UTI but treatment was delayed by 5 days. On 8/16/22 R13 had blood in his urine, the Nurse Practitioner (NP)-M was notified and a Urine Analysis (UA) with Culture and Sensitivity (C&S) was ordered. The UA was sent out 8/17/22 but the C&S was never evaluated even though it was sent to the facility on [DATE]. NP-M was not aware and ordered a resistive antibiotic for the UTI that was not effective and the infection continued. R13 had a change of condition including altered metal status (AMS) and was hospitalized with sepsis and septic shock due to a UTI and the infection spread to his kidneys resulting in pyelonephritis and an upper UTI. There was no update to the care plan or catheter care to reflect the UTI, further monitoring or consistent cleaning. R13 returned to the facility and hospitalized again 10/20/22 through 11/3/22 with multiple problems including UTI. R13 returned to the facility and hospitalized again 11/28/22 through 12/3/22 with multiple problems including another UTI. On 2/2/23 R13 had nausea and vomiting and orders were received to monitor vital signs that was not completed. On 2/4/23 resident had another change of condition that included AMS, hypotension and hyperglycemia that was not reported timely to the MD or NP. The facility did not recognize the continued pattern of hypotension and AMS related to R13's history of UTIs. Hours later NP-M was updated and resident was sent to the hospital and admitted to the ICU with hypotension and sepsis related to a UTI. The facility's failure to address signs and symptoms of a UTI, follow up on labs orders to effectively treat UTIs and daily care and prevention of catheter associated UTIs created a finding of Immediate Jeopardy (IJ) that began on 8/22/22. Surveyor notified Current Nursing Home Administrator (NHA)-P, Director of Nursing (DON)-B and RN Regional Educator (RN)-V of the IJ on 2/13/22 at 4:35 PM. The IJ was removed on 2/17/23, however; the deficient practice continues at a scope/severity level of D (Potential for Harm/Isolated) as the facility continues to implement their action plan. Findings include: Surveyor reviewed facility's Urinary Tract Infections/Bacteriuria - Clinical Protocol policy with a revision date of April 2018. Documented was: Assessment and Recognition 1. The physician and staff will identify individuals with a history of symptomatic urinary tract infections, and those who have risk factors for example, an indwelling urinary catheter, kidney stones, urinary outflow obstruction, ete,) for UTIs. 2. The staff and practitioner will identify individuals with possible signs and symptoms of a UTI. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Signs and symptoms of a UTI may be specific to the urinary tract and/or generalized. The presentation of symptomatic UTIs varies. b. Nurses should observe, document, and report signs and symptoms (for example, fever or hematuria) in detail and avoid premature diagnostic conclusions. c. New onset of nonspecific or general symptoms alone (change in mental status, decline in appetite, etc.) is not enough to diagnose a UTI, Urine odor, color and clarity also are not adequate to indicate bacteriuria or a UTI. d. Acute deterioration in previously stable chronic urinary symptoms may indicate an acute infection. Multiple concurrent findings such as fever with hematuria or catheter obstruction are more likely to be due to a urinary source. c. A positive urine culture in someone with chronic genitourinary symptoms is not enough to diagnose a symptomatic UTI. The presence of either pyuria or a positive leukocyte esterase test alone are not enough to prove that the individual has a UTI, but the absence of pyuria or a negative leukocyte esterase test is fairly strong evidence that a UTI is not present. Cause Identification 1. The physician will help nursing staff interpret any signs, symptoms, and lab test results. Diagnosis must be based on the entire picture and not just on one or several findings in isolation. a. Before diagnosing a UTI or urosepsis and ordering antibiotics, the physician should consider a resident's overall picture including specific evidence that helps confirm or refute the diagnosis of a UTI (as discussed above). 3. The physician will help identify causes of, and factors contributing to, bacteriuria or UTIs such as bladder outlet obstruction, kidney stones, neurological impairments, and medications that can cause urinary retention. 4. Because nonspecific or systemic symptoms can be due to diverse factors either instead of or along with a UTI, the staff and practitioner will also consider additional or alternative causes regardless of whether bacteriuria or urinary symptoms is present. a. For example, a patient with a UTI could also have confusion caused by fluid and electrolyte imbalance such as hypernatremia as a result of several days of inadequate food and fluid intake. Treatment/Management 1. The physician will order appropriate treatment for verified or suspected UTIs and/or urosepsis based on a pertinent assessment. a. Empirical treatment should be based on a documented description of an individual's symptoms and on consideration of relevant test results, co-existing illnesses and conditions, and pertinent risk factors. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The date and time that catheter care was given. 41. The name and title of the individual(s) giving the catheter care. 42. All assessment data obtained when giving catheter care. 43. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid pa and odor. 44. Any problems noted at the catheter-urethral junction during perineal care such as bleeding, irritation, crusting, or pain. 45. Any problems or complaints made by the resident related to the procedure. 46. How the resident tolerated the procedure. 47. If the resident refused the procedure, the reason(s) why and the intervention taken. 48. The signature and title of the person recording the data . Surveyor reviewed facility's Change in a Resident's Condition or Status policy with a revision date of May 2017. Documented was: Policy Statement Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications two (2) or more consecutive times); g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the Physician of changes in the resident's condition. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	through the next review date [as evidenced by (AEB)] clinical documentation. Interventions: Monitor for [signs and symptoms (s/s)] of UTI (pelvic pain, increased urge to urinate, pain with urination, blood in urine) and report to physician if noted. Provide catheter care to prevent urinary tract infections: Maintain a closed, sterile system, maintain catheter tubing below level of the bladder, ensure that catheter tubing does not have kinks or twists. Perform catheter care [every (Q)] shift and [as needed (PRN)]. Change catheter and catheter drainage/collection system per order/policy. Maintain resident dignity. Cover Catheter bag when out of bed in social areas of facility. Empty residents catheter bag Q shift and PRN. Record and monitor output. Surveyor reviewed Tasks for CNA (Certified Nursing Assistant) completion for R13. Documented was Catheter: Document output in mLs. There were no other tasks for CNA's to complete. Documented 5/27/2022 at 3:42 PM in R13's Progress Notes was Resident vital signs stable. No signs of distress at this time. Straight cath this AM was 350cc output. Foley inserted this afternoon. 250cc output. Obtained new order for insulin glargine. Obtained order for temporary bolus feeds. Urine output cloudy. Obtained order for UA. 30 minute checks completed today. No complaints from resident at this time. Added to MD orders for R13 on 5/27/22 was UA one time only for cloudy urine for 5 Days. There was no UA charting, collection of sample or evaluations of cloudy urine on 5/28/22, 5/29/22, 5/30/22 or 5/31/22. The sample was collected 6/1/22 but treatment was not started until 6/7/22 when an order was placed for Cipro Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet via G-Tube one time a day for UTI until 06/09/2022. On 6/15/22 R13 was hospitalized for Pneumonia. He was readmitted to the facility 6/20/22. MD orders for catheter care were not put in place except Maintain 16 FR/ 5 ML bulb foley catheter to straight drain. Change every month and PRN for Neurogenic Bladder and Intake and output every shift. There were no orders for cleansing, emptying or general catheter care. Documented in R13's Progress Notes on 8/16/2022 at 5:17 PM was Resident had considerable amount of blood in urine. [NP-M] notified, UA ordered. Added to MD orders for R13 on 8/16/22 was Urinalysis w/ C&S. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Documented in R13's Progress Notes on 8/17/2022 at 1:22 AM was 97.5 98%3L [alert and orientated (A/O)] x3 . Writer encouraging fluids: given now. Foley patent: clear light amber urine in bag: no s/s of blood in urine. Waiting to get a good U/A sample soon . Surveyor noted R13 had a catheter and UA sample could be obtained by closed system at any time. Documented in R13's Progress Notes on 8/17/2022 at 5:42 AM was Writer obtained U/A sample now: will call for [pick up]. R13's UA sample was sent to the lab and results that were positive for bacteria/UTI were sent back to the facility 8/17/22 at 11:12 AM. The C&S would be processed due to positive bacteria. Documented in R13's Progress Notes on 8/19/2022 at 5:42 AM was Patient is alert with increased confused noted from baseline. Writer called to the room by CNA. Patient screaming I am not going to the strip bar. T-99.8, b/p-143/66 SP02-95% 2L 02 via [nasal cannula.] Foley cath patent draining clear yellow urine with foul smell. A U/A was collected that reveal + [positive]for bacteria however culture and sensitivity is pending. Writer placed a call to [NP-M]. She is advised of his symptoms. New order to start Cipro 500mg PO daily x3 days. Writer left a message for his brother [name of] to call facility for updates . An MD order was added for R13 and started 8/19/22 was Cipro 500mg [by mouth (PO)] Q day x3 days DX [diagnosis]: UTI, one time a day for UTI for 3 Days. Documented in Progress Notes on 8/19/2022 at 7:32 PM was Resident's 1600 blood sugar [BS] was elevated at 487. 18 units were given per sliding scale for BS over 450 and then MD was contacted. On call MD gave [order] to give an additional 4 units of insulin which were given. Will recheck BS at HS to see the effects of the additional units. No s/s of hyperglycemia seen or reported by resident. Will continue to monitor. Documented in Progress Notes on 8/21/2022 at 1:58 AM was 98.8 now: PRN Tylenol and cool compress effective: 99.0 at start. A/O x3 at start. Sleeping well in bed now. No c/o any. No c/o pain now. Foley patent: clear light amber urine noted: No s/s of blood in urine noted. No adverse s/s with PO ATB [by mouth antibiotic] use for UTI noted. No confusion noted. Resident drinking fluids: also pushed in G-tube . Surveyor reviewed R13's lab results printed for Surveyor on 2/9/23. Surveyor reviewed C&S originally reported to facility from lab on 8/20/22 at 7:33 AM. This report was not part of R13's medical record. Documented was an abnormal urine culture growing Proteus Mirabilis and Providencia Stuartii organisms. The Culture and Sensitivity results showed both organisms were resistant to treatment by Cipro antibiotic prescribed for the UTI on 8/19/22 and was an ineffective treatment for the UTI. There is no documentation this report was given to NP-M or any other MD for follow-up on the ineffective antibiotic. On 8/22/22 R13 had a change of condition and an SBAR [Situation Background Assessment Recommendation] was completed at 12:43 PM. Documented was: eINTERACT SBAR Summary for Providers (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Situation: The Change In Condition/s reported on this CIC [change in condition] Evaluation are/were: Altered mental status Behavioral symptoms (e.g. agitation, psychosis) At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 114/69- 8/22/2022 12:32 Position: Lying r/arm - Pulse: P 129 - 8/22/2022 12:32 Pulse Type: Regular - RR: R 22.0 - 8/22/2022 12:32 - Temp: T 101.0 - 8/22/2022 12:32 . - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Other symptoms or signs of delirium(e.g. inability to pay attention, disorganized thinking) - Functional Status Evaluation: No changes observed - Behavioral Status Evaluation: Other behavioral symptoms - Respiratory Status Evaluation: - Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50 - Abdominal/GI Status Evaluation: - GU/Urine Status Evaluation: - Skin Status Evaluation: - Pain Status Evaluation: Does the resident/patient have pain? - Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Abnormal speech Nursing observations, evaluation, and recommendations are: Resident presents with AMS, incoherent non-sensical speech, inability to follow direction or describe condition associated with change in mentation Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Send to ED [emergency department] for evaluation and possible treatment . NP-M visited the resident on 8/22/22 and documented in her visit note .ASSESSMENT/PLAN: 1. UTI-stable on cipro. 2. Altered mental status-unstable send to ER for eval. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R13 was admitted to the hospital 8/22/22 through 8/26/22 for Sepsis, Acute pyelonephritis, fever, infectious encephalopathy and DM2 [type 2 diabetes mellitis]. Documented in Hospital Discharge Summary was: .Patient presented to emergency department w/ AMS, fever, hypotension -Met [Systemic inflammatory response syndrome (SIRS)] and [every] [Sequential Organ Failure Assessment (SOFA)] criteria for sepsis w/ temp or 101.3F, tachypnea w/ RR [respiration rate] of 31, AMS, SBP [systolic blood pressure] < [greater than] 90, white count of 21, lactic acid of 2.8 on admission -UA w/ moderate [Leukocyte esterase (LE)], [white blood cells (WBC)] 6-10, moderate bacteria on admission -CT [computerized tomography] [Anterior/Posterior] w/ mild bilateral hydronephrosis w/ enhancing renal pelves, ureters suggesting an upper tract infection, some heterogenous enhancement evident w/in both kidneys suggesting pyelonephritis, bladder wall thickening consistent w/ cystitis an admission -Started on Zosyn for antimicrobial coverage, [vital signs stable (vss)], mentation improved following initiation of ABX; transitioned to Cefdinir prior to discharge, per urine culture sensitivities -Patient was deemed appropriate for discharge on 08/26. He was instructed to f/u w/ [primary care physician (PCP)] within the week . R13 was admitted back to the facility with an order for Cefdinir Capsule 300 MG Give 1 capsule via PEG-Tube two times a day for UTI for 20 Administrations with a start date of 8/27/22 and an end date of 9/5/22. MD orders for catheter care were not put in place except Maintain 16 FR/ 5 ML bulb foley catheter to straight drain. Change every month and PRN for Neurogenic Bladder. There were no orders for cleansing, emptying or general catheter care. There was no other documentation besides intermittent catheter output. There were no revisions to the care plan or other documentation to monitor for infection. Documented in Progress Notes on 10/20/2022 at 9:23 AM for R13 was Patient is alert with acute confusion and lethargy noted. Vital signs 133/69, 99, 18, 91% 2l, 100.8. He is being treated for upper resp [respiratory] infection with oral ABT at this time. Upon observation patient is speaking incoherently. His mentation changes from acute confusion and yelling to lethargy and uneasily aroused within minutes. Stated Please get me off the mill . R13 was admitted to the hospital 10/20/22 through 11/3/22 for multiple diagnoses and was noted to have another UTI. Documented in Hospital Discharge Summary was: .Urinary tract infection Altered mental status-resolved Presented to ED with AMS & fever Vitals and labs as pen above (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Urine culture greater than 100,000 Pseudomonas aeruginosa Sensitive to Zosyn, completed course Patient's UA + still for UTI he is being placed on Cefdinir and Cipro Via G-tube for 5 days as d/w my attending MD-this is why patient's discharge was held overnight . R13 was admitted back to the facility with an order for Cipro Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet via G-Tube two times a day for UTI for 5 Days and Cefdinir Capsule 300 MG Give 1 capsule via G-Tube two times a day for UTI for 5 Days with end dates of 11/8/2022. MD orders for catheter care were added back into the TAR [treatment administration record] on readmission. Documented with a start date of 11/3/22 was Record foley output every shift every shift for Monitoring, May irrigate foley catheter with 30 ml H2O for obstruction, Maintain 16 FR/ 5 ML bulb foley catheter to straight drain. Change every month and PRN and Foley catheter care with soap and water every shift for Indwelling Urinary Catheter Care AND as needed for Prophylaxis. Surveyor reviewed November TAR for R13 for documentation of completed Foley catheter care with soap and water. There were 12 dates blank of 65 possible treatment entries and no PRN entries. R13 was admitted to the hospital 11/26/22 through 12/3/22 for multiple diagnoses with another UTI. Documented in Progress Notes on 11/28/2022 at 12:42 PM was call placed to [name of hospital] regarding resident status. [G-Tube (GT)] was removed and he is eating. He has a nutritional consult pending and thus it is pending when he will be having GT re-inserted. He is on IV abt for a + UA (organism not specified to this writer), some BP meds were held as he is running low BP's while in hospital and his hemoglobin is dropping also. Diflucan and Vanco are ongoing at this time. R13 was admitted back to the facility with MD orders continuing for Record foley output every shift every shift for Monitoring, May irrigate foley catheter with 30 ml H2O for obstruction, Maintain 16 FR/ 5 ML bulb foley catheter to straight drain. Change every month and PRN and Foley catheter care with soap and water every shift for Indwelling Urinary Catheter Care AND as needed for Prophylaxis. Surveyor reviewed December 2022 TAR for R13 for documentation of completed Foley catheter care with soap and water. There were 19 dates blank of 83 possible treatment entries and no PRN entries. Documented in Progress Notes on 1/4/2023 at 2:36 AM was Writer changed foley and foley bag now: had 300cc clear yellow urine in old bag: new tube patent now. Surveyor reviewed January 2023 TAR for R13 for documentation of completed Foley catheter care with soap and water. There were 20 dates blank of 93 possible treatment entries and no PRN entries. On 2/2/23 R13 had a change of condition and an SBAR was completed at 1:31 PM. Documented was: eINTERACT SBAR Summary for Providers Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Nausea/Vomiting At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 139/78 - 1/19/2023 21:01 Position: Lying r/arm - Pulse: P90 - 1/19/2023 21:01 Pulse Type: Regular (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- RR: R 18.0 - 1/13/2023 18:15 - Temp: T 97.0 - 2/2/2023 01:42 Route: Forehead (non-contact) . - Mental Status Evaluation: No changes observed - Functional Status Evaluation: No changes observed - Behavioral Status Evaluation: - Respiratory Status Evaluation: - Cardiovascular Status Evaluation: - Abdominal/GI Status Evaluation: No changes observed - GU/Urine Status Evaluation: - Skin Status Evaluation: - Pain Status Evaluation: Does the resident/patient have pain? - Neurological Status Evaluation: Nursing observations, evaluation, and recommendations are: c/o nausea, no emesis as of yet. ongoing monitoring for emesis or changes Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: new order for PRN zofran, monitoring for changes in vital signs or emesis. Surveyor noted the vital signs were not current including BP and pulse on the SBAR were from 1/19/22 and RR from 1/13/22 and not at time of change of condition. There were no other vital signs documented even though the recommendations included monitor vital signs. There were no updates to the care plan or increased monitoring of the resident. Documented on 2/3/2023 at 1:22 AM was 97.1 98% RA [room air] A/O [alert and oriented] x3. Sleeping well in bed since start. No c/o any. No c/o pain. Writer did dressing change to sacrum/buttock now. 400cc clear yellow urine from foley now and MED soft formed BM from colostomy now. Air mattress working well. Pillows in place. P boots on. No SOB or coughing noted. Fluids given. Pleasant with staff. There was no BP or RR included in the charting and no mention of nausea or vomiting. Surveyor reviewed R13's vital signs taken 2/14/23 at 1:43 AM. Documented was: Blood Pressure: 95 / 52 mmHg Temperature: 97.9 F (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pulse: 92 bpm Respirations: 20 Breaths/min Blood Sugar: 423.0 mg/dL O2 Saturation: 98.0 % Documented in Progress Notes on 2/4/2023 at 3:54 AM was Resident appeared drowsy during [night] shift. This writer obtained vital signs from resident and placed them in the chart. Resident hypotensive and hyperglycemic. Resident able to respond to verbal stimuli. Resident was provided fluids and fluids pushed through g-tube. Will continue to monitor and document as necessary. Surveyor noted the vital signs of low BP and high BS were flagged as abnormal on the electronic medical record but no MD was contacted. Also the resident was noted as drowsy which may have indicated AMS but there was no assessments completed. Also, documented as part of R13's Insulin Order was if Blood glucose > [greater than] 400 give 12 units and call MD/NP for additional orders . No NP or MD was contacted. Documented in Progress Notes on 2/4/2023 at 7:06 AM was Resident blood pressure currently reading at 76/50 with blood present in foley. Assessment done with another nurse. [NP-M] notified. [Former LPN-L] aware. There was no other assessments or evaluations documented in R13's medical record. Documented in Progress Notes on 2/4/2023 at 10:58 AM was Call placed to [name of hospital] ER [emergency room] requesting report on resident status. Resident admitted to ICU for sepsis. Surveyor reviewed R13's hospital record from 2/4/23 admission. Documented was: .Patient Active Hospital Problem List: Sepsis (CMS-HCC) (2/4/2023) [present on admission (POA)]: Yes Assessment: Unstable with several episodes of hypotension raising suspicion of septic shock. Not requiring pressors at the present time. Seems to be responding fairly to IV fluid resuscitation. Plan: Continue IV fluid resuscitation. Close monitor position of electrolytes given his hyponatremia and hypochloremia. Consider pressors if refractory to IV fluid resuscitation. Consider stress dose steroids if septic shock persistent Continue IV antibiotics with Zosyn UTI (urinary tract infection) (2/4/2023) POA: Yes Assessment: UTI with secondary sepsis and likely septic shock Plan: Continue IV antibiotics. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continue IV fluid resuscitation Serial labs Careful monitoring of electrolytes given his hyponatremia and hypochloremia . On 2/9/23 at 1:26 PM Surveyor interviewed Former Unit Manager LPN-L. Surveyor asked about R13's history of UTI's and the interventions that were in place. LPN-L stated R13 had a long history of sepsis with UTI's and was treated with antibiotics at least twice. Surveyor asked what catheter care was being done for R13. LPN-L stated I hope he was getting it cleaned. LPN-L stated she was not sure if the CNA's or the nurses on the unit were in charge. LPN-L stated if she was working the floor she would do it but not sure about the other nurses. Surveyor asked where staff would know what catheter care to do and when. LPN-L stated it should be in the orders and the care plan. Surveyor asked how you know that catheter care was completed. LPN-L stated it would be signed out as completed on the TAR. On 2/13/23 at 10:10 AM Surveyor interviewed NP-M. Surveyor asked about ordering R13's Cipro antibiotic back in August. NP-M stated she did not exactly remember the situation but remember ordering the Cipro to be proactive about the symptoms of the UTI. Surveyor asked if she ever saw the C&S that stated Cipro was resistant to the UTI organisms. NP-M stated no, and if she would have she would have changed the order immediately. Surveyor asked if she remembered ordering Zofran and monitoring vitals on 2/2/23 for R13. NP-M stated not exactly but it sounds like something I would do. Surveyor asked what was expected by staff when it was recommended to monitor vital signs. NP-M stated a Blood Pressure, Pulse, Temperature, Pulse Ox and Blood Sugar if they are diabetic every shift and be updated with any significant changes. Surveyor asked if a temperature and pulse ox was acceptable. NP-M stated no. Surveyor asked about R13's low BP and high blood sugar at 1:43 AM on 2/4/23. NP-M stated someone on staff should have called the on-call MD right away. On 2/13/23 at 11:13 AM Surveyor interviewed Director of Nursing (DON)-B and LPN-G. Surveyor asked how staff know that labs were followed up on and sent to the appropriate MD or NP. DON-B stated there should be a progress note. Surveyor noted R13's 8/20/22 C&S not being reported to NP-M as there was[TRUNCATED]

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 38253 Based on record review and interview, the facility did not ensure nursing staff had the specific competencies and skill sets necessary to care for residents' needs including nursing licensure affecting 3 of 4 residents (R8, R9, and R19) who had a change in condition and potentially affecting all 69 residents in the facility. Staff Member-F completed coursework on 6/9/2022 at a nursing school and graduated with a diploma for Practical Nursing on 8/30/2022. Staff Member-F applied for a temporary Licensed Practical Nurse (LPN) license with the assistance of Director of Nursing (DON)-B on 7/20/2022. Staff Member-F was never granted the temporary LPN license. Staff Member-F never took the LPN boards to obtain an LPN license. Staff Member-F was not certified as a Certified Nursing Assistant. Staff Member-F worked as an LPN at the facility from 7/25/2022 until 12/16/2022 without an LPN license for a total of 90 days and 121 shifts. Staff Member-F worked without a Registered Nurse in the building for 16 shifts and was designated as the charge nurse for 6 shifts. Staff Member-F performed all duties assigned to LPN staff without having an LPN license, including passing medication, doing wound care, and monitoring residents with a change in condition. R8 had a change in condition on 11/27/2022. Non-nurse, Staff Member-F was assigned to R8 during R8's change in condition. On 11/27/2022, Staff Member-F did not contact an RN to conduct an assessment of R8's change in condition. On 11/27/2022, R8 was sent to the hospital. R8 passed away in the hospital on 11/28/2022. R9 had a change in condition on 11/27/2022. Non-nurse, Staff Member-F was assigned to R9 on 11/27/2022 when R9 experienced a change of condition. Staff Member-F did not obtain a complete set of vitals on 11/27/2022. On 11/27/2022, Staff Member-F did not sign out on the Medication Administration record as having administered an albuterol inhaler due to R9's decrease in oxygen saturation. Staff Member-F did not have an RN assess R9's change in condition. Staff Member-F contacted the Nurse Practitioner due to R9's shortness of breath. The Nurse Practitioner ordered R9 to be sent to the hospital. R9 refused going to the hospital. Staff Member-F did not contact the Nurse Practitioner to inform of R9's refusal to go to the hospital. On 11/28/2022, R9 continued to have low oxygen saturations levels and R9 was transferred to the hospital and did not return. R19 was sent to the hospital on 10/25/2022 for a change in condition. Staff Member-F was assigned to R19's unit on 10/25/2022. The medication administration record for 10/25/2022 indicates Staff Member-F administered some of R19's morning medication. On 10/25/2023 R19's oxygen saturation level was 63%. R19's medical record did not have any documentation on 10/25/2022 indicating R19 had a change in condition that would require hospitalization : no progress note, no change of condition evaluation documentation, and no vital signs. A timeline of events could not be determined due to lack of documentation. R19 was admitted into the hospital on 10/25/2022. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failure to verify licensure of Staff Member-F, to ensure nursing staff had the appropriate competencies and skills to provide for the care of residents, and to assure resident safety created a finding of immediate jeopardy that began on 7/25/2022. Surveyor notified Nursing Home Administrator (NHA)-P of the immediate jeopardy on 2/13/2023 at 4:35 PM. The immediate jeopardy was removed on 2/17/23. The deficient practice continues at a scope/severity of F (potential for harm/widespread) as the facility continues to implement and monitor its action plan. Findings include: Cross-reference F684 for Quality of Care. Staff Member-F was involved in changes of condition for three residents (R8, R9, and R19). The Wisconsin Department of Safety and Professional Services website https://dsps.wi.gov/Credentialing/Health/info3087.pdf states: BOARD OF NURSING CREDENTIALING INFORMATION FOR REGISTERED NURSE/LICENSED PRACTICAL NURSE APPLICANTS documents in part . 4. Temporary Permit for Exam Applicants (Form #2434) (optional) - In addition to Form #2434 and the $10.00 temporary permit fee, the Department also requires a completed application for permanent licensure and proof of graduation from a WI Board-approved school or comparable school of professional/ practical nursing prior to granting a temporary permit. A temporary permit cannot be processed until all of those requirements are satisfied. Exam applicants must have a supervising RN and the department must receive proof of graduation/ completion from the school prior to issuance. A temporary permit is valid for a period of three months or until the holder receives notification of failing the NCLEX (National Council Licensure Examination) examination. An applicant for RN/LPN licensure who holds a valid permit under this Temporary Permit section or Subchapter IV of Wis. Admin. Code ch. N2 may use the title Graduate Nurse/Graduate Practical Nurse or the letters GN/GPN and shall not practice beyond the scope of the license the holder is seeking to obtain. The holder is required to practice under the direct supervision of an RN. The supervisor must be on-site and immediately available at all times. You may not practice as an RN/LPN in Wisconsin unless you have either a permanent license or temporary permit. The facility policy and procedure entitled Competency of Nursing Staff revised 10/2017 from the MED-PASS manual (C)2001 states: Policy Statement: 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law. 2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in plans of care. Policy Interpretation and Implementation: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. The staff development and training program is created by the nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents. 2. The following factors are considered in the creation of the competency-based staff development and training program: a. An evaluation of the current program to ensure basic nursing competencies; b. Any gaps in education or training that may be contributing to poor outcomes; c. Specialized skills or training needed based on the resident population; d. A method to track, assess, plan, implement and evaluate the effectiveness of training; and e. A method to evaluate critical thinking skills and management of care in complex environments with multiple interruptions. 3. The facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population. 4. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: a. Preventing abuse, neglect and exploitation of resident property; b. Dementia management; c. Resident rights; d. Person centered care; e. Communication; f. Basic nursing skills; g. Basic restorative services; h. Skin and wound care; i. Medication management; j. Pain management; k. Infection control; l. Identification of changes in condition; and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	m. Cultural competency. 5. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. 6. Facility and resident-specific competency evaluations will include: a. Lecture with return demonstration for physical activities; b. A pre- and post-test for documentation issues; c. Demonstrated ability to use tools, devices, or equipment used to care for residents; d. Reviewing adverse events that occurred as an indication of gaps in competency; or e. Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform. 7. Competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge. 8. Inquiries concerning staff competency evaluations should be referred to the Director of Nursing Services or to the Personnel Director. Surveyor noted this policy and procedure was not dated by the facility or signed by the Medical Director. Surveyor reviewed the medical records for R8, R9, and R19 all whom experienced a change in condition and required hospitalization . Surveyor noted non-nurse staff member F, was working as a Licensed Practical Nurse during R8, R9, and R19's changes in condition and did not have the competencies and skills necessary to care for the residents. 1. R8 was sent to the hospital on 11/27/2022 via 911 for shortness of breath and low oxygenation. A non-nurse (Staff Member-F) was working as a Licensed Practical Nurse (LPN) from 11/22/2022 through 11/27/2022. Staff Member-F was assigned to R8 on 11/27/2022 when R8 experienced a change of condition. On 11/27/2022, Staff Member-F did not contact an RN to conduct an assessment of R8's change in condition. The Medication/Treatment records had no values documented for R8's saturation levels. Staff Member-F did not contact an RN to conduct an assessment of R8's change in condition. and at the time of the change of condition, no vital signs were documented, At the time of the change in condition there was documentation in R8's medical record regarding the circumstances of the change of condition. On 11/27/2022, R8 and was sent to the hospital. R8 passed away in the hospital on 11/28/2022. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. R9 had a change in condition on 11/27/2022 with an oxygen saturation level of 74%. A non-nurse (Staff Member- F) was assigned to R9 on 11/27/2022 when R9 experienced a change of condition. Staff Member-F did not obtain a complete set of vitals on 11/27/2022. On 11/27/2022, Staff Member-F did not sign out on the Medication Administration record as having administered an albuterol inhaler due to R9's decrease in oxygen saturation. Staff Member- F did not have an RN assess R9's change in condition. Staff Member-F contacted the Nurse Practitioner due to R9's shortness of breath. The Nurse Practitioner ordered R9 to be sent to the hospital. R9 refused going to the hospital. Staff Member-F did not contact the Nurse Practitioner to inform of R9's refusal to go to the hospital. On 11/28/2022 R9 continued to have low oxygen saturations levels and R9 was transferred to the hospital and did not return. 3. R19 was sent to the hospital on 10/25/2022 for a change in condition. Staff Member-F was assigned to R19 unit on 10/25/2022. The medication administration record for 10/25/2022 indicates Staff Member-F administered some of R19's morning medication. On 10/25/2023 R19's oxygen saturation level was 63%. R19's medical record did not have any documentation on 10/25/2022 indicating R19 had a change in condition that would require hospitalization : no progress note, no change of condition evaluation documentation, and no vital signs. A timeline of events could not be determined due to lack of documentation. R19 was admitted into the hospital on 10/25/2022. (Cross Reference F684) During R8's record review, Surveyor noted Staff Member-F charted a progress note on 11/27/2022 regarding R8's change in condition. Surveyor reviewed the facility employee list and noted Staff Member-F was listed as a current employee with a status of LPN. On 2/7/2023 at 1:52 PM, Surveyor requested from DON-B to speak to Staff Member-F regarding R8's change in condition. DON-B stated Staff Member-F no longer worked at the facility because Staff Member-F did not pass the nursing boards and did not want to work as a caregiver so did not return to work. In an interview on 2/8/2023 at 8:30 AM, LPN Unit Manager (UM)-G stated Staff Member-F did not have a CNA license. LPN UM-G stated Staff Member-F worked as a Graduate Nurse after going to school for an LPN but let the temporary license expire and no longer works at the facility. On 2/9/2023 at 9:13 AM, Surveyor called the Wisconsin Department of Safety and Professional Services (DSPS) and inquired if Staff Member-F had received a temporary LPN license. The DSPS staff member stated no license was found for Staff Member-F. The DSPS staff member stated Staff Member-F had submitted an application for a temporary LPN license and a notation was attached to the application that read pending applicant input. The DSPS staff member stated the temporary application had been submitted on 7/20/2022 but no other supporting documentation, such as a diploma or transcript, had been submitted and therefore a temporary license was not issued. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 2/13/2023 at 7:55 AM, Surveyor asked HR-R, the HR for the facility, what happened with the hiring process of Staff Member-F. HR-R stated Staff Member-F was the first graduate nurse the facility had hired; typically, they do not hire anyone until they are licensed. Surveyor asked HR-R what job description Staff Member-F signed when hired. HR-R thought Staff Member-F had signed a job description for Graduate Nurse and stated HR-R would get a copy of it. (Surveyor was provided a copy of the job description Staff Member-F had signed; the job description was for an LPN.) HR-R stated Staff Member-F put in an application for employment and HR-R put Staff Member-F in the computer and got the pay situated. HR-R stated DON-B interviewed Staff Member-F and DON-B did the paperwork that was faxed for a temporary LPN license. HR-R stated HR-R followed up on the temporary LPN license in December 2022 and found out there was a mistake on the application, so it was never processed. HR-R stated once they found that out, they took Staff Member-F off the working schedule. Surveyor asked HR-R if the facility had a copy of Staff Member-F's diploma or transcript from nursing school. HR-R stated no, they did not have either of those documents. HR-R stated HR-R thought Staff Member-F was still in school and about to graduate. Surveyor asked HR-R if Staff Member-F had any training records or competencies completed while working at the facility, such as an orientation packet. HR-R stated DON-B would have training information. In an interview on 2/13/2023 at 8:10 AM, DON-B stated DON-B interviewed Staff Member-F prior to hiring Staff Member-F and found out Staff Member-F was a Graduate Nurse. DON-B stated Staff Member-F showed DON-B their credentials. DON-B was unable to provide Staff Member-F's diploma or transcript from nursing school to Surveyor. DON-B stated Staff Member-F showed DON-B their notice of graduation stating Staff Member-F finished the nursing program and was eligible to be a Graduate Nurse. DON-B stated DON-B and Staff Member-F completed the application for temporary LPN license and Staff Member-F told DON-B that Staff Member-F would pay for the temporary license. DON-B stated DON-B thought Staff Member-F had completed the application process. DON-B stated Staff Member-F had scheduled a date for the LPN boards which was in mid to late summer of 2022, and then told DON-B Staff Member-F had rescheduled the boards to a later date. Surveyor asked DON-B if DON-B ever got confirmation Staff Member-F had received the temporary LPN license. DON-B stated no. Surveyor asked DON-B if DON-B ever followed up on the temporary LPN license by contacting the licensing agency. DON-B stated no. Surveyor shared with DON-B the observation of Staff Member-F being listed on the working schedule as being the charge nurse. DON-B stated Staff Member-F was a regular employee and so was designated as a charge nurse if the other nurses working were agency staff. Surveyor asked DON-B if Staff Member-F worked only when there was an RN in the building. DON-B stated it was possible there were no RNs in the building when Staff Member-F was working. Surveyor asked DON-B to see the job description for a Graduate Nurse. DON-B stated they do not have a job description for a Graduate Nurse. Surveyor asked DON-B if there were any other Graduate Nurses working at the facility. DON-B stated Staff Member-F was the first Graduate Nurse working for the facility and there will not be any more after this. Surveyor asked DON-B if Staff Member-F had provided the facility with a copy of the diploma or transcript from nursing school. DON-B stated no, but DON-B saw the transcript and knew that Staff Member-F had passed the pharmacology course. Surveyor asked DON-B to see Staff Member-F's orientation packet, training, and competencies. DON-B stated HR would have that information. Surveyor noted HR-R had said DON-B would have that information. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 2/13/2023 at 8:27 AM, Scheduler-S stated Staff Member-F was an LPN that had just graduated. Surveyor asked Scheduler-S if Staff Member-F had worked part-time or full-time. Schedule-S stated Staff Member-F worked part-time but would pick up shifts. Surveyor asked Scheduler-S if Staff Member-F could work any time or did Staff Member-F have to be scheduled when any certain nurse worked. Scheduler-S stated Staff Member-F did not have any restrictions; Staff Member-F could work anywhere with anyone. Surveyor asked Scheduler-S if Staff Member-F was ever the nurse in charge when working. Scheduler-S stated if Staff Member-F was the only nurse working that was not from an agency, then Staff Member-F would be listed as the charge nurse. Surveyor asked Scheduler-S if an RN had to be working when Staff Member-F was working. Scheduler-S stated no. In a phone interview on 2/13/2023 at 9:03 AM, University Registrar-T stated Staff Member-F completed all courses of the (LPN) nursing program on 6/9/2022, but the date of 8/30/2022 was the last date of the semester and therefore the date used for official graduation. The facility provided to Surveyor Staff Member-F's orientation packet with signed materials on 7/25/2022. No competencies were provided. No copy of a diploma or transcript was provided. Surveyor noted the LPN job description stated date of hire was 8/22/2022 for 40 hours per week and was signed by Staff Member-F on 10/19/2022. On 2/13/2023 at 4:35 PM, Surveyor shared with NHA-A and DON-B the concern Staff Member-F worked as an LPN at the facility from 7/25/2022 until 12/16/2022 without an LPN license. Staff Member-F worked without a Registered Nurse in the building for 16 shifts and was designated as the charge nurse for 6 shifts. Staff Member-F performed all duties assigned to LPN staff without having an LPN license, including passing medication, doing wound care, and monitoring residents with a change in condition. No further information was provided at that time. The Facility failure to verify licensure of Staff Member-F, to ensure nursing staff had the appropriate competencies and skills to provide for the care of residents and to assure resident safety created a finding of Immediate Jeopardy. The facility removed the jeopardy on 2/17/23 when it had completed the following: Actions for Potentially Affected Residents: -Center in-house residents reviewed by physician or physician extender for ill effects. -Current employees reviewed for active licensure and/or credentialing, upon discovery of any employees found to be not in compliance would result in the immediate removal from the schedule until requirements are met and in employee file. Systemic Actions: -Facility reviewed current practice of hiring licensed/credentialed nursing staff and updated process flow to include: Staff member will not be placed on the schedule until validation of licensed/credentials are obtained and available in employee file; At this time the facility will no longer utilize graduate nurses or nurses who had temporary licenses. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Facility conducts monthly education on various topics to include, but not limited to, Communication, Change of Conditions, Caregiver Misconduct. Each educational session includes a post quiz to validate competencies and retention of the information provided. Education: -Re-education to Human Resource Director, Administrator, and Director of Nursing by Regional Leadership applicable facility policies and procedures, which include the: Expectations around the hiring process of licensed/credential staff hiring process. -The Administrator and/or designee to audit: new hires for licenses/credentials 8 weekly times 4 weeks. Results of audits/monitoring will be provided to QAPI (Quality Assurance Performance Improvement), which may further modify audit expectations based on results of initial audits. -AD HOC QAPI meeting - the QAPI Committee (composed of but not limited to Administrator, Director of Nursing, Assisted Director of Nursing, and Medical Director) to be held to review the alleged deficiency, discuss above action items and planned audits related to findings. The following Policy & Procedures were also reviewed: Licensure, Certification, and Registration of Personnel.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 22692 Based on interview and record review, the facility did not complete a performance review of 5 of 5 CNAs (Certified Nursing Assistants) reviewed. This had the potential to affect all 69 residents who reside in the facility. Findings include: On 2/22/23, the facility policy titled In-service Training Program, Nurse Aide, dated 10/17 was reviewed and read: The facility will complete a performance review at least every 12 months. In-service training will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews. Annual in-services must include training in dementia management and abuse prevention. On 2/22/23 at 9:00 AM, Surveryor asked for the performance reviews for CNA-W who was hired by the facility on 7/29/15, CNA-Y who was hired by the facility on 11/19/20, CNA-PP who was hired by the facility on 8/3/19, CNA-QQ who was hired by the facility on 8/27/21, and CNA-RR who was hired by the facility on 6/8/15. On 2/22/23 at 1:40 PM, Administrator-P was interviewed and indicated no performance evaluations in the past 12 months could be found for CNA-W, CNA-Y, CNA-PP, CNA-QQ, or CNA-RR. On 2/22/23 at 1:45 PM, Regional Educator-V was interviewed and indicated it was the responsibility of the Director of Nurses to complete annual performance reviews and ensure training requirements are met. On 2/22/23 at 2:00 PM, DON-B was interviewed and indicated he did not complete performance evaluations for CNA-W, CNA-Y, CNA-PP, CNA-QQ, or CNA-RR and often completes training with no documentation. On 2/22/23 at 2:30 PM, Administrator-A and DON-B were informed of the of the above findings. Additional information was requested if available. None was provided.

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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** 20483 Based on interview and record review the Facility did not always provide pharmaceutical services to meet the needs of 1 (R6) of 3 Residents. R6 was readmitted to the facility on [DATE]. Buspar 5 mg (milligrams) three times daily & as needed Lorazepam was not transcribed and Risperdal 0.25 mg was transcribed once daily when the discharge summary documented it should be administered twice a day. Findings include: The Medication Orders Non-Controlled Medication Orders Policy and Procedure, dated 2007, PharMerica Corp under procedures for documentation of the medication order documents b. Written transfer orders (sent with a resident from a hospital or other health care facility) Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete or the date signed is different from the date of admission. If the order is unsigned or signed by another prescriber or the date is other than the date of admission, the receiving nurse verifies the order with the current attending prescriber before medications are administered. The nurse documents verification on the admission order record by entering the time, date, and signature. Example: Order verified by phone with Dr. [NAME]/M [NAME], RN. The nurse who transcribes the orders to the physician order sheet and/or MAR (medication administration record) documents on the admission form the date, the time and by whom the orders were noted, as follows: (Noted 3 p.m., 5/17/12, M. [NAME], RN). Orders are transmitted to the pharmacy with any additional information required for a new admission. R6 was readmitted to the facility on [DATE]. The nurses note dated 1/20/23, includes documentation of resident arrived via ambulance from hospital @ (at) 1430 (2:30 p.m.) Resident has been readmitted to the facility. The hospital patient discharge summary dated 1/20/23 under CONTINUE these medications which have NOT CHANGED includes busPIRone 5 mg (milligrams) tablet Commonly known as Buspar Take 5 mg by mouth 3 times daily. Reasons Anxiety Disorder. LORazepam 0.5 mg tablet Commonly known as: Ativan Take 0.5 mg by mouth every 6 hours as needed. Reasons Feeling Anxious. risperiDONE 0.25 mg tablet Commonly known as: Risperdal. Take 0.25 mg by mouth 2 times daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 1/22/23 documents Resident is being monitored as a 1:1 due to behaviors, CNA (Certified Nursing Assistant) requested that writer administer a PRN (as needed) dose of medication due to increased restlessness and agitation. When EMAR (electronic medication administration record) was pulled up, there was no available PRN medication, orders from Hospital discharge reviewed, findings of 2 missed medication orders Scheduled Buspar and PRN Ativan. [Name of] NP (Nurse Practitioner) updated, and orders obtained to monitor for increased behaviors of restlessness and correct orders in EMAR, ADON (Assistant Director of Nursing) updated and medication error risk management completed in PCC (pointclickcare), orders corrected and medications administered this shift per orders. VM (voice mail) left for APOA (activated power of attorney), Will continue to monitor. On 2/13/23, Surveyor reviewed R6's January 2023 MAR (medication administration record). Surveyor noted risperiDONE Oral Tablet 0.25 mg (Risperidone). Give 0.25 mg by mouth one time a day for bipolar disorder with a start date of 1/21/23. Surveyor noted the hospital discharge summary documents Risperidone is to be taken 2 times daily. R6 only received Risperidone 0.25 mg once daily on 1/21/23 & 1/22/23. On 1/23/23 R6 started receiving Risperidone 0.25 mg twice daily. busPIRone hcl oral tablet 5 mg (Buspirone hcl) Give 5 mg by mouth three times a day for anxiety disorder was started on the 12:00 p.m. dose on 1/22/23. R6 missed one dose of Buspirone 5 mg on 1/20/23, three doses on 1/21/23, and one dose on 1/22/23. LORazepam oral tablet 0.5 mg (Lorazepam) Give 0.5 mg by mouth every 6 hours as needed for anxiety disorder was not started until 1/22/23. On 2/14/23, at 9:27 a.m., Surveyor asked LPN (Licensed Practical Nurse)/UM (Unit Manager)-G what the Facility's system is for ensuring medications from the hospital discharge summary are transcribed correctly. LPN/UM-G explained normally the admitting nurse does the medication orders and they are reviewed by a second nurse or a supervisor. Surveyor informed LPN/UM-G when R6 was readmitted on [DATE] the scheduled buspar and as needed lorazepam were not transcribed and risperdal was transcribed incorrectly. LPN/UM-G informed Surveyor she was out of town that weekend. Former LPN/UM-L was on call, R6 was admitted after hours, the orders were done and not reviewed by Former LPN/UM-L as they should of been.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on observation, interview, and record review, the facility did not ensure that residents were free from significant medication errors for 1 (R5) of 3 residents reviewed for medications. R5's Seroquel (Quetiapine) order was transcribed incorrectly upon admission to the facility from the hospital. R5 was receiving the incorrect dose of Seroquel for seven months until facility was alerted about the incorrect dosage by R5's family member. Findings include: The facility policy entitled, Medication Orders- Non-Controlled Medication Orders, dated 12/2012, states: Medications are administered only upon the receipt of a clear, complete, and signed order by a person lawfully authorized to prescribe. Medication orders from physician assistants, nurse practitioners (NP), clinical nurse specialists, pharmacists, and other appropriately licensed personnel are accepted if they comply with the requirements listed below, are in accordance with state law, and comply with applicable formularies or prescribing protocols that have been provided to the nursing care center by the responsible physician. DOCUMENTATION OF THE MEDICATION ORDER 1. Care should be taken to avoid errors or misinterpretation of handwritten information. Particular attention must be given to how medication names and strengths are expressed when writing medication orders. 2. Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on . and on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). b. Written transfer orders (sent with a resident from a hospital or other health care facility). * Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician unless the order is unclear or incomplete or the date signed is different from the date of admission. * If the order is unsigned or signed by another prescriber or the date is other than the date of admission, the receiving nurse verifies the order with the current attending prescriber before medications are administered. The nurse documents verification on the admission order record by entering the time, date, and signature. * The nurse who transcribes the orders to the physician order sheet and or MAR documents in the admission for the date, the time, and by whom the orders were noted. * Orders are transmitted to the pharmacy with any additional information required for new admission. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5 was admitted to the facility on [DATE] and diagnoses that include alcohol dependence, and major depressive disorder. R5's quarterly MDS (Minimum Data Set) assessment dated [DATE], indicates R5 has moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 08. R5 is assessed as being independent with bed mobility, transfers, walking, dressing, toileting, and hygiene and requiring supervision with eating and bathing. R5 is continent of bowel and bladder. R5 often had diarrhea because of fatty liver/ alcoholism and would occasionally wear incontinence products for protection. R5 usually went home on the weekends and stayed with R5's family members. R5's Care Plan was initiated on 6/16/2022 with a focus area of: Resident is at risk for side effects/adverse reactions related to taking anti-psychotic medications with the following interventions: - Administer medications per order and monitor for effectiveness. - Complete an Abnormal Involuntary Movement Scale (AIMS) assessment every 6 months and PRN (As Needed) with change. - Monitor for drug related side effects, drowsiness, sedation, dizziness, lethargy, headache, insomnia, increased confusion, vertigo, dry mouth, and tardive dyskinesia. - Monitor, Report and Document targeted behaviors, Psychosis: hallucinations, agitation, aggression, delusions. - Utilize non- pharmacological interventions-1:1 conversation, offer activities of choice, identify triggers, remove triggers, provide calm environment, offer reassurance, redirect as needed. On 6/16/2022, R5's discharge medication list from the hospital listed medications R5 should continue taking at the facility. R5's Physician orders for Quetiapine (Seroquel) was documented as follows: - Quetiapine 25 milligram (MG) tablet, Take one tablet (25mg total) by mouth nightly. - Quetiapine 25 MG tablet, take one tablet (25mg total) by mouth two times a day as needed (PRN) for agitation, psychosis. Surveyor reviewed R5's June 2022 Medication Administration Record (MAR). R5's Quetiapine order were transcribed as follows: - Quetiapine Fumarate Tablet 25 MG- Give 1 tablet my mouth one time a day for psychosis at 2100 (9:00 PM). Start on 6/15/2022. - Quetiapine Fumarate Tablet 25 MG- Give 1 tablet by mouth two times a day for psychosis at 0800 (8:00 AM) and 1600 (4:00 PM). Start 6/16/2022. Surveyor noted the facility transcribed R5's Physician orders for Quetiapine 25 MG incorrectly upon admission into the facility and R5 received 75 MG (daily total) of Quetiapine instead of the Physician ordered 25 MG (daily total) with the availability of 2 PRN (As Needed) doses of 25 MG each. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R5's MAR from July 2022, August 2022, September 2022, October 2022, November 2022, December 2022. Surveyor observed no changes made to R5's Quetiapine order resulting in R5 receiving the wrong dose of Quetiapine for seven months. On 6/27/2022 the Clinical Pharmacist (Clinical Pharmacist) did a Medication Regimen Review (MRR) on R5's medications. The Clinical Pharmacist made a recommendation note to the attending physician/prescriber regarding R5's Quetiapine (Seroquel) order. The recommendation states: - Federal guidelines for long-term care facilities require an evaluation of antipsychotic usage upon admission. This resident was recently admitted with and order for Seroquel 25 MG twice daily. Please consider a trial dose reduction to assess continued need for treatment and check one of the following . Surveyor noted that there is not a physician's signature on the recommendation letter. Surveyor reviewed monthly MRR recommendations from the Clinical Pharmacist. Surveyor reviewed the Clinical Pharmacist's monthly recommendations and noted there were no further recommendations for Seroquel order for 8/2022, 9/2022, 10/2022, 11/2022, 12/2022, or 1/2023. On 2/13/2023, at 10:16 AM, Surveyor interviewed Clinical Pharmacist-FF. Clinical Pharmacist-FF informed Surveyor that Clinical Pharmacist-FF is not the Clinical Pharmacist for this facility. Clinical Pharmacist-FF provided Surveyor with the phone number for the Clinical Pharmacist that covers this facility. On 2/13/2023, at 10:21 AM, Surveyor attempted to call Clinical Pharmacist for the facility. There was no answer. Surveyor left message for Clinical Pharmacist to call surveyor back and provided phone number. Surveyor never received a return phone call. On 1/3/2023, on R5's January 2023 MAR. R5's Quetiapine Fumarate 25mg orders were discontinued (D/C). New orders for Quetiapine Fumarate are as follows: - Quetiapine Fumarate Tablet 25 MG- Give 1 tablet by mouth two times a day for psychosis at 8:00 AM and 1800 (6:00 PM). Monitor for symptoms for 2 weeks and re-eval. Start: 1/3/2023, D/C: 1/13/2023. - Quetiapine Fumarate Tablet 25 MG- Give 25 mg by mouth in the evening (PM) related to major depressive disorder. Start: 1/13/2023. - Quetiapine Fumarate Tablet 25 MG- Give 0.5 (1/2) tablet by mouth in the morning (AM) for psychosis. Monitor for 2 weeks and re-eval. Start: 1/14/2023. On 1/16/2023 R5's family member reported a grievance to the Director of Nursing (DON)-B regarding R5's Quetiapine medication not being transcribed correctly when R5 was admitted . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/2023, DON-B filled out a Medication Error report (#1915) regarding R5's Quetiapine order: DON-B reviewed R5's medication regimen. DON-B confirmed the discrepancy regarding R5's admission transcription medication. DON-B documented R5's Quetiapine order on admission to the facility PRN dose transcribed and entered as scheduled. Transcription error reviewed with NP, R5 did not experience any adverse reactions, no new orders provided. Psychology physician assistant (Psych PA) contacted and advised. Gradual dose reduction (GDR) initiated for R5. Education provided to staff member regarding transcription of medications and implementation of orders. On 2/7/2023, at 1:36 PM, Surveyor observed R5 lying in bed watching TV. R5 was pleasant. R5 informed surveyor of goal to get back home with a home care aide. On 2/9/2023, at 1:22 PM, in the progress notes, DON-B documented R5 had no adverse reactions to current GDR of Quetiapine. DON-B discussed with Psych PA. DON-B will D/C (discontinue) R5's 0.5 MG dose and continue nightly dose of Quetiapine for 14 days. After 14 days Psych PA will review and possibly decrease dose to 12.5 mg at bedtime (HS). R5 and R5's guardian advised of changes. R5 and guardian expressed no concerns. Nursing to continue to monitor. On 2/9/2023, in R5's February 2023 MAR. R5's Quetiapine Fumarate orders were D/C. New order for R5's Quetiapine are as follows: -Quetiapine Fumarate oral Tablet 25MG- Give 25 MG by mouth in the evening (PM) related to Major depressive disorder for 14 days. After 14 days decrease PM dose to 12.5 MG every bedtime. Start: 2/9/2023 On 2/9/2023, at 3:11 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-EE. Surveyor asked LPN-EE to explain how admission orders/medication orders are entered for residents being admitted to the facility. LPN-EE stated the admitting nurse will enter the orders into the system. LPN-EE stated DON-B will usually put the orders in if DON-B is available. The orders are double checked with another registered nurse. LPN-EE stated the DON, assistant DON (ADON), and the unit manager (UM) will review the orders. Surveyor asked LPN-EE who would review the orders if the resident was admitted after hours, on the weekend, or on a holiday. LPN-EE replied that there is a weekend clinical manager on call that looks over all the admits. On 2/13/2022, at 10:00 AM, Surveyor interviewed NP-M. Surveyor asked if NP-M saw the Clinical Pharmacist recommendation from 6/27/2022 regarding R5's Quetiapine order for a GDR. NP-M stated NP-M remembered talking to DON-B about a GDR for R5's Quetiapine order. Surveyor asked NP-M who usually changes the orders and is there any follow-up. NP-M stated that the DON will usually put the new orders in. NP-M stated NP-M reviews medications for R5 monthly. Surveyor asked NP-M what physician follows R5 for R5's Quetiapine order. NP-M stated that R5 recently had a visit with the psych PA (on 2/9/2023) so psych will now follow R5 for R5's Quetiapine orders. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/2023, at 10:55 AM, Surveyor interviewed DON-B. Surveyor asked DON-B how DON-B was informed R5's Quetiapine medication error. DON-B stated that R5's family member mentioned it to DON-B, DON-B Could not recall when R5's family member informed DON-B of the medication dosing being incorrect. Surveyor asked DON-B to explain the admission process and transcribing medications for newly admitted residents. DON-B stated that the admitting nurse transcribes the orders into the facility system and another nurse will review the orders for accuracy. Surveyor asked DON-B how MRR recommendations made by the Clinical Pharmacist are handled. DON-B stated they (DON-B) receives the recommendations, and the they will notify the prescribing physicians of the Clinical Pharmacist recommendations. Surveyor asked DON-B if there is any follow-up with the physician if changes need to be made. DON-B stated they follow up to verify changes have been made. Surveyor asked DON-B about R5's Quetiapine order and the recommendations made by the Clinical Pharmacist on 6/27/2022. DON-B stated he gave the recommendations to the Psych NP. Surveyor asked DON-B what physician was following R5 for R5's Quetiapine medication. DON-B stated R5 is being followed by Psych Physician and Psych NP. Surveyor informed DON-B that Psych was not listed on R5's list of providers. Surveyor requested all Psych consultation notes for R5. Surveyor informed DON-B and LPN Unit Manager (LPN UM)-G of Surveyor's concern that R5 received the wrong dose of Quetiapine for 7 months. On 2/13/2023, at 1:30 pm, DON-B provided Surveyor with R5's psych consultation notes. Surveyor received one psych consultation note dated 1/13/2023. On 1/13/2022 R5 was seen by the Psych PA. Psych PA's disposition for R5 is: R5 tolerating GDR Seroquel, attempt additional GDR Seroquel 12.5 mg by mouth AM, 25mg PM, redirect PRN/allow R5 to vent; monitor for side effects. Psych PA placed order in Point Click Care system. DON-B aware of changes. Psych NP to recheck R5 in the next few weeks/month. Nursing to continue to monitor R5's mood, and behaviors. R5 has good family support. No further information provided at that time.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on interview and record review, the facility did not ensure 2 (R13 and R6) of 3 residents reviewed for laboratory services received quality and timely services for labs drawn at the facility. 1. R13 had an indwelling foley catheter placed 5/27/22 for urinary retention and was noted to have signs and symptoms of a UTI at that time. The facility did not put orders and preventative measures in place to prevent R13 from Urinary Tract Infections (UTIs). R13 was noted to have a UTI but treatment was delayed by 5 days. On 8/16/22 R13 had blood in his urine, the Nurse Practitioner (NP)-M was notified and a Urine Analysis (UA) with Culture and Sensitivity (C&S) was ordered. The UA was sent out 8/17/22 but the C&S was never evaluated even though it was sent to the facility on [DATE]. NP-M was not aware and ordered a resistive antibiotic for the UTI that was not effective and the infection continued. R13 was hospitalized [DATE] through 12/3/22 and was diagnosed with osteomyelitis. The Infectious Disease (ID) MD ordered IV antibiotics and ordered weekly labs to monitor the infection. The facility did not complete the labs and they were not sent to the ID MD until 12/28/22. 2. R6 had an order for Depakote medication. Behavioral Health Services that prescribed the medication requested a Depakote level be drawn 2 weeks after the start of the medication that was not added to R6's orders and not completed as requested. Findings include: Surveyor reviewed facility's Lab and Diagnostic Test Results - Clinical Protocol policy with a revision date of November 2018. Documented was: Assessment and Recognition 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Review by Nursing Staff 1. When test results are reported to the facility, a nurse will first review the results. a. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. 2. Before contacting the physician, the person who is to communicate results to a physician will gather, review, and organize the information and be prepared to discuss the following (to the extent that such information is available): (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The individual's current condition and details of any recent changes in status, including vital signs and mental status; b. Major diagnoses, allergies, current medications, any recent pertinent lab work, actions already taken to address results and treat the resident/patient, and pertinent aspects of advance directives (for example, limitations on testing and treatment); c. Why the lab and diagnostic tests were obtained (for example, as a routine screen or follow-up; to assess a condition change or recent onset of signs and symptoms, or to monitor a serum medication level; d. How test results may relate to the individual's current condition and treatment; and e. Any concerns and questions the physician will be expected to address regarding the resident. 3. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. 4. A nurse will try to determine whether the test was done: a. As a routine screen or follow-up; b. To assess a condition change or recent onset of signs and symptoms; or c. To monitor a drug level. (1) The reason for getting a test often affects the urgency of acting upon the result. (2) If the reason for performing the test cannot be identified, the nurse should proceed as though the tests were ordered to assess a condition change or recent onset of signs and symptoms . Determining the Reason for Testing .a. If the resident has signs and symptoms of acute illness or condition change and he/she is not stable or improving, or there are no previous results for comparison, then the nurse will notify the physician promptly to discuss the situation, including a description of relevant clinical findings as well as the test results. b. If the individual is stable or improving and the results do not warrant immediate notification, then the nursing staff may notify the physician routinely (for example, a stable individual with slightly abnormal follow-up test results, or low or therapeutic drug blood levels). Options for Physician Notification A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff). (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc. b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification. c. For information that does not need immediate physician response, staff may use alternatives such as faxing, voice mail, or a clipboard in the facility. 2. Alternatively, the staff and physician may also establish designated times during the day when they will review test results with the physician by phone. Physician Responses 1. Time frames. A physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. a. A physician should respond within one hour regarding a lab test result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non-immediate lab test notification with a request for response (for example, by late Wednesday afternoon for a call made on Tuesday). b. If the Attending or Covering Physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. 2. Physician decisions. When responding to notification of test results, the physician and staff will discuss the implications of the test results for the resident, as well as subsequent actions; for example, obtaining additional tests, new or modified medication orders, additional monitoring, etc . R13 was admitted to the facility on [DATE] with diagnoses that included Unspecified Cord Compression, Quadriplegia due to Motor Vehicle Accident, Type 2 Diabetes Mellitus (DM) with Diabetic Neuropathy, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Neuromuscular Dysfunction of Bladder, Retention of Urine and Chronic Kidney Disease (CKD). Surveyor reviewed R13's Comprehensive Care Plan with initiation date of 6/5/22. Documented was: Focus: Resident has Actual impaired skin integrity . Goal: Resident will have intact skin, free of redness, blisters or discoloration by/through review date [as evidenced by (AEB)] weekly skin audits. Interventions . (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. On 5/27/2022, at 3:42 PM, R13's Progress Notes document, Resident vital signs stable. No signs of distress at this time. Straight cath (catheter) this AM (morning) was 350cc (cubic centimeter) output. Foley inserted this afternoon. 250cc output. Obtained new order for insulin glargine. Obtained order for temporary bolus feeds. Urine output cloudy. Obtained order for UA (urine analysis). 30 minute checks completed today. No complaints from resident at this time. Added to MD orders for R13 on 5/27/22 was UA one time only for cloudy urine for 5 Days. There was no charting related to a UA, collection of sample or evaluations of cloudy urine on 5/28/22, 5/29/22, 5/30/22 or 5/31/22. The urine sample was collected 6/1/22 but treatment was not started until 6/7/22 when an order was obtained for Cipro Tablet 500 MG (milligram) (Ciprofloxacin HCl) Give 1 tablet via G-Tube one time a day for UTI until 06/09/2022. Documented in R13's Progress Notes on 8/16/2022, at 5:17 PM was Resident had considerable amount of blood in urine. [NP-M] notified, UA ordered. Added to MD orders for R13 on 8/16/22 was Urinalysis w/(with) C&S (culture and sensitivity). Documented in R13's Progress Notes on 8/17/2022, at 1:22 AM. was 97.5 98% 3L (liters)[alert and orientated (A/O)] x3 . Writer encouraging fluids: given now. Foley patent: clear light amber urine in bag: no s/s of blood in urine. Waiting to get a good U/A sample soon . Surveyor noted R13 had a catheter and UA sample could be obtained by closed system at any time. Documented in R13's Progress Notes on 8/17/2022, at 5:42 AM, was Writer obtained U/A sample now: will call for [pick up]. R13's UA sample was sent to the lab and results were positive for bacteria/UTI (Urinary Tract Infection) were sent back to the facility 8/17/22, at 11:12 AM. The C&S would be processed due to positive bacteria. Documented in R13's Progress Notes on 8/19/2022, at 5:42 AM, was Patient is alert with increased confused noted from baseline. Writer called to the room by CNA (Certified Nursing Assistant). Patient screaming I am not going to the strip bar. T (temperature)=99.8, b/p (blood pressure)=143/66 SP02 (oxygen saturation)=95% 2L (liters) o2 (oxygen) via [nasal cannula.] Foley cath patent draining clear yellow urine with foul smell. A U/A was collected that reveal + (positive) for bacteria however culture and sensitivity is pending. Writer placed a call to [NP-M]. She is advised of his symptoms. New order to start Cipro 500mg PO (per oral) daily x3 days. Writer left a message for his brother [name of brother] to call facility for updates . An MD order was added for R13's and started on 8/19/22 was Cipro 500mg [by mouth (PO)] Q day x3 days DX (diagnoses): UTI, one time a day for UTI for 3 Days. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documented in Progress Notes on 8/19/2022, at 7:32 PM, was Resident's 1600 (4:00 PM)blood sugar was elevated at 487. 18 units were given per sliding scale for BS (blood sugar)over 450 and then MD was contacted. On call MD gave [order] to give an additional 4 units of insulin which were given. Will recheck BS at HS (hour of sleep) to see the effects of the additional units. No s/s of hyperglycemia seen or reported by resident. Will continue to monitor. Documented in Progress Notes on 8/21/2022, at 1:58 AM, was 98.8 now: PRN Tylenol and cool compress effective: 99.0 at start. A/O (alert and oriented) x3 at start. Sleeping well in bed now. No c/o any. No c/o pain now. Foley patent: clear light amber urine noted: No s/s of blood in urine noted. No adverse s/s with PO ATB (antibiotic) use for UTI noted. No confusion noted. Resident drinking fluids: also pushed in G-tube . Surveyor reviewed R13's lab results printed for Surveyor on 2/9/23. Surveyor reviewed C&S originally reported to facility from lab on 8/20/22 at 7:33 AM. This report was not part of R13's medical record. Documented was an abnormal urine culture growing Proteus Mirabilis and Providencia Stuartii organisms. The Culture and Sensitivity results showed both organisms were Resistant to treatment by Cipro antibiotic prescribed for the UTI on 8/19/22 and was an ineffective treatment for the UTI. There is no documentation this report was given to NP-M or any other MD for follow-up on the identified ineffective antibiotic. R13 was hospitalized from 11/26/22 through 12/3/22. Documented in the Hospital Discharge Summary was . Discharge Diagnoses: Principle Problem: Dislodged gastronomy tube. Active Problems: . Sacral and ischial decubitus ulcers. Right ischial osteomyelitis .Hospital Course: . Patient also has known decubitus ulcers of his coccyx and left buttocks. Imaging was performed to the area, with concerns about osteomyelitis in the right ischium. It was previously debrided 1 month prior. After discussion with [infectious disease (ID)], patient will have a PICC (peripherally inserted central catheter) line placed today, will continue Zosyn upon discharge and it will be needed for 6 weeks. It has been requested that he has weekly [complete blood count lab (CBC)], [basic metabolic panel (BMP)] and [C-Reactive Protein lab (CRP)] checks, for results to be sent to [ID MD]. Also follow-up with [ID MD] will need to be coordinated with wound care as they have the ability to turn and position him for better examination . Surveyor reviewed MD orders for R13 with a start date of 12/7/22. Documented was CRP: one time a day every Wed related to OSTEOMYELITIS, UNSPECIFIED (M86.9) until 01/02/2023. BMP: one time a day every Wed related to OSTEOMYELITIS, UNSPECIFIED (M86.9) until 01/02/2023. CBC: one time a day every Wed until 01/02/2023. Documented with a start date of 12/7/22 and end date of 1/4/23 was Please fax weekly lab results drawn on Wednesday (CBC, BMP CRP) to [ID MD] @ [phone number] one time a day every Wed (Wednesday), Thu (Thursday). Surveyor noted labs should have been drawn and sent to the ID MD on 12/7/22, 12/14/22 and 12/21/22. These labs were not completed. On 1/3/23, R13 went out to see the Infectious Disease MD. Noted was the IV Abx needed to continue for 2 more weeks as infection was not cleared. Documented was Antibiotics for osteomyelitis of the right ischial bone need to continue for at least 2 more weeks. I will change to once a day IV (intravenous) ertapenem now. The PICC should be kept in place until that is done. We need labs done weekly to follow his infection, which were requested upon discharge but not done except 1 CRP on 12/28/2022. This was still elevated. Continue wound care as you are doing. We will be stopping [R13's] antibiotics in 2 weeks and after that wound care should monitor. No appointment will be made in this clinic. If signs of infection appear he will need to go to the ED (Emergency Department). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/23, at 10:10 AM, Surveyor interviewed NP-M. Surveyor asked about ordering R13's Cipro antibiotic back in August. NP-M stated she did not exactly remember the situation but remember ordering the Cipro to be proactive about the symptoms of the UTI. Surveyor asked if she ever saw the C&S that stated Cipro was resistant to the UTI organisms. NP-M stated no, and if she would have, she would have changed the order immediately. On 2/13/23, at 11:13 AM, Surveyor interviewed Director of Nursing (DON)-B and Licensed Practical Nurse (LPN)-G. Surveyor asked how staff know if lab results were reviewed and sent to the appropriate MD or NP. DON-B stated there should be a progress note. Surveyor noted R13's 8/20/22 C&S not being reported to NP-M as there was no progress note and NP-M stated they were not aware because they would have changed the antibiotic order had they known. DON-B stated the C&S was reported to NP-M and it was in an email. Surveyor asked for the documentation of this. On 2/13/23, LPN-G brought Surveyor a copy an email between DON-B and NP-M with UA results but it was dated 6/14/22. On 2/14/23, at 8:34 AM, DON-B reported that he had no documentation or email reporting the C&S results to NP-M from 8/20/22. Surveyor asked about the labs not completed for the ID MD. DON-B stated he identified those not being completed on 12/28/23. DON-B stated he ordered them STAT that day and again 1/4/23. 20483 2) R6's diagnoses includes developmental disorder of speech and language, schizoaffective disorder, and bipolar depression. The physician's order note dated 1/13/23 written by PAC (Physician Assistant Certified) Psych-O documents [Name of] Psych in to see pt (patient), continues to have agitation/aggression/combativeness, grabbing at others. Bipolar depression history, lowered lamotrigine to 100 mg (milligrams) daily and added depatoke sprinkles 125 mg twice a day please check depakote level in 2 weeks results to [PAC Psych-O, name of group]. Surveyor reviewed R6's medical record and was unable to locate an order for the depakote level under the orders tab in R6's electronic medical record or the results of a depakote level for R6. On 2/8/23, at 2:55 p.m., during the end of the day meeting with Current Administrator-P, LPN (Licensed Practical Nurse)/(Unit Manager)-G, RDO (Regional Director of Operations)-U and RN (Registered Nurse)/Regional Educator-V Surveyor asked for any laboratory reports for R6 obtained in January & February. On 2/9/23, at 7:00 a.m., Surveyor reviewed the laboratory reports provided for R6. Surveyor was only provided with a CMP (comprehensive metabolic panel) and CBC (complete blood count) collected on 2/8/23. Surveyor was not provided with a depakote level for R6. On 2/13/23, at 9:57 a.m., Surveyor met with LPN/UM-G to discuss R6. Surveyor informed LPN/UM-G Surveyor had noted a physician order note dated 1/13/23 for a depakote level in two weeks and Surveyor did not note this was completed. LPN/UM-G informed Surveyor she will look into this and get back to Surveyor. On 2/13/23, at 1:09 p.m., LPN/UM-G informed Surveyor R6's depakote level was not done. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/23, at 9:27 a.m., Surveyor asked LPN/UM-G why R6's depakote level was not done. LPN/UM-G informed Surveyor it was over looked and usually DON-B would receive this. On 2/14/23, at 10:44 a.m., Surveyor asked DON-B why R6's depakote level was not done. DON-B informed Surveyor PAC Psych-O usually communicates with him and he places the order. DON-B informed Surveyor this did not happen as PAC Psych-O did not communicate with him.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on record review and interview the facility did not ensure 1 (R10) of 1 Residents who required a diagnostic service had the services obtained timely and the results reported to the physician promptly. Wound MD (Medical Doctor)-J ordered a bilateral lower extremity ultrasound for R10 on [DATE]. The imaging company did not perform this service until [DATE], the results were not reported to the Facility until [DATE] and the Facility reported the results to another physician on [DATE]. Findings include: The Lab and Diagnostic Test Results - Clinical Protocol 2005 Med-Pass Inc, (Revised [DATE]) under assessment and recognition documents: 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Under options for Physician Notifications includes documentation of Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc. R10's diagnoses includes diabetes mellitus, hypertension, hemiplegia and hemiparesis following cerebrovascular disease, and depressive disorders. R10's left dorsal foot wound evaluation completed by Wound MD (Medical Doctor) on [DATE] under notes documents BLE (bilateral lower extremities) Arterial duplex ultrasound please. The nurses note dated [DATE] documents, Seen by in house wound MD Assessed wound to right dorsal foot and toes. Areas classified as Arterial wounds, betadine ordered. Continue with heel boots. BLE Arterial Duplex Ultrasound ordered. Guardian aware. The physician order dated [DATE] documents, BLE Arterial Duplex ultrasound. The ordering physician is Wound MD-J. The nurses note dated [DATE] documents, [Name of] Imaging here for BLE ultrasound. DX (diagnosis): wounds. Results pending. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated [DATE] documents, Being monitored for bilateral heel wounds and poor appetite. Eats very little. Bilateral heels area darkened and boggy. Toes to the left foot are dark purple. Feet are cool unable to palpate pulses. Doppler flow studies are pending. Will monitor. The nurses note dated [DATE] documents, Call placed at approx (approximately) 1230 (12:30 p.m.) to [name of] mobile imaging with request for recent Doppler results to be faxed to facility at [telephone number]. Additional call made at 1349 (1:49 p.m.) as results have not been received yet with request for results to be faxed again to the same number. The nurses note dated [DATE] documents, Seen by in house wound MD. Decline noted to right foot toes 4th and 5th toes necrotic. Continue with Betadine. Wound MD awaiting Arterial ultrasound results. Guardian aware. There is no further documentation regarding the results of R10's bilateral lower extremities arterial duplex ultrasound. R10 expired on [DATE]. On [DATE], at 11:44 a.m., Surveyor informed DON (Director of Nursing)-B and LPN (Licensed Practical Nurse)/UM (Unit Manager)-G Surveyor is unable to locate R10's ultrasound and requested a copy of the results. On [DATE], at 12:30 p.m., LPN/UM-G provided Surveyor with the results. Surveyor informed LPN/UM-G Wound MD-J ordered the BLE arterial ultrasound on [DATE], wasn't completed until [DATE], five days later and inquired about the delay. LPN/UM-G informed Surveyor she put the order in, and the delay may be the diagnostic company. Surveyor inquired who would follow up to ensure the ultrasound was completed. LPN/UM-G replied the nurses. Surveyor asked when the Facility received the results as Surveyor noted the ultra sound was signed by the imaging company's physician on [DATE]. LPN/UM-G informed Surveyor they must of received the results on [DATE]. Surveyor inquired when Wound MD-J was notified of the results. LPN/UM-G informed Surveyor she will have to get back to Surveyor. On [DATE], at 9:44 a.m., Surveyor met with LPN/UM-G. Surveyor asked LPN/UM-G to explain the Facility's system for obtaining diagnostic tests. LPN/UM-G explained for R10 she didn't get the order during wound rounds and that she received a text from the wound nurse (Wound RN (Registered Nurse)-K) with multiple Doppler orders. LPN/UM-G informed Surveyor she put R10's order in herself, printed the face sheet, order, requisition form and faxed the information. Surveyor inquired who would follow up to ensure the diagnostic test was completed. LPN/UM-G informed Surveyor herself and the floor nurses. Surveyor inquired why the imaging company didn't perform the test until [DATE]. LPN/UM-G informed Surveyor they have had problems with [name of] imaging coming in timely. Surveyor informed LPN/UM-G the report was signed by [name of] imaging company on [DATE] and inquired when Wound MD-J was notified of the results as there is no documentation in R10's medical record. LPN/UM-G indicated she believed that day. LPN-UM-G informed Surveyor she knows the ultrasound was completed and will check with DON-B. On [DATE], at approximately 11:10 a.m., DON-B provided Surveyor with emails between DON-B and Physician-N dated [DATE]. Surveyor noted Physician-N was emailed the results of R10's bilateral lower extremities ultrasound on [DATE] at 11:23 a.m. Surveyor asked DON-B why he emailed the results to Physician-N when Wound MD-J ordered the diagnostic test. DON-B informed Surveyor he was unaware Wound MD-J had ordered the test.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview and record review, the facility was not administered in a manner to ensure residents attained or maintained their highest level of practicable well-being. This deficient practice had the potential to affect all 69 residents residing in the facility at the time of the survey. During a complaint survey conducted on 2/8/2023-2/14/2023, it was determined 14 deficiencies existed including the deficient practice at F835 (Administration). Each of the deficiencies identified systemic issues within the faclity that were not addressed by facility administration through established processes. Five of the deficiencies have been identified to be deficient at a severity level of immediate jeopardy at a scope of isolated, pattern, and widespread. Additionally, systemic concerns were identified regarding notification of changes of condition, the environment, allegations of abuse, reporting and investigating allegations of abuse, pharmacy services, significant medication errors, laboratory services, and radiology and other diagnostic services. Staff Member-F completed coursework on 6/9/2022 at a nursing school and graduated with a diploma for Practical Nursing on 8/30/2022. Staff Member-F applied for a temporary Licensed Practical Nurse (LPN) license with the assistance of Director of Nursing (DON)-B on 7/20/2022. DON-B submitted the temporary license application and never verified Staff Member-F received the temporary LPN license. Staff Member-F was never granted the temporary LPN license. Staff Member-F never took the LPN boards to obtain an LPN license. Staff Member-F was not certified as a Certified Nursing Assistant. Staff Member-F worked as an LPN at the facility from 7/25/2022 until 12/16/2022 without an LPN license for a total of 90 days and 121 shifts. Staff Member-F worked without a Registered Nurse in the building for 16 shifts and was designated as the charge nurse for 6 shifts. Staff Member-F performed all duties assigned to LPN staff without having an LPN license, including passing medication, doing wound care, and monitoring residents with a change in condition. *R8 was sent to the hospital on 11/27/2022 via 911 for shortness of breath and low oxygenation. R8 was under the care of Staff Member-F at the time of the change of condition. R8 was not comprehensively assessed by a licensed professional at the time of the change of condition, no vital signs were documented, and no circumstances around the change of condition were documented. A timeline of events could not be determined due to lack of documentation. R8 passed away in the hospital on 11/28/2022. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	*R9 had a change in condition on 11/27/2022 with an oxygen saturation level of 74%. R9 was under the care of Staff Member-F at the time of the change of condition. R9 was not comprehensively assessed by a licensed professional at the time of the change in condition. Staff Member-F contacted the Nurse Practitioner who ordered R9 to be sent to the hospital for evaluation and treatment. R9 refused to go to the hospital at that time. Staff Member-F did not notify the Nurse Practitioner of this refusal. R9 was sent out to the hospital by an LPN on 11/28/2022 at 1:45 AM with an oxygen saturation level of 70-71%. Complete vital signs were not documented at the time when the change of condition was first noted on 11/27/2022 or prior to leaving the facility on 11/28/2022 and no documentation was found describing the circumstances around the change of condition or between the time the change of condition was first noted and when R9 was sent to the hospital. A timeline of events could not be determined due to lack of documentation. R9 did not return to the facility. *R19 was sent to the hospital on 10/25/2022 for a change in condition. R19 was under the care of Staff Member-F at the time of the change of condition. R19's medical record did not have any documentation on 10/25/2022 indicating R19 had a change in condition that would require hospitalization : no progress note, no change of condition evaluation documentation, and no vital signs. A timeline of events could not be determined due to lack of documentation. The failure of administration to ensure the building was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident created a situation of immediate jeopardy that began on 7/25/2022. Surveyor notified Nursing Home Administrator (NHA)-A of the immediate jeopardy on 2/13/2023 at 4:15 PM. The immediate jeopardy was removed on 2/21/23. However, the deficient practice continues at a scope/severity of F (potential for harm/widespread) as the facility continues to implement its action plan. Findings include: The Wisconsin Department of Safety and Professional Services website https://dsps.wi.gov/Credentialing/Health/info3087.pdf states: BOARD OF NURSING CREDENTIALING INFORMATION FOR REGISTERED NURSE/LICENSED PRACTICAL NURSE APPLICANTS . 4. Temporary Permit for Exam Applicants (Form #2434) (optional) - In addition to Form #2434 and the $10.00 temporary permit fee, the Department also requires a completed application for permanent licensure and proof of graduation from a WI Board-approved school or comparable school of professional/ practical nursing prior to granting a temporary permit. A temporary permit cannot be processed until all of those requirements are satisfied. Exam applicants must have a supervising RN and the department must receive proof of graduation/ completion from the school prior to issuance. A temporary permit is valid for a period of three months or until the holder receives notification of failing the NCLEX examination. An applicant for RN/LPN licensure who holds a valid permit under this Temporary Permit section or Subchapter IV of Wis. Admin. Code ch. N2 may use the title Graduate Nurse/Graduate Practical Nurse or the letters GN/GPN and shall not practice beyond the scope of the license the holder is seeking to obtain. The holder is required to practice under the direct supervision of an RN. The supervisor must be on-site and immediately available at all times. You may not practice as an RN/LPN in Wisconsin unless you have either a permanent license or temporary permit. The facility policy and procedure entitled Competency of Nursing Staff revised 10/2017 from the MED-PASS manual (C)2001 states: Policy Statement: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law. 2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in plans of care. Policy Interpretation and Implementation: 1. The staff development and training program is created by the nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents. 2. The following factors are considered in the creation of the competency-based staff development and training program: a. An evaluation of the current program to ensure basic nursing competencies; b. Any gaps in education or training that may be contributing to poor outcomes; c. Specialized skills or training needed based on the resident population; d. A method to track, assess, plan, implement and evaluate the effectiveness of training; and e. A method to evaluate critical thinking skills and management of care in complex environments with multiple interruptions. 3. The facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population. 4. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: a. Preventing abuse, neglect and exploitation of resident property; b. Dementia management; c. Resident rights; d. Person centered care; e. Communication; (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	f. Basic nursing skills; g. Basic restorative services; h. Skin and wound care; i. Medication management; j. Pain management; k. Infection control; 1. Identification of changes in condition; and m. Cultural competency. 5. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. 6. Facility and resident-specific competency evaluations will include: a. Lecture with return demonstration for physical activities; b. A pre- and post-test for documentation issues; c. Demonstrated ability to use tools, devices, or equipment used to care for residents; d. Reviewing adverse events that occurred as an indication of gaps in competency; or e. Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform. 7. Competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge. 8. Inquiries concerning staff competency evaluations should be referred to the Director of Nursing Services or to the Personnel Director. Surveyor noted this policy and procedure was not dated by the facility or signed by the Medical Director. The facility policy and procedure entitled Quality Assurance and Performance Improvement (QAPI) Program revised 4/2014 from the MED-PASS manual (C)2001 states: Policy Statement: This facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Policy Interpretation and Implementation: The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data-driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Five Strategic Elements: The QAPI program has been developed with five strategic elements in mind. 1. Design and scope: a. The program is ongoing and comprehensive. b. It involves the full range of services and departments in the facility. c. It covers all systems of care and management practices, with priority given to quality care, quality of life and resident choice. d. Goals, targets and benchmarks are established and measured based on the best available evidence. 2. Governance and leadership: a. Input is sought from facility staff, residents, family members and individuals who are involved in the care of residents. b. Resources are allocated to conduct QAPI efforts. c. Members of the facility leadership are accountable for QAPI efforts. d. Staff are trained in QAPI systems and culture. e. Staff are encouraged to identify and report quality concerns as well as opportunities for improvement. 3. Feedback, data systems and monitoring: a. Systems are in place to monitor care and services. b. Systems are designed to incorporate feedback from caregivers, residents, family and staff as appropriate. c. Care processes and outcomes are monitored using performance indicators. These performance indicators are measured against quality benchmarks and targets that the facility has established. d. Adverse events are tracked, monitored and investigated as they occur. e. Action plans are implemented to prevent recurrence of adverse events. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. Performance improvement projects: a. Performance improvement projects (PIPs) are initiated when problems are identified. b. PIPs involve systematically gathering information to clarify issues and to intervene for improvements. 5. Systematic analysis and systematic action: a. Root Cause Analysis (RCA) is used to determine whether identified issues are exacerbated by the way care and services are organized or delivered, and if so, how. b. RCA serves as a highly structured approach to fully understanding the nature of an identified problem, its cause and the implications of making changes to improve the problem. QAPI Action Steps: The following steps are employed or will be employed to support and enhance the facility QAPI program: 1. Establishing a QAPI Committee/sub-committee that works in tandem with the facility leadership and the QA&A Committee. 2. Allocating resources for QAPI initiatives. 3. Providing staff, family members and residents with information about the QAPI program and inviting them to meet with QAPI leadership. 4. Providing concrete channels of communication between staff, residents, family members and leadership. 5. Establishing a zero tolerance policy for retaliation against individuals who appropriately report or communicate quality concerns. 6. Creating task-oriented or goal-oriented teams for QAPI: a. Establishing a clear purpose for each team. b. Defining specific roles for each team member. 7. Utilizing established QAPI self-assessment tools to initiate and then periodically re-evaluate the QAPI program. 8. Identifying this facility's Guiding Principles and the [sic] using them to guide decision-making and set priorities. 9. Establishing a QAPI Plan that guides quality efforts and serves as the main document that supports the QAPI implementation. 10. Communicating the QAPI plan and principles to all caregivers, including consultants, contractors and business associates. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	11. Communicating the QAPI plan and principles to residents and families, and encouraging their participation in the systems. 12. Providing frequent leadership and staff training on the QAPI plan and its underlying principles, including the concept that systems of care and business practices must support quality care or be changed. 13. Gathering and using QAPI data in an organized and meaningful way. Areas that may be appropriate to monitor and evaluate include: a. Clinical outcomes: pressure ulcers, infections, medication use, pain, falls, etc.) [sic]; b. Complaints from residents and families; c. Re-hospitalization s; d. Staff turnover and assignments; e. Staff satisfaction; f. Care plans; g. State surveys and deficiencies; and h. MDS assessment data. 14. Setting measurable goals for improvement that may include percentage of reductions (or increases) from the measured baseline of a particular goal. 15. Identifying benchmarks of performance and comparing facility data with national and state performance benchmarks. 16. Recognizing patterns in systems of care that can be associated with quality problems. 17. Prioritizing identified quality issues based on risk of harm and frequency of occurrence, and determining which will become the focus of PIPs. 18. Planning, conducting and documenting PIPs. 19. Conducting Root Cause Analysis to identify the underlying issues that contribute to recognized problems. 20. Taking systematic action targeted at the root causes of identified problems. This encompasses the utilization of corrective actions that provide significant and meaningful steps to improve processes and do not depend on staff to simply 'do the right thing.' Surveyor noted this policy and procedure was not dated by the facility or signed by the Medical Director. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Facility Assessment Tool dated 8/18/2017 was provided to Surveyor. The Facility Assessment Tool was not a completed Facility Assessment. The Facility Assessment Tool was used by the facility on 1/2022 and updated on 2/1/2022 and 2/8/2023. The facility assessment tool did not have a date that it was reviewed with QAA/QAPI committee. The Facility Assessment Tool was completed for the resident population in the following areas: the number of beds, the average daily census, the average range of residents being admitted /discharged on a weekday and a weekend, the Major RUG-IV Categories the residents were categorized as, the number of residents receiving special treatments, and the breakdown of the extent of assistance residents needed with Activities of Daily Living. The Facility Assessment Tool was completed for the overall staffing needed in the facility with no other specific hourly or shift breakdown of staffing needs. The Facility Assessment Tool had suggestions for developing an individualized Facility Assessment, but was just a tool to be used and was not a comprehensive assessment of the facility's resident population, staffing needs, or any detailed breakdown of what the facility could manage to provide quality care for their residents. Surveyor was investigating a change in condition R8 had on 11/27/2022 and noted Staff Member-F had charted in the progress notes regarding the change in condition. Surveyor reviewed the facility employee list and noted Staff Member-F was listed as a current employee with a status of LPN. On 2/7/2023 at 1:52 PM, Surveyor requested from DON-B to speak to Staff Member-F regarding R8's change in condition. DON-B stated Staff Member-F no longer worked at the facility because Staff Member-F did not pass the nursing boards and did not want to work as a caregiver so did not return to work. In an interview on 2/8/2023 at 8:30 AM, LPN Unit Manager (UM)-G stated Staff Member-F did not have a CNA license. LPN UM-G stated Staff Member-F worked as a Graduate Nurse after going to school for an LPN but let the temporary license expire and no longer works at the facility. On 2/9/2023 at 9:13 AM, Surveyor called the Department of Safety and Professional Services (DSPS) and inquired if Staff Member-F had received a temporary LPN license. The DSPS staff member stated no license was found for Staff Member-F. The DSPS staff member stated Staff Member-F had submitted an application for a temporary LPN license and a notation was attached to the application that read pending applicant input. The DSPS staff member stated the temporary application had been submitted on 7/20/2022 but no other supporting documentation, such as a diploma or transcript, had been submitted and therefore a temporary license was not issued. The Temporary Permit Request for Registered Nurse or Licensed Practical Nurse states: Applicants who wish to practice under the supervision of more than one RN must submit an additional (Form #2434) for each supervising RN. I, the above-named applicant, will be employed to work as a RN/LPN at the address listed below under the direct supervision of a RN who has an active Wisconsin RN license. The form was signed by Staff Member-F, dated 7/20/2022, and DON-B information written in DON-B's handwriting was provided as the RN Supervisor for Staff Member-F. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Surveyor reviewed all staffing schedules from 7/25/2022 through 12/16/2022. Staff Member-F worked a total of 90 days and 121 shifts in that timeframe. From 7/25/2022 through 8/31/2022, Staff Member-F worked with an RN or LPN except for three shifts where Staff Member-F was listed on the staffing schedule as an LPN working independently without shadowing a nurse. From 9/1/2022 through 12/16/2022, Staff Member-F was listed on the staffing schedule as working independently as an LPN without being paired up with a nurse. Staff Member-F worked 16 shifts with no RN on the schedule and Staff Member-F was listed as the charge nurse for 6 shifts. In an interview on 2/9/2023 at 2:59 PM, Surveyor asked Human Resources (HR)-Q, who works for a sister facility, what the process was for hiring an individual to work for that company. HR-Q stated when an individual applies for employment, the application is reviewed by HR. HR-Q stated the HR department is responsible for running the individual's background check, checking their licensure or certification depending on their position, and checking references. HR-Q stated once the background check and references are cleared, the individual's information is forwarded the Director of Nursing (DON) to schedule an interview. HR-Q stated once the interview is completed, the applicant is called to set up orientation. Surveyor asked HR-Q if the hiring process was the same for a Certified Nursing Assistant (CNA), LPN, or RN. HR-Q stated yes, the process is the same. HR-Q stated HR-Q always checks on the licensure or certification before the interview is scheduled because it has happened in the past where the individual was not certified, and they do not want to waste anyone's time by going through the interview process and not being qualified for the job. Surveyor asked HR-Q what the process was for an individual who has graduated from nursing school but has not yet taken their licensure exam. HR-Q stated the individual's information is given to the DON along with a copy of their diploma and transcript. HR-Q stated the DON helps the individual apply for a temporary license. HR-Q stated they get a test date for the exam and then follow up to get the results. Surveyor asked HR-Q what the process was for someone with a temporary license while working at the facility. HR-Q stated until the test is completed and passed, the graduate nurse must work with an RN on the same schedule and on the same unit because the RN is responsible for the graduate nurse. HR-Q stated the DON gets an email verification of the temporary license, and if they want to check on the status, there is a phone number and email address they can use to contact the licensing agency. HR-Q stated you can also go online to look up the licensure as well. Surveyor shared with HR-Q that Surveyor had been unable to find any confirmation that Staff Member-F had any type of nursing license or CNA certification. HR-Q agreed that HR-Q had the same results: no CNA certification, temporary LPN license, or official LPN license. On 2/9/2023 at 3:15 PM at the daily exit meeting with the facility, Surveyor shared with Nursing Home Administrator (NHA)-A the concern Staff Member-F did not have a temporary LPN license, was not always working under an RN while employed, was a charge nurse on the schedule at times, and no training, competencies, or orientation packet had been provided to Surveyor. Surveyor shared Staff Member-F was the employee caring for residents when they had a change in condition and was not licensed to care for residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 2/13/2023 at 7:55 AM, Surveyor asked HR-R, the HR for the facility, what happened with the hiring process of Staff Member-F. HR-R stated Staff Member-F was the first graduate nurse the facility had hired; typically, they do not hire anyone until they are licensed. Surveyor asked HR-R what job description Staff Member-F signed when hired. HR-R thought Staff Member-F had signed a job description for Graduate Nurse and stated HR-R would get a copy of it. (Surveyor was provided a copy of the job description Staff Member-F had signed; the job description was for an LPN.) HR-R stated Staff Member-F put in an application for employment and HR-R put Staff Member-F in the computer and got the pay situated. HR-R stated DON-B interviewed Staff Member-F and DON-B did the paperwork that was faxed for a temporary LPN license. HR-R stated HR-R followed up on the temporary LPN license in December 2022 and found out there was a mistake on the application, so it was never processed. HR-R stated once they found that out, they took Staff Member-F off the working schedule. Surveyor asked HR-R if the facility had a copy of Staff Member-F's diploma or transcript from nursing school. HR-R stated no, they did not have either of those documents. HR-R stated HR-R thought Staff Member-F was still in school and about to graduate. Surveyor asked HR-R if Staff Member-F had any training records or competencies completed while working at the facility, such as an orientation packet. HR-R stated DON-B would have training information. In an interview on 2/13/2023 at 8:10 AM, DON-B stated DON-B interviewed Staff Member-F prior to hiring Staff Member-F and found out Staff Member-F was a Graduate Nurse. DON-B stated Staff Member-F showed DON-B their credentials. DON-B was unable to provide Staff Member-F's diploma or transcript from nursing school to Surveyor. DON-B stated Staff Member-F showed DON-B their notice of graduation stating Staff Member-F finished the nursing program and was eligible to be a Graduate Nurse. DON-B stated DON-B and Staff Member-F completed the application for temporary LPN license and Staff Member-F told DON-B that Staff Member-F would pay for the temporary license. DON-B stated DON-B thought Staff Member-F had completed the application process. DON-B stated Staff Member-F had scheduled a date for the LPN boards which was in mid to late summer of 2022, and then told DON-B Staff Member-F had rescheduled the boards to a later date. Surveyor asked DON-B if DON-B ever got confirmation Staff Member-F had received the temporary LPN license. DON-B stated no. Surveyor asked DON-B if DON-B ever followed up on the temporary LPN license by contacting the licensing agency. DON-B stated no. Surveyor shared with DON-B the observation of Staff Member-F being listed on the working schedule as being the charge nurse. DON-B stated Staff Member-F was a regular employee and so was designated as a charge nurse if the other nurses working were agency staff. Surveyor asked DON-B if Staff Member-F worked only when there was an RN in the building. DON-B stated it was possible there were no RNs in the building when Staff Member-F was working. Surveyor asked DON-B to see the job description for a Graduate Nurse. DON-B stated they do not have a job description for a Graduate Nurse. Surveyor asked DON-B if there were any other Graduate Nurses working at the facility. DON-B stated Staff Member-F was the first Graduate Nurse working for the facility and there will not be any more after this. Surveyor asked DON-B if Staff Member-F had provided the facility with a copy of the diploma or transcript from nursing school. DON-B stated no, but DON-B saw the transcript and knew that Staff Member-F had passed the pharmacology course. Surveyor asked DON-B to see Staff Member-F's orientation packet, training, and competencies. DON-B stated HR would have that information. Surveyor noted HR-R had said DON-B would have that information. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 2/13/2023 at 8:27 AM, Scheduler-S stated Staff Member-F was an LPN that had just graduated. Surveyor asked Scheduler-S if Staff Member-F had worked part-time or full-time. Schedule-S stated Staff Member-F worked part-time but would pick up shifts. Surveyor asked Scheduler-S if Staff Member-F could work any time or did Staff Member-F have to be scheduled when any certain nurse worked. Scheduler-S stated Staff Member-F did not have any restrictions; Staff Member-F could work anywhere with anyone. Surveyor asked Scheduler-S if Staff Member-F was ever the nurse in charge when working. Scheduler-S stated if Staff Member-F was the only nurse working that was not from an agency, then Staff Member-F would be listed as the charge nurse. Surveyor asked Scheduler-S if an RN had to be working when Staff Member-F was working. Scheduler-S stated no. In a phone interview on 2/13/2023 at 9:03 AM, University Registrar-T stated Staff Member-F completed all courses of the nursing program on 6/9/2022, but the date of 8/30/2022 was the last date of the semester and therefore the date used for official graduation. The facility provided to Surveyor Staff Member-F's orientation packet with signed materials on 7/25/2022. No competencies were provided. No copy of a diploma or transcript was provided. Surveyor noted the LPN job description stated date of hire was 8/22/2022 for 40 hours per week and was signed by Staff Member-F on 10/19/2022. No signed job description was provided for Staff Member-F when Staff Member-F was hired on 7/25/2022. R8 was admitted to the facility on [DATE] with diagnoses of spastic quadriplegic cerebral palsy, anxiety, schizophrenia, intellectual disabilities, scoliosis, gastro-esophageal reflux disease, and dysphagia requiring a gastrostomy feeding tube for nutrition. R8's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R8 was severely cognitively impaired per staff assessment and was dependent for all activities of daily living. On 11/22/2022 at 12:23 PM in the progress notes, nursing charted R8 was visited by a community Case Manager and R8's Guardian. Nursing charted R8 was placed in a Broda chair with a Hoyer lift and positioned with pillows. Nursing charted R8 was able to tolerate being reclined and upright in the Broda chair for approximately one hour before being transferred back to bed. On 11/22/2022, R8's vital signs were as follows: blood pressure 129/67, temperature 97.6, pulse 71, respirations 18, and oxygen saturation 97%. Surveyor noted the vital signs were obtained on 11/22/2022 because there was a physician order to obtain vital signs and monitor edema weekly on Tuesday PM shift. Surveyor noted a physician order was in place to monitor temperature and oxygen saturation every shift and notify the physician and Director of Nursing (DON) immediately if any symptoms were present such as cough, fever greater than 100.0, decreased oxygen saturation. Surveyor noted checkmarks were placed on the Medication Administration Record/Treatment Administration Record (MAR/TAR) and no values were documented of the temperature or oxygen saturation level. No documentation was found in the progress notes between 11/22/2022 and 11/27/2022. No vital signs were documented after 11/22/2022. Surveyor noted Staff Member-F was assigned to work on 11/22/2022, 11/23/2022, 11/24/2022, 11/25/2022 (AM and PM shift), 11/26/2022 (AM and PM shift) and 11/27/2022. No RN was on the schedule for 11/23/2022, 11/24/2022, and 11/25/2022 when Staff Member-F was working and Staff Member-F was listed as the charge nurse with no RN on the schedule for 11/27/2022 AM shift. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/27/2022 at 11:34 AM in the progress notes, Staff Member-F, an unlicensed employee, charted R8 was sent out 911 at 11:00 AM for shortness of breath and low oxygen saturation. Staff Member-F charted the community Case Manager was unavailable and a message was left for them to call the facility for an update on the changes in R8. Staff Member-F charted R8's Guardian was called and notified of changes, the Nurse Practitioner was updated, and the DON was aware. Surveyor did not find any documentation of Staff Member-F contacting a Registered Nurse to do an assessment of R8 for the change in status. No vital signs were documented. No details surrounding the change in condition were documented. Surveyor requested and received the Emergency Medical Service (EMS) report of R8's change of condition on 11/27/2022. The report states the following: EMS received the 911 call on 11/27/2022 at 11:11 AM and an ambulance unit and fire engine were dispatched to the scene for a call regarding a resident with complaints of difficulty breathing. On arrival, R8 was lying in bed in the care of staff. R8 was noted to have an altered mental status with the last known well time being 30 minutes ago. Staff stated R8 was not verbal and normally with an altered mentation, but this morning when giving R8 a bath, R8 became more altered than normal and was gasping for air. Staff stated R8's oxygen saturation was in the 70's and they applied oxygen via nasal cannula with no relief. R8's past medical history of cerebral palsy and scoliosis was noted. At 11:25 AM, R8's vital signs were assessed: blood pressure 98/58, oxygen saturation 71%, pulse 140 and regular, respirations 24 and rapid, blood glucose over 500, and temperature 98.0. (Surveyor noted R8's blood pressure and oxygen saturation were low and R8's pulse, respirations, and blood glucose were high.) R8's lungs were noted

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 22692 Based on interview and record review the Facility did not ensure 5 (CNA-W, CNA-Y CNA-PP, CNA-QQ and CNA-RR,) of 5 randomly sampled CNA's (Certified Nursing Assistants) who had been employed for over a year received dementia management and resident abuse prevention training. This has the potential to affect all 69 of the Residents residing in the Facility. Findings include: On 2/22/23 the facility policy titled in-service Training Program, Nurse Aide dated 10/17 was reviewed and read: The facility will complete a performance review at least every 12 months. In-service training will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews. Annual in-services must include training in dementia management and abuse prevention. On 02/22/23, Administrator-P was provided the names of CNA-W, CNA-Y, CNA-PP, CNA-QQ, and CNA-RR who were five randomly selected CNAs and requested their in-service training in the past year for Abuse and Dementia training. On 02/22/23 in-service training records were provided and included: 1. CNA-W was hired on 07/29/2015, and is assigned to work throughout the facility as needed. The Surveyor was not provided with any in-service training hours for Abuse or Dementia training in the past 12 months. 2. CNA-Y was hired on 11/19/2020, and is assigned to work throughout the facility as needed. The Surveyor was not provided with any in-service training hours for Dementia training in the past 12 months. 3. CNA-PP was hired on 08/03/2019, and is assigned to work throughout the facility as needed. The Surveyor was not provided with any in-service training hours for Dementia training in the past 12 months. 4. CNA-QQ was hired on 08/27/2021, and is assigned to work throughout the facility as needed. The Surveyor was not provided with any in-service training hours for Abuse or Dementia training in the past 12 months. 5. CNA-RR was hired on 06/08/2015, and is assigned to work throughout the facility as needed. The Surveyor was not provided with any in-service training hours for Abuse or Dementia training in the past 12 months. On 2/22/23 at 1:40 PM Administrator-P was interviewed and indicated the above abuse and dementia training's for CNA-W, CNA-Y, CNA-PP, CNA-QQ, and CNA-RR for the last 12 months could not be found. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/22/23 at 1:45 PM Regional Educator-V was interviewed and indicated it was the responsibility of the Director of Nurses and Administrator to complete annual performance reviews and ensure training requirements are meet. On 2/22/23 at 2:00 PM DON-B was interviewed and indicated he often completes training with no documentation and realizes this is not the best practice and needs to work on it. On 2/22/23 at 2:30 PM Administrator-A and DON-B were informed of the of the above findings. Additional information was requested if available. None was provided.