STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Care Center	400 County Rd R Black River Falls, WI 54615

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview and record review, the facility did not ensure 1 of 12 sampled residents (R28), medical records clearly identified the residents advanced directives, regarding code status. R28's code status was conflicting in the medical record. Evidenced by: The facility policy titled, Cardiopulmonary Resuscitation (CPR) or Do-Not-Resuscitate (DNR) Orders, with a revised date of ,d+[DATE], includes, in part: Purpose: Each resident will choose between CPR or DNR designation upon admission to the nursing home. Protocol: 1. Upon admission, the licensed nurse or social worker will discuss the options, CPR or DNR and any other advance directives with the resident and/or legal representative and receive the corresponding physician orders. The Physician Order Summary (POS) is the designated place in the medical record for staff to record/find the CPR/DNR designation for each resident. a. The POST (Provider Orders for Scope of Treatment) form (WI and IN) and the POLST (Provider Orders for Life Sustaining Treatment (MT) [sic] form, and other state specific forms should be completed at the time as the resident or resident representative desires .2. The CPR or DNR designation will be reviewed with the resident and/or resident representative quarterly during care plan review, at the time of a significant change or at the request of the resident, and appropriate orders obtained as necessary . R28 was admitted to the facility on [DATE] with diagnoses that include, in part: History of Falling; Anemia; Type II Diabetes Mellitus .; Chronic combined systolic (congestive) and diastolic (congestive) heart failure; Restlessness and Agitation; Major Depressive Disorder; Unspecified Dementia ([DATE]); Neurocognitive disorder with Lewy bodies ([DATE]) . R28's most recent quarterly Minimum Data Set (MDS) dated [DATE] documents the following: Section C: A BIMS (Brief Interview for Mental Status) of 8, indicating R28 has a moderate cognitive impairment. R28 has an activated Power of Attorney for Health Care (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's Provider Orders for Scope of Treatment (POST) Form indicated R28's code status as Do Not Attempt Resuscitation/DNR. This form is signed by R28's POAHC (Power of Attorney for Health Care), however is not signed by a physician. R28's signed physician orders, with a signature date of [DATE], indicated that R28's code status is Cardiopulmonary Resuscitation (CPR). R28's Code status listed in the facility Electronic Health Record notes CPR. On [DATE] at 3:43 PM, Surveyor spoke to FM L (Family Member) via telephone and asked if she recalled filling out the POST form for R28. Surveyor reviewed with FM L what this form is and the information regarding DNR being marked. FM L indicated she did not recall when it was filled out. FM L indicated, that R28 said he did not want to be resuscitated if he was in a vegetative state. Surveyor clarified with FM L, if R28 was here and his heart stopped he did not want them to do CPR. I guess that would be correct. On [DATE] at 1:22 PM Surveyor interviewed LPN F and asked where he would look for a resident's code status. LPN F indicated, in the computer. LPN F showed Surveyor an example of where he would look for code status in the electronic health record. On [DATE] at 4:08 PM, Surveyor interviewed RN J (Registered Nurse) and asked where she would look for a resident's code status. RN J indicated in the front of chart, there is a plastic file and then held up a yellow POST (Physician Order for Scope of Treatment) form. Surveyor asked RN J what she would do if the order was not signed. RN J replied she would look in the computer and can also check the physician orders. Surveyor asked RN J if the DNR order is not signed do you go by the physician orders. RN J indicated, yes. On [DATE] at 4:22 PM, Surveyor interviewed LPN K (Licensed Practical Nurse) and asked where she would look for a resident's code status. LPN K indicated; she would look at the POST form. Surveyor provided a copy of R28's POST form and LPN K pointed to the code status which was marked DNR. Surveyor asked LPN K what she would do if this POST were not signed. LPN K indicated, she would go to the physician orders and demonstrated by pointing to the top of the physician orders that is says to do CPR. Surveyor asked LPN K with the POST form not being signed and the physician orders showing CPR what would you follow. LPN K indicated, I would not honor the POST form and go to the physician orders, and I would do CPR. On [DATE] at 4:14 PM, Surveyor interviewed RN G regarding the code status of R28. RN G stated to the Surveyor she would look at the POST to look for the code status. Surveyor provided a copy of R28's POST and asked what RN G would do if the POST was not signed. RN G replied she would go to the physician orders. RN G indicated R28's physician orders note CPR and so she would go with CPR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:39PM, Surveyor interviewed SS O (Social Services) and asked if she is responsible for ensuring completion of the POST form. SS O indicated, yes. Surveyor asked SS O what the process is for advanced directives. SS O indicated, at admission I will get their advanced directive and then I have a POST form. Usually, I get the advanced directive with the referral or from family, and usually the hospital has the advanced directive. If it's a local person and they clinic at the local clinic then it's usually available through the local clinic and we can get from them. Surveyor asked SS O, how soon the post form must be completed. SS O indicated, I usually get it over to the [Name] Clinic in town the day of admission, but sometimes I don't get it back, like if it's a Friday, then I won't get it until Monday and so we use the POST from the hospital. Surveyor asked SS O if she is in charge of making sure they have the POST from the hospital if the facility POST form cannot be signed right away. SS O indicated, yes. SS O indicated, if they have an activated POA (Power of Attorney) at admission then they come with, and we have them sign it at that time. Surveyor asked SS O if it is her responsibility to make sure the form is signed by the physician. SS O indicated, yes. Surveyor showed SS O R28's POST that was in his chart and asked if there should be a physician signature on the form. SS O indicated, yes. SS O indicated she wanted checked for further information in the electronic health record for any notes about a possible code status change. SS O check the computer and then indicated R28's last care conference was in November and that she brings the code status with for review, so she is unsure how it was missed. On [DATE] Surveyor interviewed DON B (Director of Nursing) and asked what her expectation is for the POST form being signed. DON B indicated, once physician orders are received, the POST form should be completed; however, it is not a mandatory piece of paper. Surveyor asked DON B, what staff should go by for code status if this is not a mandatory form. DON B indicated, the physician orders. Surveyor asked DON B if the POST form is something that is filled out for everyone. DON B indicated, it's not the official place to look for code status. It should be the physician orders. Some people don't want to fill them out and that is their right. Surveyor asked if the POST form should match the physician orders. DON B indicated, yes. Surveyor asked DON B if the POST form should be signed if it is filled out. DON B indicated, yes, that would be the final step in the process. Surveyor showed DON B R28's POST form and asked if it should be signed by the physician. DON B indicated if the document is going to exist it should be signed. If the POST form exists, they should match the physician orders. But the official place for code status is the physician orders.

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F 0689 Level of Harm - 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** 39849 Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 2 of 5 residents reviewed (R28 and R35) of a total sample of 12. R28 has a history of multiple falls. R28 is resistive to assistance and frequently self-transfers despite the risk of fall with major injury. R28 requested assistance to the use the bathroom from a non-direct care staff member on 9/28/22. The staff member noted that R28's pants were lowered when asking for assistance. The staff member did not remain with R28 until assistance was available. R28 fell requiring sutures. R35 fell on [DATE] and an RN assessment was not completed. This is evidenced by: The Facility's Policy entitled Fall Assessment and Prevention Protocol, with a revised date of 8/21, includes, in part: Purpose: A comprehensive, proactive falls assessment will be conducted upon resident admission to the skilled nursing facility and will be reassessed at the time of a resident fall. If/when a resident experiences a fall, a root cause analysis will be conducted to assist in planning appropriate evidence-based interventions to prevent further falls. Protocol: .After a fall or intercepted fall: .See Fall Checklist for licensed nurse to follow. 1. Ensure that the resident needs are met, and the resident is safe. Make them comfortable. Attend to any immediate medical needs and provide appropriate intervention . Ongoing: .2. Any trends or patterns in falls will be evaluated through the facility QAPI (Quality Assurance and Performance Improvement) process on a monthly/quarterly basis. 3. All staff members are regularly educated on resident fall prevention and safety, including proper use and placement of safety devices, use of different kinds of available safety equipment and pertinent manufacturer's directions, and daily surveillance of possible hazards . The Facility Fall Checklist, with a reviewed date of 8/21, includes, in part: 1. Ensure that resident needs are met, and the resident is safe. Make them comfortable. Attend to any immediate medical needs and provide appropriate first aid . R28 was admitted to the facility on [DATE] with diagnoses that include in part: History of Falling; Anemia; Type II Diabetes Mellitus .; Chronic combined systolic (congestive) and diastolic (congestive) heart failure; Restlessness and Agitation; Major Depressive Disorder; Unspecified Dementia (2/3/2021); Neurocognitive disorder with Lewy bodies (2/3/2021) . R28's most recent quarterly Minimum Data Set (MDS) dated [DATE] documents the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Section C: A BIMS (Brief Interview for Mental Status) of 8, indicating R28 has a moderate cognitive impairment. Section G: .bed mobility 3/2 (extensive assistance/1-person physical assist), transfer 3/2 (extensive assistance/one-person physical assist), locomotion on unit 0/0 (Independent/No setup or physical help from staff), toileting 3/2 (extensive assistance/one-person physical assist) .mobility device: wheelchair. Section J: .Number of falls since prior admission or prior assessment: A. No injury .2 (=Two or more); B. Injury (Except major) 2 (=Two or more); C. Major Injury .0 (=None) . R28's care plan includes, in part: Problem: 7/21/22 Problem: Trauma-Falls, frequent falls with and without injury, risk for major injury/death from fall related to trauma. Approach: 7/25/22 (Discontinued 7/28/22): Nurses - Encourage to ask for assistance, instruct resident in use of adaptive equipment, instruct on safety, remind R28 to toilet before going outside 12/1/20 remind and encourage resident to go slow when completing tasks to prevent injury. Notify provider of increased behaviors causing R28 to become agitated. Offer resident grabber to retrieve items on the floor, frequent checks on room to ensure there are no items on his floor. Offer gentle reminder(s) and cue(s) for toileting after meals and activities. Housekeepers to check resident supplies in bathroom daily and are to leave him with extra supplies. Two trash cans should be in resident's bathroom. Additional furniture, i.e., chair to be placed strategically to allow for clear, clutter free walkway in bedroom. Receives therapy by [Name] in [Name of City]. Provide stable chair of appropriate height for resident when sitting at nurse's station to make his phone calls and a wooden chair while in the dining room per request. Family informed to call staff when returning to facility after out of building trips to request staff assist out of vehicles to prevent falls from vehicles. Grab bar on wall near sink, R28 is known to yell at staff when offering unsolicited assistance, will say to get out of room and that he doesn't want help, continue to encourage R28 to allow at least stand by assist to help prevent major injuries from falls, do leave the room if he is adamant, gripper strips x 2 sets in front of bed exit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9/22/22 (Discontinued 10/25/22): Nurses -- Encourage to ask for assistance. Call light in reach, Bed height 22 inches marked with tape, ensure tray table within reach while in bed with water pitcher near edge. Gripper strips by toilet bathroom door and bed. Toilet rails with padding, while rounding proactively ensure floor is dry, free from clutter. Laundry hamper by exit of room. Remind him to go slow. Housekeepers to check resident supplies in bathroom daily and are to leave him with extra supplies. Two trash cans should be by the sink in resident's bathroom. Strategically to allow for clear, clutter free walkway in bedroom. Encourage resident to be out of room while housekeeping completes cleaning duties. R28 is no longer able to be in shower room without assist throughout the task. Not to leave him alone. Make sure the shower door is kept locked when not in use. *NOC (Night) shift CNA to offer use of restroom between 5am and 6am. Grab bar on wall near sink. R28 is known to yell at staff when offering unsolicited assistance, will say to get out of room and that he doesn't want help, do leave the room if he is adamant, gripper strips x 2 sets in front of bed exit, gripper strips in place in dining room in from [sic] of his chair, Please have resident use w/c (wheelchair) in room and hallways, needs assist of 1 with all transfers, ADLs (Activities of Daily Living) and toileting, push him to meals and activities in his w/c as needed, please call don't fall signs in bathroom and at bedside, perimeter mattress, mug of thickened liquids at bedside at all times 1/6/23 (Current Approach): Nurses -- Encourage to ask for assistance. Call light in reach, Bed height 22 inches marked with tape, ensure tray table within reach while in bed with water pitcher near edge. Gripper strips by toilet bathroom door and bed. Toilet rails with padding, while rounding proactively ensure floor is dry, free from clutter. Laundry hamper by exit of room. Remind him to go slow. Housekeepers to check resident supplies in bathroom daily and are to leave him with extra supplies. Two trash cans should be by the sink in resident's bathroom. Strategically to allow for clear, clutter free walkway in bedroom. Encourage resident to be out of room while housekeeping completes cleaning duties. R28 is no longer able to be in shower room without assist throughout the task. Not to leave him alone. Make sure the shower door is kept locked when not in use. *NOC (Night) shift CNA to offer use of restroom between 5am and 6am. Grab bar on wall near sink. R28 is known to yell at staff when offering unsolicited assistance, will say to get out of room and that he doesn't want help, do leave the room if he is adamant, gripper strips x 2 sets in front of bed exit, resident use w/c in room and hallways, needs assist of 1 with all transfers, ADLs and toileting, push him to meals and activities in his w/c as needed, please call don't fall signs in bathroom and at bedside, perimeter mattress, mug of thickened liquids at bedside at all times, toileting on NOC at MN, 0200, 0400, 0600 Observe, record, and report all unsafe conditions and situations, Goal: 1/6/23 Free from major injury resulting from falls R28's CNA Assignment Sheet with a Printed date of 1/11/23 includes, in part: Transfer Assist: Assist of 1 at all times. Encourage to ask for assistance, instruct on safety when staff observes him moving quickly . Supportive Devices: dynergo scoot chair. Wheelchair pommel cushion in w/c Grab bar(s) on toilet to assist with standing. Bed has transfer loop, gripper strips in front of bed, toilet and bathroom door, grabber, Hamper at room exit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Safety Equipment: Encourage to use appropriate light in room at night; padding applied to toilet seat arm rails, offer grabber to retrieve items on floor or where reaching is required, while rounding ensure floor is free from clutter i.e., paper towels on floor in bathroom clothes on floor by exit. keep tray table close to side of bed so water pitcher is in reach, perimeter mattress. Toileting: Assist of 1 Attended, wears pull up brief .Offer reminder after meals and activities. Must remain with R28 with toileting at all times, please toilet on NOC (night) shift at MN (Midnight), 2:00AM, 4:00AM, and 6:00AM. Special Care Remarks: .anticipate needs Remind to wear prescription glasses. (Refuses eye glass use) Housekeepers check his supplies daily and leave with extra .Keep room clear and clutter free, inc. furniture. Ensure floor is dry and free of obstacles after he finishes his meals. Keep appropriate footwear at bedside. Encourage to activities outside of room while room is being cleaned. Gripper strips in front of sink, in front of the toilet, and at bedside, please call don't fall sign in bathroom and resident room. Use printed daily agenda for R28's routine, assist with bedtime routine at 7pm, call don't fall sign in room and bathroom. Of note, on 1/12/23 at 2:35 PM, Surveyor observed the agenda on R28's wall to contain, in part: 10AM bathroom; 11:30 Bathroom and to activities; 12:45 pm bathroom; 2:00 pm bathroom; 4:00 pm bathroom; 7:00 - 7:30 pm bathroom cares and to bed. These interventions were not clearly defined in R28's plan of care; a staff member would need to go to the bathroom and read the printed agenda to have knowledge of R28's routine. On 1/10/23 at 1:02 PM, Surveyor interviewed R28 as part of the initial screening process. Surveyor asked R28 if he recalled having any falls in the last few months. R28 stated he had a fall out of his chair, and something happened to his head, and he went to the hospital. R28 was not able to give a date or any more detail regarding the fall. Review of July 2022 through September 2022 fall incident reports and Nursing notes provided to Surveyor for R28, include in part, the following: Risk and Benefit documentation, dated 6/29/22 at 10:08AM, related to R28's falls, was provided to the Surveyor by the facility and includes the following: Spoke with family/guardian, FM L (Family Member) and [Name]. Regarding: recent falls and R28's continued refusals to let staff assist with ambulation and ADLs . Risk and benefit discussion as to allowing R28 to assert his right to maintain his independence despite risk to his personal safety including major injury and death resulting from falls is discussed. FM L and [Name] agree that R28 has a right to choose although they wish he would allow staff to help, they are aware of his right and choice to refuse assistance despite many education sessions discussing with R28 the risks of his choice to be independent when he clearly is not safe and will continue to have falls . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/12/23 at 3:39 PM, Surveyor spoke with FM L (Family Member) and asked if she recalled a conversation regarding risk and benefits in relation to R28's falls and him having the right to choose to be independent despite the risk of major injury. FM L indicated she did not recall this conversation with the facility and that the facility needs to be helping him transfer from that chair especially when you can't put the brakes on. Surveyor clarified with FM L that she did not recall a discussion of risks and benefits of R28 self-transferring and that despite the education and attempts at interventions he still self-transfers. FM L indicated, no, I don't. Surveyor asked FM L if she recalled agreeing that R28 has the right to maintain his independence and choose to self-transfer. FM L indicated, no, he doesn't, they need to help him transfer. July 2022: 7/3/22 1:57 AM Incident Report, includes, in part: Incident Type: Lowered to Floor Injury: No apparent injury Location: Bathroom Activity at the time: Walking to the bathroom unassisted with walker in the dark, yelled at staff when lights were turned on, right leg dragging behind and unable to stay safely standing, gently lowered to the floor, and assisted back up. Assessment Supporting Intervention: Resident care planned for injury prevention as he is anticipated to fall r/t (related to) his desire to remain independently. [sic] 7/6/22 9:23AM Nurses notes: Follow-up of Incident: Lowered to floor 7/3/2022 1:57AM, Injury: No apparent injury. Actions: .IDT team review. R28 continues to transfer, ambulate, and perform ADLs independently despite being unsafe to do so, staff continue to monitor and intervene as resident will allow. 7/9/22 5:45AM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: No apparent injury Location: Resident's room Activity at the time: Walking (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Assessment Supporting Intervention: Resident refused to ask for assistance and falls frequently. Care Planned for frequent falls. A handwritten note in this section indicates, Grab bar on wall near sink. 7/10/22 6:05AM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: No apparent injury Location: Bathroom Activity at the time: Toileting; hygiene care via the sink in his bathroom Assessment Supporting Intervention: Bathroom sink filled with water, resident verbalized that he was washing himself with the water he collected in the sink and slipped on the water that spilled on the floor. A handwritten note in this section indicates: Grab bar on wall near sink. 7/12/22 1:30AM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: Skin tear left forearm reopened Abrasion between nose Location: left forearm, lip, between upper lip and nose Location: Resident's room Bathroom Activity at the time: Toileting Assessment Supporting Intervention: resident refuses to use his call light for assistance, staff has heard the walker and went to assist him, and he tells us to get out and mind our business and that he does not need our help. A handwritten note in this section indicates: Set-up conference; Review Mayo notes; -Neuro; Rehab director contact [Name] therapy 7/12/22 6:00 AM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: No apparent injury Location: Resident's Room Activity at the time: Transferring/Walking Assessment Supporting Intervention: IDT (Interdisciplinary team) to review 7/12/22 6:09AM Nurses Notes: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Follow-up of Incident: Resident found on floor in bathroom. Had a cutt [sic] on his left forearm, lip was cutt [sic], and between his mouth and nose is an abrasion. He refused vitals and said he didn't hit his head. MD and DON (Director of Nursing) were updated, POA (Power of Attorney) still needs to be updated. 7/12/22 12:54PM Nurses Notes: Follow-up of Incident: Observed on floor 7/12/22 @ 1:30AM and 6:30AM. Injury: Skin tear: Abrasion: Actions: .IDT team review: Comprehensive discussion held on 7/12/22, plan: conference to be set up with medical Director, [Name of outside Therapy] Therapy Team, Dr [Name] Facility IDT, resident and POA to discuss resident's multiple falls and comprehensive plan of action, [Name of outside Therapy] notes for last 6 months reviewed and yield little information not already known, Director of Rehab services to contact [Name of outside Therapy] Therapy to discuss case, also will discuss with resident the use of w/c locomotion. Further interventions based on outcome of above. 7/20/22 1:00PM Incident Report, includes, in part: Incident Type: Witnessed fall Injury: Laceration right upper arm, next to elbow 0.2cm x 0.5cm First Aid: cleansed with wound cleaner, covered with xeroform and gauge [sic] dressing immediately applied Location: Dining room Activity at the time: Transferring/Walking Assessment Supporting Intervention: IDT to review 7/21/22 2:25PM Nurses Notes: Follow-up of Incident: Witnessed fall 7/20/22, observed to stand up in dining room when his foot caught on the chair which caused him to slide to the floor Injury: Laceration: small laceration right upper arm Actions: .IDT team review: R28 continues to assert self-determination and ambulate and complete ADLs independently despite not being safe to do so. R28 does not allow staff to assist even when he is observed being unsafe and staff attempt to intervene .Care plan is current with care plan for falls but to avoid major injury which at this time likely will be unavoidable due to his level of resistance and self determination to continue to be independent. POA has been contacted on several occasions to schedule specialized care conference to discuss concerns with R28 but has declined to give any available times for this to occur . 7/22/22 6:00AM Incident Report, includes, in part: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Incident Type: Observed on Floor Injury: No apparent Injury Location: Resident's room Activity at the time: Transferring Assessment Supporting Intervention: ongoing review of care plan. A handwritten note in this section includes 2nd set of gripper strips in front of bed, update care plan with care refusal. 7/25/22 1:09PM Nurses Notes: Follow-up of Incident: Observed on floor 7/22/22, resident was sitting up on edge of bed, unassisted as per his usual choice, lifted his leg to take off his pajama pants and slipped off the edge of the bed to the floor. Resident has grab bar in place as well as one set of gripper strips in front of bed. Injury: No apparent injury. Actions: .IDT Team review: Room assessment shows gripper strips in place on floor in front of bed, these possibly do not cover the entire surface area of where his feet potentially could end up when attempting to self-transfer or perform ADLs independently. Will have maintenance place a second set of strips adjacent to current set. Also care plan updated to reflect his continued refusals for help even when staff comes in to attempt to intervene and assist when noted to be unsafe, he will yell and say to get out of here, I'm fine, I don't want help 7/26/22 4:00PM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: Skin tear Laceration Resident verbalized that he bit (documentation ends here) . Location: left arm Measurement: 1 cm x 0.5cm First Aid: Immediately applied Location: Bathroom Activity at the time: Toileting Assessment Supporting Intervention: Resident verbalized that he fell over his walker 7/28/22 11:55AM Nurses Notes: Follow-up of Incident: Observed on floor 7/26/22, observed on the floor in his BR (bathroom), stated his walker fell over causing him to fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Injury: Laceration left upper lip, states he bit it while falling, however blood was noted on the toilet bowl leading to the conclusion he may have struck his face on the toilet, Skin tear: left forearm. Actions: .IDT team review met with case worker from [Name] 7/27/22, discussed R28 at length and challenges with R28's self-determination leading to his numerous falls and the risk that places him at for major injuries .Also discussed his POA and unwillingness to meet with our IDT team to further discuss care plan and challenges. Case worker will be reaching out to the POA as well as asking his supervisory team to review R28's case and offer any suggestions for fall management .Monitoring with R28 will be ongoing and falls are anticipated and unavoidable related to his self determination to continue to remain independent, goal continues to remain at prevention of injury. 7/27/22 1:45PM Incident Report, includes, in part: Incident Type: Witnessed fall Injury: No apparent injury Location: Dining room Activity at the time: Transferring Assessment Supporting Intervention: IDT to review 7/28/22 12:51PM Nurses Notes: Follow-up of Incident: Witnessed fall 7/27/22 in the dining room while getting up from his chair. Injury: Other (Specify): did strike the back of his head on the shelf of a metal cart that was nearby [sic], resident was adamant that he did not hit his head, even though this was witnessed and did not want his POA contacted or told he had struck his head. Actions: .IDT team review: R28 continues to have multiple falls, will place gripper strips in DR (dining room) in front of his chair he always sits in and will place chair up against the wall to help prevent the chair from tipping when he is getting up as he does not allow assist with this. 7/30/22 8:10PM Incident Report, includes, in part: Incident Type: Observed on floor by staff but witnessed by Injury: No apparent injury. Location: complains of neck hurting Location: Activity room Activity at the time: Transferring from chair to standing First Aid: Neuro checks WNL (within normal limits) no apparent injury but does state it hurts to turn his head. Transferred to emergency room (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Assessment Supporting Intervention: send to ER 7/31/22 5:25PM Incident Report, includes, in part: Incident Type: Witnessed Fall Injury: No apparent injury Location: Hallway Activity at the time: Walking Assessment Supporting Intervention: Per staff resident sped out his room after being assisted, took a sharp turn in his doorway, and stumbled to the floor. 8/1/22 11:43AM Nurses Notes: Follow-up of Incident: Observed on floor 7/30/22 @ 8:10PM Witnessed fall 7/31/22 at 5:25 PM. Injury: c/o neck pain and right knee pain. IDT team review: Numerous interventions are in place for R28, continues to ambulate unsafely without assist. Most recent falls are 7/30 and 7/31 after which he was c/o neck pain and knee pain. Seen in ED 7/30/22 and discharged in the AM on 7/31/22. Multiple scans performed in the ED, including CT head/c-spine, which were negative but limited d/t motion artifact as R28 was being uncooperative .R28 told the ED MD he feels he may have blacked out, [sic] EKG (Electrocardiogram) performed NSR (Normal Sinus Rhythm) with right BBB (Bundle Branch Block), recommendation is to have [NAME] monitor placed at [Name] Clinic on outpatient basis to r/o (rule out) cardiac causes. Staff will continue to attempt to intervene and assist as R28 will allow and outpatient visit at [Name] clinic for f/u (follow-up) is pending. August 2022: 8/1/22 2:25PM Incident Report, includes, in part: Incident Type: Witnessed Fall. Injury: No apparent injury Location: Hallway Activity at the time: Walking Assessment Supporting Intervention: Resident was leaving shower room, he attempted to close the door, the shoe on his right foot came off he tried to put his foot back in it, but he started stumbling and fell backward. 8/1/22 4:39PM Incident Report, includes, in part: Incident Type: Observed on Floor (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Injury: Laceration bridge of nose and linear in his hair line. Location: face and head. Measurement: R28 refused any assessment Location: Resident's Room Activity at the time: Transferring trying to pick up a clock that he had dropped First Aid: pressure dressing to nose and head immediately applied. Transferred to emergency room . 8/2/22 3:55PM Nurses Notes: Follow-up of Incident: Observed on floor 8/1/22 @ 4:39PM Witnessed fall 8/1/22 @ 2:25PM falls x 2 this date. resident continues to be unsafe to ambulate, sent to ED via ambulance after 2nd fall this date with possible head injury. New scans were obtained and do show a C5 spinous process fracture which is new compared to previous studies from 7/2022, non-concerning per ED MD assessment. Multiple recent falls, including a fall this AM 8/2/2022 .R28 was unable to stand unassisted at that time, he was placed in a w/c and extensive education given regarding w/c safety and the need for R28 to call for assist with all transfers and ADLs (Activities of Daily Living), very reluctant but did concede to this. So far this date he has been compliant with w/c use. After multiple attempts by floor RN staff the POA was updated on his condition and appears to be in agreement with change of care plan . An emergency room note for R28, dated 8/1/22, indicates, in part, the following: Chief Complaint: States trip and fall and has hematoma to head and abrasion to the nose. History of Present Illness: R28 .presenting via ambulance following a repeat fall .On 7/30/22 he had a witnessed fall in the common area of the nursing home at approximately 2005 (8:05PM). After the fall he was able to get up and use his walker and go back to his room. Nursing home has called the ambulance this evening because patient had an unwitnessed fall. He struck his head; he has a nasal abrasion .Patient has told us about a cervical spine fracture in the past and this is included on his [Name] Clinic documentation/problem list . Physical Exam: .He has a large area of contusion on the mid cranial scalp region .Neck: Supple, non-tender. There is no palpable step-off .Skin: Large area of contusion at this cranial scalp and an abrasion to his nose . Assessment/Plan: 1. Fracture of cervical spinous process .Patient has a new C5 spinous process fracture compared to studies from late July 2022 also done at this facility. Dr. [Name], radiologist, has reviewed images from late July and from today. He this [sic] is a stable fracture because he has previous cervical spine fusion. Neurosurgeon, Dr. [name] .has reviewed patient history and at this time indicates that pain control only is indicated at this time. No collar is indicated. Because of patient's previous history of spinal fusion patient should have imaging of his neck if he has a fall that is unwitnessed . Impression CT Cervical: 1. C5 spinous process fracture extending into the inferior articular facets. 2. Otherwise, no acute displaced osseous injury or traumatic malalignment . 8/2/22 8:15AM Incident Report, includes, in part: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Incident Type: Observed on Floor Injury: No apparent injury Location: Bathroom Activity at the time: Walking Assessment Supporting Intervention: R28 is unsteady on his feet and his walker is not sufficient to aid his steadiness. IDT to review. 8/2/22 9:30PM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: No apparent injury Location: Resident's room Activity at the time: Transferring Assessment Supporting Intervention: Resident did not use his call light for assistance, resident attempted self-transferred [sic] from bed to wheelchair. 8/3/22 4:00AM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: No apparent injury Location: Resident's room Activity at the time: Walking Assessment Supporting Intervention: resident walked around w/c which was at bedside and fell behind it when attempting to walk to the bathroom. Non-skid strips by toilet. 8/3/22 7:45AM Incident Report, includes, in part: Incident Type: Witnessed fall - did not hit head Injury: Laceration. Location: dorsal side of left hand. Measurement: 1.25cm long. Location: Resident's room Activity at the time: Transferring First Aid: Immediately applied (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Assessment Supporting Intervention: IDT to review 8/4/22 3:16PM Nurses Notes: Follow-up of Incident: Observed on floor 8/2/22 @ 8:15am, observed on floor 8/3/22 @ 4:00AM, and Witnessed fall 8/3/22 @ 7:45AM. Actions: .IDT team review: R28 has agreed to w/c us [sic] and requesting staff assist as he is too weak and unstable to provide cares for himself, he is weak and unsteady to the point he cannot [sic] sit up at bedside unassisted and this is believed to be the cause of his falls on 8/3/22, extensive education to R28 by this writer on 8/3/22 that he must remain in the laying position in bed and wait until staff arrive to the room to assist him up and out of bed .He states understanding and has been compliant over the last 36 hours. Care Conference with Managed Care team, POA and IDT scheduled for 8/8/22 . 8/4/22 8:17PM Incident Report, includes, in part: Incident Type: Observed on floor Injury: Skin tear. Location: Right elbow. Measurement: 1cm x 1 cm Location: Resident's room Activity at the time: Transferring First Aid: Immediately applied Assessment Supporting Intervention: Resident verbalized that he slipped out of his wheelchair. 8/6/22 7:00PM Incident Report, includes, in part: Incident Type: Observed on floor Injury: No apparent injury Location: Bathroom Activity at the time: Transferring Assessment Supporting Intervention: Resident resistive to recommended treatment and care. 8/9/22 7:40AM Incident Report, includes, in part: Incident Type: Witnessed Fall Injury: Skin tear. Location: Left Forearm. Measurement: 1.2cm x 1cm. Location: Resident's room (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Activity at the time: Transferring First Aid: Immediately applied skin flap in place, wound cleansed, xeroform placed and covered with 4x4 gauze, wrapped with kerlix. Assessment Supporting Intervention: IDT to review 8/9/22 6:00PM Incident Report, includes, in part: Incident Type: Observed on Floor Injury: Laceration. Location: right forehead. Measurement: 1 cm x 1 cm x .2cm. Location: Bathroom Activity at the time: washing his hands in the sink First Aid: Immediately applied Assessment Supporting Intervention: Resident has his of nonuse [sic] of his push button call light. 8/10/22 12:15PM Nurses Notes include, in part: Spoke with R28 at great length this am about concerns for his floors in his room are slippery and difficult to dry when wet both in his bathroom and room. Did show him an alternative room with floors not as slippery and closer to writer's office to allow more access for assist and he was stern about staying where he is. Did discuss risk vs benefits but he states he is not moving. Also reviewed his daily routine in detail to present a visual itinerary for both the staff and resident to review and plan when he is of need for assistance closer. Will print this up on bright colored paper to alert for reminders. R28 states he does not intend to call for help all the time as he can do it himself and is in denial of needing help .Reviewed the care plan with him and he states he does not need all of that on there for assist with cares and became assertive. Discussed bathroom floor being extra slippery when he uses the soap dispenser, and it falls to the floor, and he washes up getting floor very wet with standing water and soap. To try to provide him a hand pump soap dispenser that he may be able to manage better. Incident Report, includes, in part: 8/11/22 6:45PM: Incident Type: Witnessed Fall Injury: Skin tear. Location: left arm posterior. Measurement: 1cm x 1cm. Location: Activity room Activity at the time: I was trying to move the chair First Aid: Immediately applied (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Assessment Supporting Intervention: Resident verbalized that he was moving a chair that was in his way. 8/19/22 3:41PM late entry for 8/18/22 Nurses notes: Follow-up of Incident: Witnessed fall, 8/17/22, fell backwards into the toilet tank. Injury: Abrasion: mid lumbar region. Actions: .IDT team review: . [Initials] was with resident in bathroom, stated she left bathroom to retrieve linen items, on her return she observed R28 to be standing up from the toilet without assist in her absence, witnessed him to fall backwards striking his back on the toilet tank. RN had requested maintenance to pad toilet tank, this request was cancelled by this writer as this is unsanitary and will not prevent falls, root cause is him being left unattended in the bathroom, care plan update [TRUNCATED]

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45695 Based on observation, interview and record review the facility did not ensure medication error rates are not 5% or greater during medication administration, this affected 2 of 4 Residents (R8 and R12) observed for medication pass. The facility medication error rate was 6.45%, for 2 errors out of 31 opportunities. R8 and R12 were administered their scheduled medication an hour early. This is evidenced by: The facility's policy titled Medication Administration Scheduling Guidelines, revision date 5/19, states in part: . 2. The nurse will schedule meds on a liberal basis in order for the resident to maintain as normal or similar past routine as possible yet being mindful of pharmacologic properties of the meds. The following standard medication administration times are utilized unless specifically ordered/requested otherwise by the physician or the resident (Note: Nursing staff passing medications which are not specifically time-ordered by the doctor are considered in compliance for the AM (morning), Noon, PM (afternoon), Bedtime and NOC (night) medication passes if the medications are administered within the following time frames and according to the resident's individualized plan of care): . AM 0700 to 1030 (7:00AM to 10:30AM) . Example 1: R8 was admitted on [DATE] with a diagnosis that include Immune thrombocytopenic purpura, Peripheral Vascular Disease, Restless Leg Syndrome, Gout and Chronic Respiratory Failure. R8's Physician Orders, provided to Surveyor on 1/11/23, states in part: Omeprazole 20mg (milligram) Capsule Delayed Release dose ordered: (1 capsule/20mg) by mouth daily 1000 (10:00AM). On 1/10/23 at 8:02 AM, Surveyor observed LPN F (Licensed Practical Nurse) prepare R8's morning medications for administration. During this observation LPN F prepared R8's Omeprazole 20mg capsule delayed release that is scheduled for 10:00 AM. Surveyor observed LPN F administer the prepared morning medications to R8 at 8:06 AM. On 1/10/23 at 1:36 PM, Surveyor interviewed LPN F. Surveyor asked LPN F the time parameters for scheduled medication administration, LPN F replied an hour before to an hour after the scheduled time. Surveyor asked LPN F to view R8's order in the MAR (Medication Administration Record) of the Omeprazole. Surveyor asked LPN F what time should R8's Omeprazole should have been administered, LPN F replied it is scheduled for 10:00 AM and so it should have been given between 9:00 AM- 11:00 AM. Example 2: R12 was admitted on [DATE] with a diagnosis that include Pathological fracture, left femur, restless leg syndrome, and Type 1 Diabetes Mellitus with Diabetic Neuropathy. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Physician Order, provided to Surveyor on 1/11/23, states in part: Acetaminophen 325mg table dose ordered: (2 tablet/650mg) by mouth every 6 hours 1600 (4:00 PM), 2200 (10:00 PM), 0400 (4:00 AM), 1000 (10:00 AM) For: pain and /or fever. Therapeutic Goal: Reduced pain, fever. On 1/10/23 at 8:05 AM, Surveyor observed RN G (Registered Nurse) prepare R12's morning medications for administration. During the observation, RN G prepared R12's Acetaminophen 325mg, 2 tablets that is scheduled for 10:00 AM. Surveyor observed RN G administer the prepared morning medications to R12 at 8:05 AM. On 1/10/23 at 1:30 PM, Surveyor interviewed RN G (Registered Nurse) and asked when a medication should be administered if it is ordered at a specific time. RN G replied, an hour before or after that time. Surveyor asked RN G what time R12's acetaminophen was ordered. RN G replied, 10:00 AM. Surveyor asked RN G if the acetaminophen should have been given at 8:05 AM, RN G replied no. On 1/11/23 at 2:50 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B the expectation of a scheduled medication time to be administered, DON B replied one hour before and one hour after the scheduled time. Surveyor asked DON B, if a medication is ordered for 10:00 AM, what time should the medication be administered. DON B replied to the Surveyor between 9:00 AM-11:00 AM. Surveyor explained to DON B R8 and R12's scheduled 10:00 AM medication administration. Surveyor asked DON B if R8 and R12 should have received their medication an hour prior to the time frame between 9:00 AM- 11:00 AM, DON B replied no.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36253 Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect all 42 residents. Food items were not dated and stored correctly. Facility equipment was visibly dirty. Kitchen staff were observed without hair coverings. Findings include Example 1 On 1/09/23 at 11:47 AM, Surveyor observed the following along with CDM D (Certified Dietary Manager): * 2 half consumed one-gallon containers of milk with use by date of 1/22/23 and no open date. * 2 opened bags of macaroni pasta with no open dates. * 1 container of white granulated sugar with and 1 container of cheerios, both with styrofoam scoops lying on top. CDM D stated all opened items should be dated and the facility policy is to discard milk on the use by date or 3 days after opening. CDM D also stated scoops should never be stored with food items as it can be a cross contamination issue. Example 2 On 1/9/23 at 11:50 AM, Surveyor, along with CDM D, observed the facility kitchen's hood vents to be completely covered with visible clumps of grease an dust. Facility staff was observed cooking food directly under the hood vents. CDM D stated she too noticed the dirty hood vents, which is why she looked to find out when the next cleaning was due, which was not scheduled until April 2023. Example 3 On 1/9/23 at 11:58 AM, Surveyor, along with CDM D, observed DA E (Dietary Aide) with a visibly long beard, but was not wearing a beard net. DA E was observed cooking and plating food without a beard net. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CDM D stated it was probably best practice to always wear a beard net, even though state code is any beard over a half inch. CDM D also stated that she did not measure, or have a way to measure, DA E's beard.