STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525318	A. Building B. Wing	03/22/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 38829 Based on Resident interview, staff interview, and record review the facility did not provide feedback as to the steps taken to address Resident grievances voiced at Resident Council meetings for 2 (R29 and R30) of 5 Resident Council attendees. During the Resident Council Group interview held on 3/17/22, at 10:00 AM, R29 and R30 were both in agreement the facility has not provided them with feedback related to steps taken to resolve grievances reported by the group at previous Resident Council meetings. Findings Include: Surveyor reviewed the facility's Resident Council policy and procedure revised April 2017. Policy Statement The facility supports Residents' rights to organize and participate in the Resident Council. Policy Interpretation and Implementation 1. The purpose of the Resident Council is to provide a forum for: a. Residents, families and Resident representatives to have input in the operation of the facility b. Discussion of concerns and suggestions for improvements c. Consensus building and communication between Residents and facility staff d. Disseminating information and gathering feedback from interested Residents . 5. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. 6. The Quality Assurance and Performance Improvement (QAPI) Committee will review information and feedback from the Resident Council as part of their quality review. Issues documented on council response forms may be referred to the QAPI Committee, if applicable. (continued on next page)

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/22, at 2:39 PM, Surveyor reviewed the Resident Council minutes provided by the facility. Surveyor notes there are concerns documented as being discussed from month to month, and there is no documented resolution to the concerns. 9/18/21 Resident Council minutes documented concerns: Would like less pasta; New bags not being put in room trash cans after being taken out and south hall mopping and room garbage not being done daily. 10/7/21 Resident Council documented concerns: Food is being passed out late for every meal; Need to have different variety of meals; Would like to have fresh fruit; Not being given items that are on their tickets; Trash not taken out on the weekends; Rooms not being cleaned on the weekends; Clothes not being returned and receiving other Residents' clothing; Bathroom sink has not been fixed for months; Call lights not being answered right away; Medications not being given on time; Residents not getting showers; Overall issues with not getting cares as needed and attitude of staff. 11/3/21 Resident Council minutes documented concerns: Food is always cold; Not being given items that are on their tickets; Would like more options of lunch meat; Trash not taken out on the weekends; Rooms not being cleaned on the weekends; (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clothes not being returned and receiving other Residents' clothing; Medications not being given on time; Call lights not being answered right away; Overall issues with not getting cares as needed and attitude of staff. 1/27/22 Resident Council minutes documented concerns: Food is always cold; Preferences on tickets aren't being recognized; Not receiving laundry back on a timely matter, potentially also missing laundry; Medications not being given on time, so late that they come with next set that is received 4 hours later, not always receiving all of the medications; Call lights are being ignored. 2/28/22 Resident Council minutes documented concerns: Food is always cold; Not being given items that are on their tickets; Would like more options of lunch meat; Rooms not being cleaned on the weekends; Clothes not being returned and receiving other Residents' clothing; Trash not taken out on the weekends; Medications not being given on time; Call lights are being ignored; Overall issues with not getting cares as needed and attitude of staff. On 3/17/22, at 10:02 AM, Surveyor conducted a Resident group interview. Of the 5 Residents in attendance, 2 Residents (R30 and R29) attended facility Resident Council meetings on a regular basis, and for 3 Residents it was their first time attending a Resident group meeting. R29 confirmed with Surveyor that R29 is the Resident Council president. R29 and R30 confirmed the same concerns are discussed every month according to the Residents who attended the group interview. R29 and R30 affirmed the facility did not provide any feedback related to expressed concerns and how they are addressed by the facility and the steps taken by the facility to resolve concerns. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29 and R30 gave examples of concerns discussed routinely at Resident Council meetings such as: cold food, lack of food variety, long call light response times, clothing concerns related to laundry, and medication concerns. R29 and R30 confirmed these concerns are brought up at several Resident Council meetings and Residents did not see any changes made and no facility staff explained a plan to address the grievances. Surveyor reviewed R29's electronic medical record (EMR) and notes R29's Quarterly Minimum Data Set (MDS) assessment, dated 1/13/22, documents R29's Brief Interview for Mental Status (BIMS) score to be 15, indicating R29 is cognitively intact for daily decision making. Surveyor reviewed R30's electronic medical record (EMR) and notes R30's Quarterly Minimum Data Set (MDS) assessment, dated 12/8/21, documents R30's Brief Interview for Mental Status (BIMS) score to be 14, indicating R30 is cognitively intact for daily decision making. On 3/17/22, at 11:07 AM, Surveyor interviewed Activities Director (AD-K) in regards to the process for addressing concerns that are expressed at the Resident Council Meetings. AD-K explained AD-K takes the concerns from Resident Council, types the minutes up, and gives the written minutes to the Nursing Home Administrator (NHA-A). AD-K stated that NHA-A is supposed to take care of the concerns and address them. Sometimes, if it's a specific concern, like a missing clothing item, AD-K will let laundry know. AD-K does not know if any concerns are followed up, and that is on me. AD-D stated there are no written concerns/grievances or resolutions from each of the Resident Council meetings. On 3/22/22, at 10:45 AM, Surveyor spoke to AD-K again. AD-K explained that during COVID, AD-K went room to room for Resident Council meetings. As of January 2022, the Residents were able to gather for a group meetings. AD-K stated there are no minutes from December 2021 because there was no meeting. Surveyor reviewed the facility grievance/concern log and notes there was no grievances from Resident Council included. On 3/22/22, at 11:58 AM, Surveyor interviewed NHA-A about the process of concerns/grievances brought up at Resident Council meetings. Surveyor spoke to NHA-A in regards to documentation of resolutions for Resident Council meeting concerns. NHA-A verified that NHA-A is the Grievance Officer. NHA-A stated NHA-A does not have written resolution or steps/interventions taken to resolve the Resident Council meeting concerns. NHA-A has no completed Resident Council Response Forms utilized to track issues and their resolution. NHA-A explained that NHA-A verbally shares concerns with the designated department manager. NHA-A stated that the expectation would be that the department manager would verbally provide a resolution to the Resident. NHA-A confirmed there is no documentation of the concern/grievance and no documentation of the resolution provided to the Resident. NHA-A agreed that based on the same concerns/grievances being brought up several months in a row, that the concerns/or grievances must not be addressed as they keep coming up. NHA-A understands the concern that there is no process in place for concern/grievances to be resolved from the Resident Council group meetings. Surveyor shared the concern with NHA-A that there is no evidence of concerns/grievances from the Resident Council group that facility staff provided responses, actions, and rationale regarding Resident concerns. NHA-A acknowledges and understands the concern. No further information was provided at this time.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, interview and record review, the Facility did not ensure that 1 (R68) of 1 Residents reviewed for restraints was free from physical restraints. R68 was observed to have an abdominal binder on. The Facility did not assess or care plan R68's abdominal binder and there is no documentation as to when the abdominal binder should be released. Findings include: On 3/17/22, the facility's policy and procedure for use of Restraints, 2001 Med-Pass Inc. (Revised April 2017) under the section: Policy Interpretation and Implementation, documents: . 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. 17. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). 18. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. R68 was admitted to the facility on [DATE], with diagnoses which included gastronomy tube use, dysphasia and Di [NAME] Syndrome. On 3/15/22, at 11:05 AM, R68 was observed in bed on her back wearing a gown. An abdominal binder was observed around R68's abdominal covering her gastronomy tube. On 3/16/22, at 12:26 PM, R68 was observed in bed on her back wearing a gown. Certified Nursing Assistant (CNA)-P was in the room and was asked to show the Surveyor R68's abdominal binder. CNA-P lifted R68's gown and the abdominal binder was observed around R68's abdomen. On 3/16/22, R68's current physician's orders were reviewed and read: Apply Abdominal Binder - gastronomy (G)-Tube protection, monitor skin underneath every shift, start date: 12/6/21. On 3/16/22, R68's current care plan was reviewed and the only mention of R68's abdominal binder was an intervention under the care plan for alteration in gastrointestinal status, dated: 12/6/21: which documents: Abdominal binder-G tube protection. On 3/16/22, at 3:00 PM, Director of Nurses (DON)-B was interviewed and indicated the abdominal binder was placed after R68 pulled out her G-tube and it was being used to prevent her from doing it again. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/22, R68's medical record was reviewed and no assessment for the need for the abdominal binder or directions for use could be found. On 3/17/22, at 3:00 p.m., Administrator-A and DON-B were informed the observations of R68 having an abdominal binder without an assessment or care plan for the use of the physical restraint.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on record review and interview, the facility did not comprehensively assess residents for their functional capacity either initially or periodically by documenting a summary of information regarding the care areas triggered when completing the Minimum Data Set (MDS) assessment for 15 (R9, R68, R57, R30, R49, R31, R50, R7, R19, R35, R55, R62, R59, R69 and R64) Care Area Assessments of a comprehensive MDS assessment. R9, R68, R57, R30, R49, R31, R50, R7, R19, R35, R55, R62, R59, R69, and R64 did not have Care Area Assessments completed with a summary of the triggered areas on comprehensive MDS assessments. Findings include: The facility policy and procedure entitled MDS 3.0 Process dated 10/2021 reads: . D. The center will address the needs and strengths of each resident through completion of the MDS 3.0 and the Care Area Assessments (CAA) to develop a comprehensive, individualized plan of care. E. Triggered Care Areas will be evaluated by the interdisciplinary team to determine the underlying causes, potential consequences and relationships to other triggered care areas. F. The Care Area Assessments (CAAs) process consists of the following steps: 1. Identify areas of concern triggered on the MDS: -This can be done using software or by manually using the CAT (Care Area Trigger) logic tables in the RAI (Resident Assessment Instrument) User's Manual. 2. Review the triggered CAAs by doing an in-depth, resident-specific assessment of the triggered condition: -History taking; -Physical assessment; -Gathering of relevant information (labs, tests, etc.); and -Sequencing of clinically significant events. 3. Define the problem (s): -Identify the functional, physical, and/or behavioral implications of the problem (s); -Identify the relationships between risk factors, triggers and problems; (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Distinguish between causes and consequences; and -Look for common causes of multiple issues. 4. Make decisions about the care plan: -Determine whether the problem (s) needs intervention; -Evaluate the resident's goals, wishes, strengths and needs; -Design interventions that address causes, not symptoms; and -Establish which items need further assessment or additional review. 5. The IDT (Interdisciplinary Team) will employ tools and resources during the CAA process, including evidenced-based research and clinical practice guidelines, along with sound clinical decision making and problem-solving. 6. CAA documentation explains the basis for the care plan. This documentation should include: -Causes and contributing factors for the triggered care areas; -The nature of the condition or issue (i.e., What exactly is the problem and why is it a problem?); -Complications contributing to (or caused by) the care area; -Risk factors related to the condition; -Factors that should be considering in developing the care plan (including reasons to care plan or not to care plan particular findings); -Any need for further evaluation by the physician or other healthcare provider; -Resources and tools used for decision-making; -Conclusions that arose from the care area assessment process; and -Completion of Section V of the MDS. 1.) R9 was admitted to the facility on [DATE]. An Annual MDS assessment, dated 9/12//21, was completed. The Surveyor reviewed R9's Annual MDS assessment, dated 9/12/21, and the following CAAs were triggered on the assessment: Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, and Pressure Ulcer. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 2.) R68 was admitted to the facility on [DATE]. An Admission MDS assessment, dated 11/17/21, was completed. The Surveyor reviewed R68's Admission MDS assessment dated [DATE] and the following CAAs were triggered on the assessment: Delirium, Cognitive loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Activities, Falls, Tube Feeding, Dehydration/Fluid Maintenance, Pressure Ulcer, and Psychotropic Drug Use. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 3.) R57 was admitted to the facility on [DATE]. An Admission MDS assessment, dated 7/3/21, was completed. The Surveyor reviewed R57's Admission MDS assessment, dated 7/3/21, and the following CAAs were triggered on the assessment: Cognitive Loss/Dementia, ADL Functional/ Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use and Return to Community Referral. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 4.) R30 was admitted to the facility on [DATE]. An Annual MDS assessment dated [DATE] was completed. The Surveyor reviewed R30's Annual MDS assessment, dated 3/12/21, and the following CAAs were triggered on the assessment: Visual Function, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer and Psychotropic Drug Use. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with the Administrator and Director of Nursing on 3/21/22 at 3:00 PM. Additional information was requested if available. None was provided. 5.) R49 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. The Surveyor reviewed R49's Admission MDS assessment, dated 11/18/21, and the following CAAs were triggered on the assessment: ADL Functional/ Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use and Return to Community Referral. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS RN-I also informed Surveyor that she would not be going back to previous CAA assessments to correct them or add information into the Analysis of Findings and Care Plan Considerations sections. No additional information was provided. 38829 8) R7 was admitted to the facility on [DATE], with diagnoses of Encephalopathy, Unspecified Dementia with Behavioral Disturbances, and Major Depressive Disorder. R7 has a legal guardian. Surveyor reviewed R7's Admission Minimum Data Set (MDS) assessment, dated 5/21/21, and the following Care Area Assessment (CAAs) were triggered on the assessment: Delirium, Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Behavioral Symptoms, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Return to Community Referral. Surveyor notes the CAAs were not completed to include a summary of the triggered areas. 9) R19 was admitted to the facility on [DATE], with diagnoses of Multiple Sclerosis, Paraplegia, Neuromuscular Dysfunction of Bladder, and Colostomy Status. R19 is his own person. Surveyor reviewed R19's Admission Minimum Data Set (MDS) assessment, dated 10/13/21, and the following Care Area Assessment (CAAs) were triggered on the assessment: Activities of Daily Living(ADL) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Activities, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Pain, and Return to Community Referral. Surveyor notes the CAAs were not completed to include a summary of the triggered areas. 10) R35 was admitted to the facility on [DATE], with diagnoses of End Stage Renal Disease, Paroxysmal Atrial Fibrillation, Type 1 Diabetes Mellitus, and Morbid Obesity. R35 is her own person. Surveyor reviewed R35's Admission Minimum Data Set (MDS) assessment, dated 10/20/21, and the following Care Area Assessment (CAAs) were triggered on the assessment: Activities of Daily Living(ADL) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, and Pressure Ulcer. Surveyor notes the CAAs were not completed to include a summary of the triggered areas. 11) R55 was admitted to the facility on [DATE], with diagnoses of Nondisplaced Bimalleolar Fracture of Left Lower Leg, Type 1 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Bipolar Disease. R55 is her own person. Surveyor reviewed R55's Admission Minimum Data Set (MDS) assessment, dated 1/12/22, and the following Care Area Assessment (CAAs) were triggered on the assessment: Activities of Daily Living(ADL) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well Being, Mood State, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance, and Pressure Ulcer, Psychotropic Drug Use, and Return to Community Referral. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor notes the Nutrition CAA was not completed to include a summary of the triggered areas. Surveyor also notes the other CAAs are all identical word for word in the summary of triggered areas. The above findings were shared with the Administrator (NHA-A) and Director of Nursing (DON-B) on 3/22/22, at 2:00 PM. Additional information was requested if available. None was provided. 42037 12.) R62 was admitted to the facility on [DATE]. R62 had an Admission MDS (Minimum Data Set) assessment, dated 11/5/21 completed. Surveyor reviewed R62's Admission MDS assessment dated [DATE]. The following CAAs were triggered on the assessment: Delirium, Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance and Pressure Ulcer. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with NHA-A and DON-B on 3/21/22 at 3:00 PM. Additional information was requested if available. The facility could not supply any additional information during the Survey. 13.) R59 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. Surveyor reviewed R59's Admission MDS assessment dated [DATE]. The following CAAs were triggered on the assessment: ADL Functional/Rehabilitation Potential, Urinary incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Pressure Ulcer. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with NHA-A and DON-B on 3/21/22 at 3:00 PM. Additional information was requested if available. The facility could not supply any additional information during the Survey. 14.) R69 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. Surveyor reviewed R69's Admission MDS assessment dated [DATE]. The following CAAs were triggered on the assessment: Delirium, Cognitive Loss/Dementia, Communication, Urinary incontinence, Psychosocial Well-Being, Mood State, Activities, Falls, Nutritional Status, Pressure Ulcer, Psychosocial Drug use and Pain. The Surveyor noted the CAAs were not completed to include a summary of the triggered areas. The above findings were shared with NHA-A and DON-B on 3/21/22 at 3:00 PM. Additional information was requested if available. The facility could not supply any additional information during the Survey. 15.) R64 was admitted to the facility on [DATE]. An Admission MDS assessment dated [DATE] was completed. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on interview and record review, the facility did not ensure that 1 (R31) of 18 residents reviewed, had assessments that accurately reflect the resident's status. * R31's MDS (Minimum Data Set) assessment, dated 1/12/22, incorrectly documented R31 had no pressure injuries present upon admission. R31's Pressure Ulcer/Injury CAA (Care Area Assessment) incorrectly documented R31 did not have any open areas present upon admission. Findings include: 1.) R31 was admitted to the facility on [DATE] with a diagnosis that included Dementia without Behavioral Disturbance, Diabetes Mellitus Type II, Sepsis and Dysphagia. R31's Admission MDS (Minimum Data Set) assessment, dated 1/12/22, documents that R31 has short and long term memory problems. Section C1000 (Cognitive Skills for Daily Decision Making) documents that R31 has severely impaired cognitive skills for daily decision making. Section G (Functional Status) documents that R31 requires extensive assistance and a one person physical assist for his bed mobility needs. Section G0400 (Functional Limitation of Range of Motion) documents that R31 has no impairment to either side of his upper or lower extremities. Section M (Skin Conditions) documents that R31 has no unhealed pressure ulcers/injuries and that he is not at risk for the development of pressure injuries/ulcers. R31's Pressure Injury/Ulcer CAA (Care Area Assessment), dated 1/12/22, documents under the Care Plan Considerations section, No presence of pressure areas, ongoing interventions to reduce risks for potential skin integrity impairment weakness present and reliance on staff for assist with adls (activities of daily living) and mobility. R31's admission assessment, dated 1/5/22, documents that R31 had a coccyx stage II, and right and left heel pressure injuries present on admission the facility. R31's nursing note dated 1/5/22 documents, Nurses Note Text: Resident arrived by stretcher per Ambulance services. Admitting Dx (diagnosis): Hematuria r/t (related to) blood clot formed from newly placed suprapubic catheter 12/22/22 .Rarely verbalizes d/t (due to) dementia .Reported pressure areas to bilateral heels, and pink stage 2 to coccyx. Mepilex in place for protection. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's physician progress note dated 1/6/22 documents, Physician Progress Note Text: Patient seen today following recent admission. He was recently hospitalized from 12/4/21 to 01/05/22 for sepsis, hematuria, and UTI (urinary tract infection) . He is non-verbal at baseline. He is awake and alert resting in bed grinding his teeth at this time. He has suprapubic foley catheter draining blood tinged urine with noted blood clots. He has a wound to his right heel that is dressed. Surveyor noted that despite R31's admission assessment and nursing note dated 1/5/22, and R31's physician progress note dated 1/6/22, R31's Admission MDS dated [DATE] incorrectly documented that R31 did not have any pressure injuries present. Surveyor also noted that despite the above documentation, R31's Pressure Ulcer/Injury CAA dated 1/12/22 incorrectly documents under the Care Plan Considerations sections that R31 did not have any open pressure areas. On 3/22/22, at 12:00 p.m., Surveyor informed MDS RN-I of the above findings. Surveyor asked MDS RN-I why the section under the Care Plan Considerations for R31's Pressure Ulcer/Injury CAA dated 1/12/22 documented R31 had no open pressure areas when R31's admission assessment and nursing note dated 1/5/22, and R31's physician progress note dated 1/6/22 documented the presence of a pressure injury to R31's coccyx and heels. MDS RN-I informed Surveyor that it must have been an error on her part and that she would have to go and review R31's medical record to correct R31's Pressure Ulcer/Injury CAA. Surveyor asked MDS RN-I if Section M in R31's Admission MDS, dated [DATE], was also incorrect as it documented that R31 had no unhealed pressure injuries present upon admission. MDS RN-I again informed Surveyor that it must have been an error on her part and that she would have to go and review R31's medical record to correct R31's admission MDS dated [DATE]. No additional information was provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38937 Based on record review and interview, the facility did accurately complete a Pre-Admission Screening & Resident Review (PASARR) assessment for 1 (R50) of 2 residents reviewed. * R50's PASARR Level I screen was completed incorrectly and should have been resubmitted for reevaluation after the correct information was documented. Findings include: 1. R50 was admitted to the facility on [DATE] with a diagnosis that included: Morbid Obesity, Right Artificial Hip Joint, Major Depressive Disorder and Bipolar Disorder. R50's Quarterly MDS (Minimum Data Set) assessment, dated 2/7/22, documents a BIMS (Brief Interview for Mental Status) score of 14, indicating that R50 is cognitively intact. Section N (Medications) documents that R50 had taken 7 out of 7 days a prescribed antidepressant medication during the assessment period. R50's Psychotropic Drug Use CAA (Care Area Assessment), dated 5/10/21, documents that R50 triggered for further assessment for the use of psychotropics medications, however the Analysis of Findings and Care Plan Considerations sections were left blank and provided no additional information. R50's physician order, dated 5/3/21, documents, Ziprasidone HCl Capsule 40 MG (milligrams), Give 40 mg by mouth two times a day for mood/agitation. On 3/15/21, at 2:26 p.m., Surveyor reviewed R50's PASARR Level 1 screen dated 4/27/21. R50's PASARR Level 1 screen documents, The resident is not suspected of having a serious mental illness. Surveyor noted that No is selected for all the questions for section A, B and section C of R50's PASARR Level I screen despite R50 having a diagnosis of Bipolar Disorder upon admission. Surveyor noted that No is answered in Section A despite R50 being on the above antipsychotic medication for mood/agitation upon admission to the facility. R50's PASARR Level I screen documents, Check one of the boxes below based on the responses to the questions in Section A of this form. The resident is suspected of having (check the appropriate box below and forward a copy of this Level I Screen to the regional screening agency): A serious mental illness. Surveyor was unable to locate a Level II screen for R50. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/22, at 12:15 p.m., Surveyor informed SS (Social Services)-G of the above findings. Surveyor asked if R50's PASARR Level I dated 4/27/21 was accurate, as Surveyor informed SS-G that R50 had a diagnosis of Bipolar Disease and was regularly taking an antipsychotic medication. SS-G informed Surveyor that she was unsure if R50's PASARR Level 1 was accurate but that she would review it and let Surveyor know. On 3/16/22, at 1:38 p.m., SS-G informed Surveyor that R50's PASARR Level 1 was incorrect and was resubmitted to reflect R50's Bipolar Disorder diagnosis and psychotropic drug use. On 3/16/22, at 3:20 p.m., during the daily exit, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. No additional information was provided as to why R50's PASARR Level I was completed incorrectly and not resubmitted for reevaluation after the correct information was included.

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

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

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

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

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

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation, interview and record review, the facility did not ensure that 2 (R31 & R2) of 11 residents reviewed and at risk for developing pressure injuries received consistent measures to prevent the development of pressure injuries. * R31 did not have a coccyx/sacrum stage II pressure injury assessed or provided with treatment from admission to 2/2/22. R31's sacrum pressure injury then progressed to a stage III. * R2 did not have initial left heel pressure injury assessed by an RN (Registered Nurse). R2 did not have his left heel pressure injury assessed on the week of 1/5/22. Findings include: 1. R31 was admitted to the facility on [DATE] with a diagnoses that include: Dementia without Behavioral Disturbance, Diabetes Mellitus Type II, Sepsis and Dysphagia. R31's Admission MDS (Minimum Data Set) dated 1/12/22, documents that R31 has short and long term memory problems, has severely impaired cognitive skills for daily decision making, and requires extensive assistance and a one person physical assist for his bed mobility needs. Section M (Skin Conditions) documents that R31 has no unhealed pressure ulcers/injuries and that he is not at risk for the development of pressure injuries/ulcers. R31's Pressure Injury/Ulcer CAA (Care Area Assessment), dated 1/12/22, documents under the Care Plan Considerations section, No presence of pressure areas, ongoing interventions to reduce risks for potential skin integrity impairment weakness present and reliance on staff for assist with adls (activities of daily living) and mobility. In contrast, R31's admission assessment, dated 1/5/22, documents that R31 had a coccyx stage II, and right and left heel pressure injuries present on admission the facility. R31's nursing note, dated 1/5/22, documents, Nurses Note Text: Resident arrived by stretcher per Ambulance services. Admitting Dx: Hematuria r/t (related to) blood clot formed from newly placed suprapubic catheter 12/22/22 .Rarely verbalizes d/t (due to) dementia .Reported pressure areas to bilateral heels, and pink stage 2 to coccyx. Mepilex in place for protection. R31's physician progress note, dated 1/6/22 documents, Physician Progress Note Text: Patient seen today following recent admission. He was recently hospitalized from 12/4/21 to 01/05/22 for sepsis, hematuria, and UTI (urinary tract infection) . He is non-verbal at baseline. He is awake and alert resting in bed grinding his teeth at this time. He has suprapubic foley catheter draining blood tinged urine with noted blood clots. He has a wound to his right heel that is dressed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that despite R31's admission assessment and nursing note dated 1/5/22, and R31's physician progress note dated 1/6/22 all referencing to R31 having pressure injuries, R31's Admission MDS dated [DATE] incorrectly documented that R31 did not have any pressure injuries present. Surveyor also noted that despite the above documentation, R31's Pressure Ulcer/Injury CAA dated 1/12/22 incorrectly documents under the Care Plan Considerations sections that R31 did not have any open pressure areas. R31's Admission Braden Scale For Predicting Pressure Sore/Injury Risk, assessment dated [DATE], documents a score of 12, indicating that R31 is at high risk for the development of pressure injuries. R31's nursing note, dated 1/29/22, documents, Nurses Note Text: 97.3 (degrees Fahrenheit) .Dressing change now to coccyx: no BM (bowel movement) now .Turned off coccyx: air mattress and P (Prevalon) boots used. Surveyor was unable to locate any documentation that facility nursing staff assessed, measured or staged R31's pressure injuries upon R31's readmission to the facility on [DATE] through 2/2/22. Surveyor was unable to locate any wound treatments ordered for R31's sacrum pressure injury from 1/5/22 to 2/2/22. R31's initial wound assessment, completed by Wound physician and dated 2/2/22 documents, Wound Location: Sacrum; Length: 4.24 cm (centimeters); Width: 3.62 cm; Maximum Depth: 0.2 cm; Etiology: Pressure Ulcer-Unstageable; Woundbed assessment: Granulation 1-25%, Slough 51-75 %.; Formularies: Cleanse with 1/2 strength Dakin's solution, Protect Periwound with Skin Prep, apply Santyl to wound bed, cover with bordered gauze, change daily. Surveyor noted that R31 had pressure injury interventions, weekly wound assessments and treatments as ordered by the wound physician from 2/2/22 to 2/23/22. R31's wound physician assessment dated [DATE] documents, Wound Location: Sacrum; Length: 2.13 cm (centimeters); Width: 2.06 cm; Maximum Depth: 0.2 cm; Etiology: Pressure Ulcer-Stage 3; Woundbed assessment: Granulation 76-100%.; Formularies: Cleanse with saline, protect periwound with skin prep, apply alginate to wound bed, cover wound with bordered gauze, change daily, change PRN (as needed) for soiling and/or saturation. Surveyor noted that R31 had pressure injury interventions, weekly wound assessments and treatments as ordered by the wound physician from 2/24/22 to 3/16/22. Surveyor noted that despite the facility's lack of initial assessment and treatment to R31's sacrum/coccyx wound, R31's sacrum pressure injury started improving when treatment was started on 2/2/22. On 3/21/22, at 11:44 a.m., Surveyor informed ADON (Assistant Director of Nursing)-D, whom was in charge of wound care at the facility, of the above findings. Surveyor asked ADON-D if the facility had done any weekly assessments and or daily treatments of R31's coccyx/sacrum pressure injury from 1/5/22 to 2/2/22, as Surveyor was unable to locate any in R31's medial record. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ADON-D informed Surveyor that she could not recall if R31 had any pressure injuries upon admission. ADON-D informed Surveyor that around 1/29/22, a facility staff member came up to her and informed her R31 had a pressure injury to his sacrum. ADON-D informed Surveyor that she could not provide any information regarding R31's sacrum pressure injury prior to 1/29/22. ADON-D informed Surveyor that she and wound physician did not formally assess R31's sacrum pressure injury until 2/2/22. ADON-D informed Surveyor that if facility staff were aware of open areas when R31 was admitted to the facility, they should have notified her so she could assess and get a treatment in place. No additional information was provided as to why the facility did not ensure R31 received necessary treatment and services from 1/5/22 to 2/2/22, to promote healing of a pressure injury. 2. R2 was admitted to the facility on [DATE] with a diagnosis that included Schizophrenia, Dysphagia, Asthma and Overactive Bladder. R2's Quarterly MDS (Minimum Data Set), dated 3/4/22, documents a BIMS (Brief Interview for Mental Status) score of 3, indicating that R2 is severely cognitively impaired. Section G (Functional Status) documents that R2 requires extensive assistance and a one personal physical assist for his bed mobility needs. Section G also documents that R2 has total dependence on staff and requires a one person physical assist for his transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R2 has no impairment to either side of both his upper and lower extremities. Section M (Skin) documents that R2 is at risk for the development of pressure injuries. R2's Pressure Ulcer CAA (Care Area Assessment), dated 12/2/21, documents under the Care Plan Considerations section, Resident has episodes of incontinence and relies on staff for assist with mobility and presence of weakness. R2's Braden Scale for Predicting Pressure Sore/Injury Risk Assessment, dated 6/5/21, documents a score of 15, indicating that R2 is at moderate risk for the development of pressure injuries. R2's skin integrity plan of care, dated 12/7/20, documents the following interventions as in place prior to 12/5/21, Turn and Reposition Q (every) 2-3 hours; Prevalon boots or pillow to offload heels; Skin Prep to heels for protection; avoid friction and shearing-use lift sheet for transfers. R2's nursing note completed by LPN-R and dated 12/5/21 documents, Nurses Note Text: Writer was walking past resident room in beginning of shift when it was noticed that prevlon boot was off. Writer went to put boot back on resident left foot and the suspected deep tissue injury was seen. Boot was reapplied and scheduled skin prep applied. Area measures 3.5 cm x 4 cm. On call NP (nurse practitioner) with [name of medical group] notified, DON (Director of Nursing) notified, and healthcare POA (power of attorney) updated. On call NP with [name of medical group] said to continue with keeping the prevlon boot on and skin prep to both heels. Resident was compliant with keeping prevlon boot on left foot. Resident denies having any pain on the suspected deep tissue injury area. Surveyor was unable to locate any RN (Registered Nurse) assessment for R2's initial wound assessment dated [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's initial wound assessment completed by Wound physician and dated 12/8/21 documents, Wound Location: Left Medial Heel; Length: 4.19 cm (centimeters); Width: 3.71 cm; Maximum Depth: 0.0 cm; Etiology: Pressure Ulcer-Suspected DTI (deep tissue injury); Woundbed assessment: Purple; Formularies: Change daily, cleanse with betadine. Surveyor noted that R2 had pressure injury interventions, weekly wound assessments and treatments as ordered by the wound physician from 12/8/22 to 1/5/22. Surveyor was unable to locate a weekly wound assessment for R2's left heel pressure injury for the week of 1/5/22. Surveyor also noted that despite the facility's lack of weekly wound assessment of R2's left heel, R2's left heel pressure injury continued healing while R2 resided at the facility. R2's Weekly Pressure Ulcer Log dated 3/16/22 documents, Site: Left Heel; Unstageable, 0.75 cm length; width: 1.25 cm Depth: 0.1 cm, Comments: Improvement. On 3/21/22 at 11:44 a.m., Surveyor informed ADON (Assistant Director of Nursing)-D, whom was in charge of wound care at the facility, of the above findings. Surveyor asked ADON-D if the facility had done any weekly assessment on R2's left heel pressure injury for the week of 1/5/22, as Surveyor was unable to locate any in R2's medial record. ADON-D informed Surveyor that she was out sick and not working at the facility for the week of 1/5/22 and that she could not provide any additional information as to why R2 did not have a weekly assessment on his left heel pressure injury for the week of 1/5/22. Surveyor asked ADON-D if R2's left heel had been assessed by an RN on 12/5/21, as Surveyor noted that the initial finding of the wound was only assessed by LPN-R. ADON-D informed Surveyor that she could not provide any information as to if there was an RN assessment of R2's left heel on 12/5/21. ADON-D informed Surveyor that there should have been an RN assessment following up LPN-R's initial left heel pressure injury assessment on 12/5/21. On 3/21/22 at 4:11 p.m., Surveyor informed DON (Director of Nursing)-B of the above findings. No additional information was provided as to why the facility did not ensure that R2 received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new injuries from developing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observation, interview and record review, the facility did not ensure that 3 (R69, R59, R62) of 7 residents reviewed received adequate supervision and assistance devices to prevent accidents. *R69 had 3 falls (1/4/22, 1/10/22 and 1/12/22) while residing at the facility. The facility did not conduct a thorough investigation into R64's fall on 1/4/22 contributing to the continuation of falls. On 1/10/22, R69 sustained a fall that resulted in a laceration which required application of surgical staples to R69's scalp. The facility did not conduct a through investigation including including witness statements or interviews with staff members related to R69's falls. *R59 was observed to not have their bed in the lowest position per care plan interventions. *R62 had sustained a fall on 10/30/21. The facility did not conduct through investigations including witness statements or interviews with staff members related to R62's falls. Findings include: The Facility's Falls and Fall Risk, Managing Policy, with a review date of March 2018, documents . Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk. 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systemic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. Monitoring Subsequent Falls and Fall Risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. R69 was admitted to the facility on [DATE] with diagnoses of Stroke, Parkinson's Disease, and Muscle Weakness. R69's Admission MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 1/10/22 indicates that R69 was rarely to never understood. R69 required extensive assistance of 1 staff member with bed mobility, ambulation, dressing and personal hygiene. R69 required extensive assistance of 2 staff with transfers to different surfaces. R69's Admission MDS notes that R69 had multiple falls prior to admission to the facility. Surveyor reviewed R69's closed medical record. A fall risk assessment was completed on 1/3/22 which indicated that R69 was at a moderate risk for falls. Surveyor reviewed R69's fall investigation/incident reports from 1/4/22, 1/10/22 and 1/12/22 and noted the following: Fall 1 Surveyor reviewed the facility's fall investigation dated 1/4/22 which reads .R69 with medical diagnoses including Schizoaffective Disorder - Bipolar type, DM, Hemiplegia affecting R side, Anemia, and Generalized muscle weakness attempted independent transfer resulting in fall. On discovery staff observed resident sitting on floor in no apparent distress next to his bed. When asked intent resident indicated that he was going to get pudding. Room lighting adequate, call light and personal effects within reach, wheelchair next to bed but out-of-sight d/t (due to) resident impulsivity, no other extrinsic factors observed; staff notes resident may have slid off side of bed. Physical assessment unremarkable, PROM (Passive Range of Motion) to all extremities did not illicit any verbal or nonverbal indicators of pain, VSS resident afebrile without s/sx (signs/symptoms) of acute illness. Intervention: Scoop mattress. POC (Plan of care) updated. The Fall investigation indicates that R69's bed was placed in a low position with a fall mat placed next to the bed. Surveyor reviewed R 69's fall care plan with an creation date of 1/4/22 which reads: The Resident is at risk/has potential for falls, accidents and incidents r/t (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Deconditioning, Gait/balance problems, generalized weakness, Hx (History) of stroke with weakness poor safety awareness, takes psychotropicmedications, unsteady gait. Surveyor noted the initiation of a scoop mattress being applied to R69's bed on 1/4/22. On 3/22/22 Surveyor asked DON (Director of Nursing)-B who would be responsible for conducting the fall investigations. DON-B told Surveyor that the facility's Interdisciplinary team works together to conduct fall investigations. Surveyor asked who would be responsible for gathering witness and staff statements during a fall investigation. DON-B reported that the nurse working at the time of a resident's fall would be responsible for initiating the investigation and collecting interviews at the time of the fall. DON-B told Surveyor there were no interviews from staff or residents conducted related to R69's fall on 1/4/22. Fall 2 Surveyor reviewed the facility's fall investigation dated 1/10/22 which reads: .Unobserved fall with head injury 1/10/2022 .Room lighting adequate, no clutter observed; pathways clear, bed in lowest functional position, resident wearing appropriate non-skid grippy socks, resident continent; resident unable to provide explanation or intent. Physical assessment unremarkable, PROM does not illicit any verbal or nonverbal indicators of pain, laceration noted to R posterior side of head. Gauze with pressure applied .In house NP (Nurse Practitioner) advised; resident seen orders provided for ER (emergency room) f/u (follow up) due to suspected head injury . Emergency services dispatched for transfer to ED (Emergency Department) for evaluation and possible treatment. Case Manager notified; message left to contact facility when able. Guardian advised. Therapy advised to screen for possible service needs; recommendations pending. Care plan reviewed - If resident is up in chair keep in close visual proximity. Surveyor reviewed R69's fall care plan with an initiation date of 1/4/22. Surveyor did not note any new care plan interventions documented related to R69's fall on 1/10/22. On 3/22/22 at 11:34 AM, Surveyor conducted interview with LPN (Licensed Practical Nurse)-T. LPN-T did not recall R69's fall on 1/10/22. LPN-T told Surveyor that they were not assigned to R69 on 1/10/22. Surveyor asked LPN-T when a resident falls if there should be an investigation conducted on the fall including a root cause analysis, interviews and witness statements with staff and/or residents. LPN-T I believe so .I don't do that part though. LPN-T told Surveyor that they don't know who is responsible for conducting fall investigations but it must be someone in management. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/22/22 at 12:04 PM, Surveyor conducted interview with LPN (Licensed Practical Nurse)-S. LPN-S recalled that they had been on their way out of the facility when a staff member that they do not recall approached LPN-S and informed them that R69 was sitting on the floor in their room. LPN-S recalled that they had not been working with R69 that day but assisted when they noted that R69 had sustained a laceration to their scalp. LPN-S added that LPN-S recalled R69 had gone out to the hospital but was not sure what the outcome was after the fall on 1/10/22. Surveyor reviewed nurse progress notes with LPN-S which showed that LPN-S documented on 1/10/22 that R69 returned from the emergency room with staples in place to scalp. LPN-S responded they are a pool employee and do not work at the facility often lately. Surveyor asked LPN-S when a resident falls if there should be a investigation conducted with interviews or witness statements being obtained from staff or residents. LPN-S responded there should be a full investigation conducted . LPN-S responded that the facility's DON or ADON (Assistant Directors of Nursing) would be involved with the investigations and that LPN-S would not collect statements from staff or residents. Fall 3 Surveyor reviewed the facility's investigation dated 1/12/22 which reads: IT note regarding unobserved fall without injury 1/12/2022 .light adequate, call light and personal effects within reach; call light not activated, resident wearing incontinence brief (dry) and grippy socks, surrounding area free of clutter or obstacles . Physical assessment unremarkable for injury .does not illicit verbal or non-verbal indicators of pain, VSS, resident afebrile without s/sx of acute illness, initial neuro check at baseline. Resident assisted back to bed via mechanical lift and assist of two. Medications reviewed for possible contributing factors .Care plan reviewed - Place fall matt to R side of bed, maintain bed in lowest functional position. Surveyor reviewed R69's fall care plan with an initiation date of 1/4/22. On 1/12/2022 DON-B updated R69's care plan with the following intervention Fall matt place to R side of bed, bed in lowest functioning position. Surveyor noted that these interventions were previously in place for R69's falls on 1/4/22 and 1/10/22. On 3/22/22 at 1:15 PM, Surveyor asked DON (Director of Nursing)-B who would be responsible for conducting fall investigations. DON-B told Surveyor that the facility's Interdisciplinary team works together to conduct fall investigations. Surveyor asked who would be responsible for gathering staff and resident statements during a fall investigation. DON-B reported that the nurse working at the time of a resident's fall would be responsible for initiating the investigation and collecting interviews at the time of the fall. DON-B told Surveyor that they would expect the nurse on duty at the time of the fall to initiate an investigation including interviews and witness statements with staff and residents. Surveyor asked if DON-B was aware of any statements that were gathered for R69's falls on 1/4/22, 1/10/22 and 1/12/22. DON-B responded that they would have to look into this. Surveyor asked who would be responsible for updating R69's care plan after each fall. DON-B told Surveyor that it would be a team effort and that themselves or another member of the nursing staff would update care plans. Surveyor asked why DON-B had updated R69's care plan on 1/12/22 with interventions that were documented to be in place for previous falls on 1/4/22 and 1/10/22. DON-B responded that they did not realize that the interventions they had selected for R69's fall on 1/12/22 had already been implemented. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/22/22 at 2:00 PM, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R69's falls on 1/4/22, 1/10/22/ and 1/12/22 as Surveyor has not received any statements from staff or residents related to each individual fall investigation for R69. Surveyor shared concern related to R69's 1/10/22 fall in which R69 sustained a laceration to the scalp which resulted in application of surgical staples at the emergency room . No additional information was provided to Surveyor at this time. 2. R59 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Metabolic Encephalopathy and Left below knee amputation. An Admission MDS assessment dated [DATE] was completed. Surveyor noted R59 sustained a fall in the last month previous to admission to the facility. Surveyor reviewed R59's Fall care plan with an initiation date of 2/10/22 which reads: The Resident is at risk/has potential for falls, accidents and incidents r/t Deconditioning, impaired cognition R59's current fall interventions read: .3/13/22 bed to be put in lowest position. On 3/15/22 at 11:43 AM, Surveyor observed R59 in bed with the bed positioned approximately 3 feet from the floor. R59 was noted with their right lower extremity dangling from the bed. R59's bed was not in the lowest possible position. On 3/15/22 at 1:45 PM, Surveyor observed R59 in bed with the bed positioned approximately 3 feet from the floor. R59's bed was not in the lowest possible position. On 3/15/22 at 3:15 PM, Surveyor observed R59 in bed with the bed positioned approximately 3 feet from the floor. R59's bed was not in the lowest possible position. On 3/16/22 at 8:05 AM, Surveyor observed R59 in bed with the bed positioned approximately 3 feet from the floor. R59 was noted with their right lower extremity dangling from the bed. R59's bed was not in the lowest possible position. On 3/16/22 at 10:25 AM, Surveyor observed R59 in bed with the bed positioned approximately 3 feet from the floor. R59's bed was not in the lowest possible position. On 3/22/22 at 11:00 AM, Surveyor conducted interview with ADON (Assistant Director of Nursing)-D. Surveyor asked how staff are made aware of safety interventions for residents. ADON-D responded that staff should check resident's care plans to know how to care for them safely. Surveyor asked how staff would know if a resident should have their bed in a low position. ADON-D told Surveyor that this would be documented on resident care cards and in their comprehensive care plan. On 3/22/22 at 2:00 PM, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R59's being observed in a bed that was not in the lowest position on 3/15/22 and 3/16/22 when R59's care plan stated their bed should be in the lowest position. No additional information was provided to Surveyor at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R62 was admitted to the facility on [DATE], and has diagnoses that include: End Stage Renal Disease, Schizophrenia, Cerebral Infarction and Dependence on Renal Dialysis. R62's Admission MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 11/5/21 indicates that R62 was has a BIMS (Brief Interview for Mental Status) Inteview score of 6, which indicates R62 does not have the mental capacity for making daily decisions. R62 requires supervision of 1 staff member with cares and is unsteady when walking but are able to stabilize without staff assistance. Surveyor reviewed R62's fall investigation from 10/30/21 which reads: Regarding unobserved fall without injury 10/29/2021. Comment: Resident observed lying on the floor by care staff during routine rounds. Prior to discovery resident resting in bed without complaint. Resident unable/unwilling to provide explanation or intent; crawled back to bed independently prior to RN's arrival. Immediate intervention - assess surroundings to ensure pathways unobstructed and free of clutter. VSS, resident febrile s/sx of acute illness, resident offering no complaints of pain with physical assessment .Neuro check at baseline .Fall risk assessment reviewed - resident remains moderate risk .Therapy advised to screen; recommendations pending. Care plan reviewed - maintain bed in lowest functional position. On 3/22/22 at 10:15 AM, Surveyor asked DON (Director of Nursing)-B who would be responsible for conducting fall investigations. DON-B told Surveyor that the facility's Interdisciplinary team works together to conduct fall investigations. Surveyor asked who would be responsible for gathering staff and resident statements during a fall investigation. DON-B reported that the nurse working at the time of a resident's fall would be responsible for initiating the investigation and collecting interviews at the time of the fall. DON-B told Surveyor that they would expect the nurse on duty at the time of the fall to initiate an investigation including interviews and witness statements with staff and residents. Surveyor asked if DON-B was aware of any statements that were gathered for R62's fall on 10/29/21. DON-B responded that they would have to look into this. On 3/22/22 at 2:00 PM, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R62's fall on 10/29/21 as Surveyor has not received any statements from staff or residents related to each individual fall investigation for R62. No additional information was provided to Surveyor at this time.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on interview and record review the facility did not ensure 1 (R31) of 4 residents reviewed for weight loss maintained acceptable parameters of nutritional status. * R31 experienced a weight loss of 22.4 lbs. (pounds) in 58 days (14.7%). The facility identified the need for supplements upon R31's admission, however they did not implement the supplement recommendations until 3/7/22. Findings include: R31 was admitted to the facility on [DATE] with a diagnosis that included Dementia without Behavioral Disturbance, Diabetes Mellitus Type II, Sepsis and Dysphagia. R31's Hospital Discharge Summary dated 1/5/22 documents, His (R31) condition is declining and his nutritional status is extremely poor .He will be discharged with puree level for diet and thick liquids. His condition will most likely continue to decline since his nutritional status is poor. His daughter has been able to get him to eat somewhat and may be involved in his feedings. R31's admission weight as obtained by the facility on 1/5/22 was documented in R31's medical record as 152.4 lbs (pounds.) R31's Admission MDS (Minimum Data Set) dated 1/12/22 documents R31 has short and long term memory problems. Section C1000 (Cognitive Skills for Daily Decision Making) documents R31 has severely impaired cognitive skills for daily decision making. Section G (Functional Status) documents that R31 has total dependence and requires a one person physical assist for his eating needs. Section G0400 (Functional Limitation of Range of Motion) documents that R31 has no impairment to either side of his upper or lower extremities. Section K (Swallowing/Nutritional Status) documents that R31 has not experienced any unplanned weight loss. R31's Nutritional Status CAA (Care Area Assessment) dated 1/12/22, documents that R31 triggered for further assessment for his nutritional status, however the Analysis of Findings and Care Plan Considerations sections were left blank and provided no additional information. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Nutritional Assessment (conducted by Dietician-H) dated 1/13/22 documents, Assessment: BMI (body mass index) indicates normal weight. Noted hospital weight 148# (pounds). Noted improving intake after poor appetite; consuming 26-75% mechanically-altered diet; dysphagia. Lactose-restricted. Resident eats better for daughter. Food preferences honored. Noted pressure areas. Meds and labs reviewed. May benefit from supplement for wound healing and additional protein/calories; Plan/Recommendations: Regular, Puree, Nectar-thick Liquids Fluids throughout the day Recommend Prosource, 30 ml BID; 30 g (grams) protein/200 cal. Surveyor was unable to locate any documentation in R31's medical record that R31's nutritional plan and recommendation by Dietician-H was implemented for R31 on 1/13/22. R31's weight as obtained by the facility on 3/4/22 was documented in R31's medical record as 130.0 lbs. Surveyor noted that on 01/05/2022, R31 weighed 152.4 lbs and that on 03/04/2022, R31 weighed 130 pounds which is a -14.70 % Loss or a 22.4 pound weight loss in 59 days, which is considered a sever weight loss. R31's nutritional note (written by Dietician-H) dated 3/7/22 documents, Nutrition Text: Current weight 130#, demonstrating unplanned significant weight loss of - 14.7% ~ 60 days (152). 70 inches. BMI 18.7. Resident consumes a usual 51-100% Regular, Puree, Nectar-thick Liquids diet. Lactose-restricted. Dependent for eating and drinking. Sacrum, unstageable; improved. Noted some loose stools. Estimated needs based on actual weight 130# / 59 kg: 1475-1770 calories (kg x 25-30), 1475-1770 ml fluids (kg x 25-30), 71-83 g protein (kg x 1.2-1.4). Recommend provide fluids throughout the day. Recommend Prosource, 30 ml BID for additional calories and protein. R31's physician order dated 3/7/22 documents, Prosource 30 ml (milliliters) B.I.D. (twice a day) daily; two times a day for Weight Loss. Surveyor noted that R31 experienced a weight loss of 22.4 lbs. (pounds) in 58 days (14.7%) and that the facility did not implement the supplements recommended by Dietician-H on 1/13/22 until 3/7/22. On 3/17/22 at 1:03 p.m., Surveyor informed Dietician-H of the above findings. Surveyor asked Dietician-H why there was a delay in providing R31 with the supplements that were initially recommended by her (Dietician-H) on 1/13/22 and not provided until 3/7/22. Dietician-H informed Surveyor that she did not know why there was a delay in providing R31 with the supplements that were initially recommended by her on 1/13/22 and not provided until 3/7/22. Dietician-H informed Surveyor that she should speak with DON (Director of Nursing)-B for additional information. On 3/17/22 at 2:51 p.m., Surveyor informed DON-B of the above findings. Surveyor asked DON-B why there was delay in providing R31 with the supplements that were initially recommended by Dietician-H on 1/13/22 and not provided until 3/7/22. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON-B informed Surveyor that R31's initial dietician recommendations for supplements on 1/13/22 did not make it into R31's medical record and that he noticed the need for supplements on 3/7/22 after it was re-recommended. No additional information was provided as to why 312 did not receive nutritional supplements on 1/13/22 to prevent further weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on interview and record review the facility did not ensure 2 (R10 and R3) of 3 sampled residents received respiratory care and services in accordance with professional standards of practice and resident's plan of care. * R10's tracheostomy stoma was left open to air and not covered per physician orders. * R3 received oxygen therapy while at the facility. R3 did not have physician orders for when staff should change oxygen equipment. Findings include: The facility's policy dated as revised August 2013 and titled, Tracheostomy Care documents, Site and Stoma Care: 7. Apply a fenestrated gauze pad around the insertion site. 1. R10 was admitted to the facility on [DATE] with a diagnosis that included Quadriplegic Cerebral Palsy, Contracture, Chronic Respiratory Failure, Tracheostomy and Cognitive Communication Deficit. R10's Quarterly MDS (Minimum Data Set) dated 12/17/21 documents short and long term memory problems. Section C1000 (Cognitive Skills for Daily Decision Making) documents that R10 has severely impaired skills for daily decision making. Due to R10's mental status, Surveyor was unable to interview R10 regarding the ADL (Activities of Daily Living) care she received from staff at the facility. Section G (Functional Status) documents that R10 requires total assistance and two person physical assist for her bed mobility, transfer and personal hygiene needs. R10's respiratory care plan dated as initiated on 2/25/22 documents under the Focus section, Resident has altered respiratory status/Difficulty Breathing r/t Chronic Respiratory Failure with Hypoxia; History of Tracheostomy. R10's Hospital Discharge notes dated 3/10/22 documents, Hospital Course: Tracheostomy Malfunction: Patient has a history of tracheostomy and it got pulled out around noon on day of admission. She normally wears a size 7.0 Portex tracheostomy tube, ER (emergency room) was only able to get a 4.0 Shiely fenestrated uncuffed; stoma swelling likely; Wound Care: Split 4 x 4 gauze around trach (tracheostomy) site. Surveyor was unable to locate the above physician order in R10's medical record. On 3/15/22 at 10:22 a.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed that R10's tracheostomy stoma site was open to air and that R10 had copious amounts of phlegm and sputum coming from the stoma site. Surveyor noted that R10's tracheostomy stoma site was left uncovered despite R10's physician orders dated 3/10/22 for Split 4 X 4 gauze around the tracheostomy site. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/15/22 at 1:01 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed that R10's tracheostomy stoma site was open to air and that R10 had copious amounts of phlegm and sputum coming from the stoma site. Surveyor noted that R10's tracheostomy stoma site was left uncovered despite R10's physician orders dated 3/10/22. On 3/16/22 at 7:56 a.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed that R10's tracheostomy stoma site was open to air and that R10 had copious amounts of phlegm and sputum coming from the stoma site. Surveyor noted that R10's tracheostomy stoma site was left uncovered despite R10's physician orders dated 3/10/22. On 3/16/22 at 12:26 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed that R10's tracheostomy stoma site was open to air and that R10 had copious amounts of phlegm and sputum coming from the stoma site. Surveyor noted that R10's tracheostomy stoma site was left uncovered despite R10's physician orders dated 3/10/22. On 3/16/22 at 2:08 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed that R10's tracheostomy stoma site was open to air and that R10 had copious amounts of phlegm and sputum coming from the stoma site. Surveyor noted that R10's tracheostomy stoma site was left uncovered despite R10's physician orders dated 3/10/22. On 3/16/22 at 3:20 p.m., during the daily exit meeting, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. Surveyor asked DON-B if R10's tracheostomy stoma should be left open to air despite R10's physician orders dated 3/10/22. DON-B informed Surveyor that he would look at R10's medical orders and evaluate R10's tracheostomy site. On 3/17/22 at 8:31 a.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed that R10's tracheostomy stoma site was open to air and that R10 had copious amounts of phlegm and sputum coming from the stoma site. Surveyor noted that R10's tracheostomy stoma site was left uncovered despite R10's physician orders dated 3/10/22. On on 3/17/22 at 1:41 p.m., Surveyor observed R10 laying supine in bed with her tracheostomy stoma open and uncovered. Surveyor observed that R10's tracheostomy stoma site was open to air and that R10 had copious amounts of phlegm and sputum coming from the stoma site. Surveyor noted that R10's tracheostomy stoma site was left uncovered despite R10's physician orders dated 3/10/22. On 3/21/22 at 3:31 p.m., Surveyor asked DON-B why R10 did not have her tracheostomy stoma covered per R10's physician orders dated 3/10/22. DON-B informed Surveyor that R10 had decannulated herself and that she had declined to have her tracheostomy tube placed again. DON-B informed Surveyor that he had had spoken to staff about having R10's tracheostomy stoma covered per R10's physician orders. DON-B informed Surveyor that he had added R10's physician order to R10's medical record to ensure that R10's tracheostomy stoma remained covered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/22/22 at 11:56 a.m., Surveyor reviewed R10's medical record and noted the following physician order dated 3/17/22 for R10, Monitor and cleanse tracheotomy area every shift for Tracheotomy care Wash and pat dry tracheotomy area with saline. Cover with 4 x 4 Gauze and secure with paper tape. AND as needed Wash and pat dry tracheotomy area with saline. Cover with 4 x 4 Gauze and secure with paper tape. No additional information was provided as to why staff did not ensure R10 received necessary respiratory care consistent with professional standards of care. 38829 Surveyor reviewed the facility's Oxygen Administration policy and procedure revised 10/2010. Purpose The purpose of this procedure is to provide guidelines for safe oxygen (O2) administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the Resident's care plan to assess for any special needs of the Resident. 3. Assemble the equipment and supplies as needed. 2. R3 was admitted to the facility on [DATE] with diagnoses of Hereditary and Idiopathic Neuropathy, Chronic Obstructive Pulmonary Disease (COPD), Adult Failure to Thrive, Dyspagia, and Anxiety Disorder. R3 is her own person. R3's Significant Change Minimum Data Set (MDS) dated [DATE] documents R3's short and long term memory is impaired, and R3 demonstrates severely impaired skills for daily decision making. Surveyor notes that R3's MDS documents R3 is receiving O2 therapy. Surveyor notes that R3's comprehensive care plan has a focus that R3 has COPD initiated on 10/18/21 and the only intervention involving O2 is to give O2 therapy as ordered by the Physician initiated on 10/18/21. On 3/15/22 at 9:28 AM, Surveyor observed R3 in bed on continuous O2 at 2 liters. Surveyor observed that the O2 tubing with nasal cannula was not marked with a date on the tubing. Surveyor did not locate a date on the humidifier bottle. On 3/17/22 at 8:50 AM, Surveyor interviewed Assistant Director of Nursing(ADON-C) who stated the expectation is to change the O2 tubing 1 time a week and it needs to be dated. ADON-C stated there should be an order to change the tubing and documentation of the tubing being changed would be found on on Medication Administration Record (MAR). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/22 at 8:55 AM, Surveyor observed R3 in bed on continuous O2 at 2 liters. Surveyor observed that the O2 tubing with nasal cannula was not marked with a date on the tubing. Surveyor did not locate a date on the humidifier bottle. Surveyor reviewed R3's physician orders active as of 3/16/22 which contains no order to change R3's O2 tubing on a weekly basis. Surveyor notes that R3's MARS and Treatment Administration Record (TAR) does not contain documentation that R3's O2 tubing has been changed on a weekly basis. On 3/17/22 at 1:47 PM, Surveyor interviewed Corporate Registered Nurse (RN-O). RN-O stated that the expectation would be that there should be an order to change R3's O2 tubing 1 time a week, dated when changed, and documentation of this would be located in the MAR. Surveyor shared the concern that R3's O2 tubing is not marked with the date it was last changed and there is no documentation on the MAR. Surveyor notes that R3's physician orders active as of 3/21/22 reflect that on 3/18/22 orders to change and label humidifier bottle on oxygen concentrator weekly one time a day every Wednesday and change O2 tubing every week and label one time a day every Wednesday was initiated. On 3/21/22 at 3:14 PM, Surveyor shared the concern with Administrator (NHA-A) and Director of Nursing (DON-B) that R3's O2 tubing or humidifier bottle has been not been marked with a date during the survey process, and there was no order for both to be changed. No further information was provided at this time.

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

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

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

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

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

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observation, interview and record review, the facility did not ensure that 1 (R62) of 1 resident requiring dialysis services received monitoring of their dialysis catheter site. * R62 did not have monitoring of their dialysis catheter site on a daily basis by facility since their admission to the facility on [DATE]. Findings include: The Facility's Dialysis policy (not dated) states the following: . The intent of this requirement is that the facility assures each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including the: Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility; . Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring the resident's condition during treatments, monitoring for complications, implementing appropriate interventions and using appropriate infection control practices; and Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Communication with the Dialysis Facility: Provide the following information to dialysis treatment facility by sending a completed dialysis communication form with the resident: access location site, bruit, thrill, bleeding at graft/fistula site after last dialysis treatment (describe), post-dialysis complications, signs of infection, blood pressure, pulse and respiration, time of last meal, diet, medications given prior to dialysis treatment, new medications since last dialysis treatment. Following dialysis, the Dialysis facility should provide communication to the facility on : lab work/results if available, pre-dialysis blood pressure, pulse, respiration and weight, post-dialysis blood pressure, pulse, respiration and weight, access site difficulties, signs of infection, change in resident condition after dialysis treatment, medication given at dialysis facility, and new medications started at the dialysis facility. The Facility's End-Stage Renal Disease, Care of a Resident with Residents with end-stage renal disease (ESRD) (not dated) states the following: .Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: The nature and clinical management of ESRD (including infection prevention and nutritional needs); The type of assessment data that is to be gathered about the resident's condition on a daily or per shift (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Basis .The care of grafts and fistulas .How the care plan will be developed and implemented; How information will be exchanged between the facilities .The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. R62 was admitted to the facility on [DATE], and has diagnoses that include: End Stage Renal Disease, Schizophrenia, Cerebral Infarction and Dependence on Renal Dialysis. R62's care plan with an initiation date of 11/1/21 states: Resident needs Hemo Dialysis. I will have no s/sx of complications from dialysis. Interventions include: Monitor/document/report to MD PRN (as needed) any s/sx (signs/symptoms) of infection to access site: Redness, Swelling, warmth or drainage, Check dressing daily at permacath access site. (Right Upper Chest). Surveyor reviewed R62's MAR (Medication Treatment Record) and TAR (Treatment Administration Record). Surveyor could not identify monitoring of R62's permacath on a daily basis in R62's medical record. On 3/16/22 at 2:45 PM, Surveyor conducted interview with DON (Director of Nursing)-B. Surveyor asked DON-B how often a resident receiving dialysis should have monitoring of their dialysis access site. DON-B responded that a resident's dialysis site should be monitored on at least a daily basis. Surveyor shared concern that they could not identify staff's monitoring of R62's dialysis site in the medical record. DON-B told Surveyor that they would look into this matter further. On 3/17/22, Surveyor noted the following order from 3/16/2022 which was entered into the electronic charting system at 11:54 PM: Monitor Dialysis Port (Right upper Chest) Q shift for bleeding or s/sx of infection, every shift for Monitoring. Surveyor confirmed with DON-B that the daily monitoring of R62's dialysis site had not been documented in their medical record since their admission to the facility on [DATE].

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on record review and interview, the facility did not have an attending physician review and document that an identified medication irregularity, based on a pharmacist report, for 1 (R50) of 5 residents was addressed and reviewed. Findings include: R50 was admitted to the facility on [DATE] with a diagnosis that included Morbid Obesity, Right Artificial Hip Joint, Major Depressive Disorder and Bipolar Disorder. R50's Quarterly MDS (Minimum Data Set) dated 2/7/22 documents a BIMS (Brief Interview for Mental Status) score of 14, indicating that R50 is cognitively intact. Section N (Medications) documents that R50 had taken 7 out of 7 days of antidepressant medication during the assessment period. R50's Psychotropic Drug Use CAA (Care Area Assessment) dated 5/10/21, documents that R50 triggered for further assessment for the use of psychotropics medications, however the Analysis of Findings and Care Plan Considerations sections were left blank and provided no additional information. R50's physician order dated 5/3/21 documents, Ziprasidone HCl Capsule 40 MG (milligrams) Give 40 mg by mouth two times a day for mood/agitation. R50's Pharmacy Medication Review Active Recommendations dated 1/18/22 documents, Recommendation: This resident has been taking the antipsychotic Ziprasidone 40 mg (milligrams) twice daily since 5/3/21. Please evaluate the current dose and consider a dose reduction. IMPORTANT: Please add resident specific documentation to support the above action or check below if information was added to physician progress notes. Surveyor was unable to locate any evidence in R50's medical record that an attending physician reviewed and documented a rationale for R50's above identified medication recommendation as documented in R50's pharmacist report dated 1/18/22. Surveyor reviewed R50's physician orders for the above recommendation and noted that the above recommendation were not implemented and that R50's medication orders remained the same despite R50's pharmacy recommendations report dated 1/18/22. Surveyor reviewed R50's January, February and March 2022 MAR (Medication Administration Record) and noted that R50 continued to receive the above medication without any changes despite R50's pharmacy recommendations report dated 1/18/22. On 3/16/22 at 3:02 p.m., Surveyor informed DON (Director of Nursing)-B of the above findings. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked DON-B if R50's physician had reviewed and documented a rationale for R50's above identified medication recommendation as documented in R50's pharmacist report dated 1/18/22, as Surveyor was unable to locate any in R50's medical record. DON-B informed Surveyor that R50 is followed by a psychiatrist that does not prescribe medication and that he could not provide any information as to why R50's physician did not review or document a rationale for R50's above identified medication recommendation. On 3/17/22 at 11:19 a.m., Surveyor asked SS (Social Services)-G, whom deals with psychotropic medication use at the facility, if R50's physician had documented a rationale for R50's above identified medication recommendation as documented in R50's pharmacist report dated 1/18/22. SS-G informed Surveyor that she had no information as to why R50's physician did not review or document a rationale for R50's above identified medication recommendation. No additional information was provided as to why R50 did not have have an attending physician review and document that an identified medication irregularity, based on a pharmacist report, was addressed and reviewed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36161 Based on observation, record review, and interview the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety in 1 of 1 serving kitchens. * Cook-F was observed touching ready to eat food with gloved hands after touching non-sanitized food surfaces. This food was then observed being served to residents to eat. This deficient practice has the potential to affect 69 of 72 residents whom receive food from the main serving kitchen at the facility. Findings include: The facility's policy dated October 2017 and titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices documents under the Policy Interpretation and Implementation section, Employees must wash their hands: f. After handling soiled equipment or utensils . h. After engaging in other activities that contaminate the hands; 9. Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness; 10. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing. 1. Food Handling On 3/21/22 at 8:20 a.m., Surveyor observed Cook-F serving from the main serving table which serves all of the food, including room trays, for the entire facility. Surveyor observed Cook-F wearing gloves on both hands and touching the top of the metal plate warmer and grabbing paper food slips with both gloved hands. Surveyor then observed Cook-F use her right gloved hand to grab a piece of ready to eat toast and place it on a plate for a resident to eat. Surveyor noted that Cook-F did not remove her gloves or wash her hands after contaminating her gloves after touching non-sanitized food surfaces and before touching ready to eat food. On 3/21/22 at 8:22 a.m., Surveyor observed Cook-F wearing gloves on both hands and grabbing a food bowl, a plate base and paper food slips with both gloved hands. Surveyor then observed Cook-F use her right gloved index finger to scoop up ready to oatmeal back into a bowl for a resident to eat. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted that Cook-F did not remove her gloves or wash her hands after contaminating her gloves after touching non-sanitized food surfaces and before touching ready to eat food. On 3/21/22 at 8:23 a.m., Surveyor observed Cook-F wearing gloves on both hands and grabbing a food bowl and paper food slips with both gloved hands. Surveyor then observed Cook-F use her right gloved hand to grab a piece of ready to eat toast and place it on a plate for a resident to eat. Surveyor noted that Cook-F did not remove her gloves or wash her hands after contaminating her gloves after touching non-sanitized food surfaces and before touching ready to eat food. On 3/21/22 at 8:24 a.m., Surveyor observed Cook-F wearing gloves on both hands and grabbing a plate base and paper food slips with both gloved hands. Surveyor then observed Cook-F use her right gloved hand to grab a piece of ready to eat toast and place it on a plate for a resident to eat. Surveyor noted that Cook-F did not remove her gloves or wash her hands after contaminating her gloves after touching non-sanitized food surfaces and before touching ready to eat food. On 3/21/22 at 8:26 a.m., Surveyor observed Cook-F wearing gloves on both hands and grabbing paper food slips with both gloved hands. Surveyor then observed Cook-F use her right gloved hand to grab a piece of ready to eat toast and place it on a plate for a resident to eat. Surveyor noted that Cook-F did not remove her gloves or wash her hands after contaminating her gloves after touching non-sanitized food surfaces and before touching ready to eat food. On 3/21/22 at 8:28 a.m., Surveyor observed Cook-F wearing gloves on both hands and grabbing paper food slips and a plate base with both gloved hands. Surveyor then observed Cook-F use her right gloved hand to grab a piece of ready to eat toast and place it on a plate for a resident to eat. Surveyor noted that Cook-F did not remove her gloves or wash her hands after contaminating her gloves after touching non-sanitized food surfaces and before touching ready to eat food. On 3/22/22 at 9:29 a.m., Surveyor informed Dietary Manager-E of the above findings. Surveyor asked Dietary Manager-E if dietary staff should be washing their hands or using utensils before handling ready to eat food after touching non-sanitized food surfaces. Dietary Manager-E informed Surveyor that she would provide education to dietary staff about washing their hands or using utensils before handling ready to eat food after touching non-sanitized food surfaces. On 3/22/22 at approximately 9:40 a.m., Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. No additional information as to why food was not prepared, distributed, and served in accordance with professional standards for food service safety.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and interviews, the facility did not ensure hospice services providing end of life were coordinated for 1 (R3) of 1 sampled Resident receiving hospice services, including the coordination of pain management. * R3 had been admitted to hospice services on 10/23/21. On 3/11/22, R3 was admitted to a new hospice provider. As of 3/22/22, the facility did not have a hospice plan of care, a schedule of hospice visits, list of hospice staff, hospice medication specific to R3 or physician certification of the terminal illness specific to R3. The facility did not process hospice orders for pain medications causing uncontrolled pain to R3 (Cross-reference F697). Findings include: Surveyor reviewed the facility's Hospice Program policy and procedure revised July 2017. Policy Statement Hospice services are available to Residents at the end of life. Policy Interpretation and Implementation 5. Hospice providers who contract with this facility: a. must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency; and c. are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility. 9. In general, it is the responsibility of the hospice to manage the Resident's care as it relates to the terminal illness and related conditions, including: a. Determining the appropriate hospice plan of care d. Changing the level of services provided when it is deemed appropriate e. Providing medical direction, nursing, and clinical management of the terminal illness f. Providing spiritual, bereavement and/or psychosocial counseling and social services as needed g. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. In general, it is the responsibility of the facility to meet the Resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual Resident's needs. These include: h. Notifying the hospice about the following: 1. A significant change in the Resident's physical, mental, social, or emotional status 2. Clinical complications that suggest a need to alter the plan of care 3. A need to transfer the Resident from the facility for any condition 4. The Resident's death i. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the Resident are addressed and met 24 hours per day 12. The facility has designated a representative to coordinate care provided to the Resident by our facility and staff and the hospice staff. a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for Residents receiving these services k. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the Resident and family l. Ensuring that the facility communicates with the hospice medical director, the Resident's attending physician, and other practitioners participating in the provision of care to the Resident as needed to coordinate the hospice care with the medical care provided by other physicians m. Obtaining the following information from the hospice: 1. The most recent hospice plan of care specific to each Resident 2. Hospice election form 5. Physician certification and recertification of the terminal illness specific to each Resident 6. Names and contact information for hospice personnel involved in hospice care of each Resident 7. Instruction on how to access hospice's 24 hour on call system 8. Hospice medication information specific to each Resident 9. Hospice physician and attending physician (if any) orders specific to each Resident (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	n. Ensuring that the facility staff provides orientation on the policies and procedures of the facility, including Resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the Residents. 13. Coordinated care plans for Resident receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility(including the responsible provider and discipline assigned to specific tasks) in order to maintain the Resident's highest practicable physical, mental and psychosocial well-being. 14. The coordinated care plan will reflect the Resident's goals and wishes, as stated in his or her advance directives and during ongoing communication with the Resident or representative, including: a. Palliative goals and objectives b. Palliative interventions c. Medical treatment and diagnostic tests 15. The coordinated care plan shall be revised and updated as necessary to reflect the Resident's current status including: a. Diagnosis b. Problem list c. Symptom management d. Bowel and bladder care o. Nutrition and hydration needs p. Oral care q. Skin integrity r. Spiritual, activity and psychosocial needs s. Mobility and positioning The facility had a signed contract with the hospice provider which was initiated October 4, 2018. The contract indicates the hospice and facility share the responsibility of documentation of communication between hospice and facility to ensure the Hospice patient needs are addressed 24 hours a day. Duties and Obligations of Hospice 2.3 Communication of Plan of Care and Information Hospice shall furnish to facility at the time of the patient's admission to the facility or as soon as possible: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Patient identification information and information necessary for billing and claims processing as needed -Copies of the hospice current plan of care and any subsequent updates thereto -Copies of the patient's hospice election for any advance directives -Physician certification and recertification of terminal illness as applicable -Names and contact information for hospice personnel involved in hospice care of the patient -Hospice patient medication information for the specific patient -Hospice and attending physician orders if any specific to the patient Other Applicable: 2.7-Updates to Assessments and Plan of Care -Hospice shall include input from facility representatives in interdisciplinary (IDT) meetings in which hospice plans of care, assessments, and ongoing needs of hospice patients are developed, reviewed, updated, and discussed. 2.9-Documentation of Communication -Hospice shall document all communications with facility representatives or facility staff in writing, in the patient's record. Hospice staff shall promptly document all information related to visits, orders, revisions to orders, patient status,changes in status or condition, responses to medication or therapies, patient and family needs or requests in the patient's clinical record. Duties and Obligations of Facility 3.1 Facility Services Facility will furnish facility services to each hospice patient in accordance with the hospice patient's plan of care 3.4 Participation in Hospice Plan of Care In accordance with applicable Federal and State laws and regulations, a representative of the facility shall participate in and/or give input to the IDT and other clinical and planning meetings, and coordinate with Hospice in the development of the Plan of Care, abide by and furnish facility services in accordance with the plan of care. Coordination of Services 4.1 Development and Implementation of Plan of Care- When a Resident is authorized by hospice for admission to the hospice program, or when the facility admits a hospice patient to the facility, hospice and facility shall jointly develop and agree upon the hospice patient's plan of care. The hospice patient's plan of care shall specifically identify whether the hospice or the facility is responsible for performing the respective functions that are detailed in the hospice patient's plan of care. 4.2 Modification of Plan of Care-Hospice and facility shall jointly coordinate and participate in periodic review and modification of each hospice patient's plan of care at intervals specified in the plan of care, taking into account any changes in the hospice patient's condition. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 was admitted to the facility on [DATE] with diagnoses of Hereditary and Idiopathic Neuropathy, Chronic Obstructive Pulmonary Disease (COPD), Adult Failure to Thrive, Dyspagia, and Anxiety Disorder. R3 is her own person. R3's Significant Change Minimum Data Set (MDS) dated [DATE] documents R3's short and long term memory is impaired, and R3 demonstrates severely impaired skills for daily decision making. Surveyor notes that R3's MDS documents R3 is receiving hospice care. The MDS also documents that R3 requires total dependence for bed mobility, transfers, dressing, toileting, and bathing. The MDS also documents that R3's PHQ-9 (Mood Score for the Patient Health Questionnaire) is 14 indicating that R3 has moderate depression. Surveyor notes that R3 elected to accept hospice care on 10/23/21. R3 then transferred to a new hospice provider on 3/11/22. Surveyor reviewed R3's comprehensive care plan on 3/16/22 which did not contain or document anywhere that R3 was hospice care. R3's care plan did not address R3's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment related to hospice care. On 3/15/22 at 1:03 PM, Surveyor noted the nurse's station had a binder specific to R3's hospice services. Hospice Certified Nursing Assistant (CNA-Q) confirmed this was R3's hospice binder of documentation. Surveyor notes that the binder did not contain a list of medications, physician certification, list of hospice staff providing care to R3, and no hospice plan of care for R3. Surveyor noted there is a fax communication dated 3/13/22 documenting for R3's Norco Tablet 5-325 MG two times daily to be discontinued and changed to Norco Tablet 5-325 MG four times daily for pain and a new order for Morphine oral concentrate 20 MG/1 mL. Give 10 MG (0.5mL) every 2 hours as needed sublingual. (Cross-reference F697). Surveyor reviewed R3's current MARS and physician orders as of 3/16/22 and notes that R3's medication changes were not reflected on the MARS or current physician orders. On 3/16/22 at 1:01 PM, Social Services (SS-G) informed Surveyor that R3's family requested the switch in hospice providers due to lack of communication from the first hospice provider. SS-G stated Director of Nursing (DON-B) handled the transfer of services. On 3/16/22 at 3:05 PM, DON-B confirmed that DON-B is the liaison between the facility and hospice providers. On 3/17/22 at 12:50 PM, Surveyor interviewed hospice nurse (RN-J) who confirmed that on 3/11/22 RN-J initiated the change of R3's pain medication. RN-J stated RN-J verbally informed DON-B of the medication change. RN-J stated that RN-J always faxes the medication changes to the pharmacy and the facility and that is what RN-J did with R3's medication changes. RN-J states that RN-J visited R3 on 3/13/22 and checked to make sure the facility's MAR for R3 reflected the medication change. RN-J stated RN-J was informed by the 2nd shift agency nurse that the change in pain medication had been done. Surveyor notes the fax communicating the change in R3's medication was sent on 3/13/22 to the attention of DON-B. Surveyor notes there is no documentation of this conversation. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/22 at 1:15 PM, Surveyor shared with Administrator (NHA-A) and Corporate Registered Nurse (RN-O) that R3's pain medication had been changed significantly on 3/11/22 with follow up by fax on 3/13/22 and the facility had not made the change as reflected in R3's current MAR and physician orders. This resulted in R3 not receiving the revised pain medications as prescribed by hospice. Surveyor shared the concern at this time of the break down in communication between hospice and the facility. Surveyor notes that R3's electronic medical record (EMR) contains a note dated 3/17/2022 at 7:00 PM stating the following: Spoke with Hospice RN-J, discussed current regimen, made aware of Medication Error with no adverse effects. Son was called with message left to update, .RN to also attempt to call Son .to discuss. All medications reviewed for accuracy with no new changes at this time. On 3/21/22 at 1:48 PM, Surveyor spoke to RN-J again. RN-J stated RN-J sent the morphine order to the pharmacy on 3/11/22, and called the pharmacy about 6:30 PM. RN-J stated RN-J wanted the medications sent out that night (3/11/22) . RN-J was informed the facility got the medications. RN-J recalls talking to the floor nurse, and talked to DON-B who was in the building on 3/11/22 regarding the pain medication changes. RN-J stated DON-B acknowledged understanding. RN-J stated RN-J informed DON-B the medications were coming for R3. RN-J felt comfortable R3 would be getting the medications right away. RN-J is not sure why it did not happen. On 3/21/22 at 3:14 PM Surveyor shared the concern with NHA-A and DON-B that the communication process including how the communication will be documented between the facility and the hospice provider, in order to ensure that the needs of R3 are addressed and met 24 hours per day did not happen as evident of the medication error. Surveyor also shared that collaboration with the hospice representatives and coordinating facility staff participation in the hospice care planning process for R3 including obtaining the most recent hospice plan of care specific to R3 did not occur. No further information was provided at this time by the facility.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation and interview, the facility did not provide a working call light system for 2 (R2 & R52) of 18 sampled residents. Findings include: 1. R2 was admitted to the facility on [DATE] with a diagnosis that included Schizophrenia, Dysphagia, Asthma and Overactive Bladder. R2's Quarterly MDS (Minimum Data Set) dated 3/4/22 documents a BIMS (Brief Interview for Mental Status) score of 3, indicating that R2 is severely cognitively impaired. Section G (Functional Status) documents that R2 requires extensive assistance and a one personal physical assist for his bed mobility needs. Section G also documents that R2 has total dependence on staff and requires a one person physical assist for his transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R2 has no impairment to either side of both his upper and lower extremities. On 3/15/22 at 10:11 a.m., Surveyor observed R2 laying supine in bed and yelling out for help. Surveyor approached R2 and asked him what he needed help with. R2 informed Surveyor that he needed help from staff and that when he calls for help, he has to yell at the top of his lungs to get staff to help him as no one comes to help him. Surveyor asked R2 why he doesn't press his call light to ask for staff assistance. R2 informed Surveyor that the call light did not work and that staff do not come when he pressed the call light. R2 stated, That [Expletive] (referring to the call light) doesn't work. Surveyor observed R2's call light button to be taped down, preventing the call light from being activated. Surveyor then pressed R2's call light push pad and walked outside of R2's room. Surveyor observed that despite pressing and activating R2's call light push pad, R2's call light would not activate and the light outside of R2's room did not turn on. On 3/15/22 at 12:58 p.m., Surveyor observed R2 laying supine in bed. Surveyor walked into R2's room and observed R2's call light button to be taped down, preventing the call light from being activated. Surveyor then pressed R2's call light push pad and walked outside of R2's room. Surveyor observed that despite pressing and activating R2's call light push pad, R2's call light would not activate and the light outside of R2's room did not turn on. On 3/15/22 at 2:56 p.m., Surveyor observed R2 laying supine in bed. Surveyor walked into R2's room and observed R2's call light button to be taped down, preventing the call light from being activated. Surveyor then pressed R2's call light push pad and walked outside of R2's room. Surveyor observed that despite pressing and activating R2's call light push pad, R2's call light would not activate and the light outside of R2's room did not turn on. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor then walked over and informed ADON (Assistant Director of Nursing)-C of the above findings. On 3/15/22 at 2:58 p.m., Surveyor walked into R2's room with ADON-C and asked ADON-C why R2's call light button was taped down and not working. ADON-C pressed R2's call light pad and confirmed that R2's call light was not working. ADON-C informed Surveyor she did not know why R2's call light button was taped down and not working. On 3/16/22 at 7:55 a.m., Surveyor observed R2 laying supine in bed. Surveyor pressed R2's call light push pad and walked outside of R2's room. Surveyor observed that the light bulb outside of R2's room was changed and R2's call light was now on and activated. No additional information was provided as to why the facility did not provide a working call light system for R2. 2. R52 was readmitted to the facility on [DATE] with a diagnosis that included Speech and Language Deficits, Diabetes Mellitus Type II, Chronic Obstructive Pulmonary Disease and Major Depressive Disorder. R52's Quarterly MDS (Minimum Data Set) dated 2/9/22 documents a BIMS (Brief Interview for Mental Status) score of 15, indicating that R52 is cognitively intact. On 3/15/22 at 1:05 p.m., Surveyor interviewed R52 regarding the quality of life at the facility. Surveyor asked R52 if she had any environmental concerns with her room. R52 informed Surveyor that her call light was not working and informed Surveyor that she had to connect the wires to activate her call light. Surveyor observed R52's call light cord to be missing the call light button and in its place, Surveyor observed two exposed wires, one white and one black coming from the call light cord that was connected to the wall. On 3/15/22 at 2:57 p.m., Surveyor walked into R52's room and observed R52's call light cord to be missing the call light button and in its place, Surveyor observed two exposed wires, one white and one black, coming from the call light cord that was connected to the wall. On 3/15/22 at 3:03 p.m., Surveyor walked into R52's room with ADON-C and asked ADON-C why R2's call light button missing and had exposed wires instead. ADON-C informed Surveyor she did not know why R2's call light button was missing and not working. ADON-C then removed R52's call light cord with the exposed wires and informed Surveyor that she would replace it with a working call light button. No additional information was provided as to why the facility did not provide a working call light system for R52.