STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menomonee Falls Health Services	N84 W17049 Menomonee Ave Menomonee Falls, WI 53051

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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 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** 20483 Based on interview and record review the Facility did not ensure 1 (R3) of 3 Residents had accurate MDS (Minimum Data Set) assessments. * R3's significant change MDS with an assessment reference date of 3/12/21 was inaccurate for staging R3's pressure injury. Findings include: R3 was admitted to the facility on [DATE] for short term rehab without any pressure injuries. The wound evaluation for date of wound data collection is documented as 2/26/21. Site is documented as 53) sacrum, type pressure, length 4.91, width 4.52, depth 2 and Stage is documented as Unstageable. For the question when was the wound identified documents, 02/26/2021. Under the exudate section for color/type documents seropurulent, consistency Thin, watery, Amount Large/copious, and Odor Foul. The Wound bed is 40% granulation, 5% slough and 55% necrotic. The wound evaluation for date of wound data collection 03/05/2021 documents length 6.33, width 7.85, and depth 3.3. Under staging documents IV (4). Under the exudate section for color/type documents serous, consistency Thin, watery, Amount moderate, and Odor not present. The Wound bed is 45% granulation, 15% slough and 40% necrotic. WD (Wound Doctor)-M sacrum wound assessment dated [DATE] documents length 6.33 cm (centimeter), width 7.85 cm and depth 3.3 cm. Etiology is documented as Pressure Ulcer - Stage 4. The significant change MDS with an assessment reference date of 3/12/21 under Section M0300 Current number of unhealed pressure ulcers at each stage for D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. 0 is coded for number of stage 4 pressure ulcers. F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1 is coded for number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted R3's sacrum pressure injury assessment on 3/5/21 indicates R3's pressure injury is Stage 4 and was incorrectly coded on the significant change MDS. On 7/27/21 at 1:36 p.m. Surveyor asked Corporate RN (Registered Nurse)-H who the MDS nurse is as Surveyor would like to speak with them. Corporate RN-H informed Surveyor the Facility currently does not have an MDS nurse and staff from other buildings are supporting. Surveyor informed Corporate RN-H R3's significant change MDS with an assessment reference date of 3/12/21 codes R3's pressure injury as unstageable but the 3/5/21 wound evaluation documents the pressure injury is Stage 4 and WD-M's wound evaluation dated 3/8/21 also documents Stage 4. At 1:44 p.m. Corporate RN-H telephoned DCR (Director of Clinical Reimbursement)-O and placed the call on speaker. DCR-O was informed there was a significant change MDS with an assessment reference date of 3/12/21 with a pressure injury being coded as unstageable. The Facility wound assessment on 3/5/21 and WD-M's wound evaluation on 3/8/21 documents the pressure injury as Stage 4. DCR-O indicated the pressure injury should have been coded as a stage 4 and they would modify the MDS.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on record review and interview the Facility did not ensure 1 (R2) of 1 Residents with non pressure injuries received the necessary care and treatment. On 7/20/21 LPN (Licensed Practical Nurse)-D did not cover R2's entire surgical wound during the treatment observation. An assessment of R2's surgical wound was not completed during the week of July 11 through July 17, 2021. On 7/6/21 R2 was identified as having a skin tear to the right buttocks. This area was not measured or assessed and the treatment did not start until 7/12/21. Findings include: The Skin Tears - Abrasion and Minor Breaks, Care of policy and procedure from 2001 Med-Pass Inc. (Revised September 2013) under the section documentation documents Record the following information in the resident's medical record: 1. Complete in-house investigation of causation. 2. Initiate the Weekly Wound UDA in the electronic medical record. 3. Document physician and family notification, and resident education (if completed) in medical record. 4. How the resident tolerated the procedure. 4. Any problems or resident complaints related to the procedure. 5. Any complications related to the abrasion (e.g. pain, redness, drainage, swelling, bleeding, decreased movement). 6. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. 7. Interventions implemented or modified to prevent additional abrasions (e.g. clothes that cover arms and legs). 8. When an abrasion/skin tear/bruise is discovered complete a Report of Incident/Accident. R2 was admitted to the facility on [DATE] with surgical wounds on his left lateral and left medial calf. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 5/21/21 documents Resident monitored for new admit Left lower leg fasciotomy. Wrapping intact leg elevated on and off during the night encouraged to keep leg elevated. PRN (as needed) Tylenol given for comfort and was effective. Will continue to monitor. Fasciotomy is a surgery to relieve swelling and pressure in a compartment of the body. Surveyor noted weekly wound assessment of R2's left medial calf and left lateral calf surgical wounds with the latest assessment dated [DATE]. R2's left medial calf wound evaluation dated 7/9/21 documents length 13, width 6.8, and depth 0.4. The description for the wound bed has not been completed. R2's left lateral calf wound evaluation dated 7/9/21 documents length 24, width 9, and depth 0.3. The description for the wound bed has not been completed. Surveyor noted during the week of 7/11/21 to 7/17/21 R2's left medial calf and left lateral calf surgical wounds were not assessed. On 7/21/21 at 12:51 p.m. Surveyor asked LPN-G if she was working at the Facility last week (7/11/21 to 7/17/21). LPN-G replied no and explained she was on vacation. Surveyor informed LPN-G of not being able to locate any skin assessments when she was on vacation. On 7/20/21 at 11:44 a.m. Surveyor entered R2's room with LPN (Licensed Practical Nurse)-D. Surveyor observed R2 was sitting on the edge of his bed. LPN-D cleaned off the over bed table and placed treatment supplies on the over bed table. R2 placed a pillow behind his head, took off his shirt stating he has shortness of breath. LPN-D informed R2 when he (R2) was set to hit his button, as he (LPN-D) was going to get someone to help lift his (R2's) leg and left R2's room. At 11:51 a.m. R2 placed his call light on. At 11:55 a.m. LPN-D, CNA (Certified Nursing Assistant)-I and CNA-J entered R2's room and placed gloves on. CNA-I & CNA-J assisted R2 with moving his lower extremities further onto the bed. CNA-J then held up R2's left leg while LPN-D started to unwrap the ace bandage from R2's left lower leg. At 11:58 a.m. CNA-I started to hold up R2's left leg up and LPN-D removed the kerlix from R2's left lower leg. LPN-D removed the tape and abdominal pads from R2's left medial and lateral surgical wounds. LPN-D removed his gloves, moved the over bed table closer, and placed gloves on. LPN-D removed the gauze from R2's medial and lateral surgical wounds. LPN-D cleansed the medial and lateral surgical wound with Dakins 0.25%, removed his gloves and placed gloves on. LPN-D poured Dakins into three gauze sponge packages, pressed on the dressings to disperse the Dakins, and then placed the Dakins soaked gauze over R2's left medial surgical wound, covering the entire wound. LPN-D opened gauze sponge packages and poured Dakins into the packages. LPN-D placed an abdominal pad over R2's medial surgical wound, pressed on the gauze sponge packages with Dakins to disperse the Dakins and placed the gauze sponge over R2's left lateral surgical wound. Surveyor noted on R2's left lateral surgical wound there is approximately one inch on the proximal (top) uncovered with Dakins soaked gauze and approximately two inches on the distal (bottom) portion of R2's left lateral surgical wound not covered with the Dakins soaked gauze pad. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-D placed two abdominal pads over R2's left lateral surgical wound. The abdominal pad did not cover approximately two inches on the distal portion of R2's left lateral surgical wound. LPN-D wrapped R2's left lower leg with kerlix. The kerlix wrap did not cover approximately two inches distal portion of R2's left lateral surgical wound. LPN-D then wrapped the left lateral leg with an ace wrap. The box which LPN-D removed the ace wrap only had one ace wrap and this ace wrap was not long enough to cover all the kerlix wrap and the distal portion of R2's left lateral calf surgical wound. On 7/21/21 at 3:04 p.m. Surveyor asked Interim DON (Director of Nursing)-B when a nurse is doing a treatment should any of the wound be left uncovered. Interim DON-B replied no and explained in doing the treatment you are trying to safe guard the wound bed. Surveyor informed Interim DON-B of the observation on 7/20/21 during R2's treatment a portion of the wound bed was not covered by the dressing. The weekly skin review dated 7/6/21 documents for site 31) Right buttock Under description documents ST (skin tear) dt (due to) moisture tx. (treatment) obtained from MD (medical doctor). Surveyor reviewed R2's July 2021 TAR (treatment administration record) and noted the treatment for R2's right inner buttocks did not start until 7/12/21. The treatment is document as Zinc Oxide Paste 25% Apply to Inner R (right) buttocks topically two times a day for wound healing Apply cream to R inner buttock. The weekly skin review dated 7/13/21 documents under site 31) Right buttock. Under description ST d/t moisture tx obtained from MD. On 7/21/21 at 12:15 p.m. Surveyor asked LPN-G, who is the Facility's wound nurse, about R2's skin tear on his right buttocks which was identified on 7/6/21. Surveyor informed LPN-G Surveyor was not able to locate measurements or an assessment of this area. LPN-G informed Surveyor she has not seen the area and R2 has been asleep all morning. Surveyor asked LPN-G if this area is something she would look at. LPN-G replied, yes, but I didn't know about it. LPN-G informed Surveyor who ever identified the area should have written a note, measured and started a wound tracker. On 7/21/21 at 2:06 p.m. Surveyor asked LPN-G how she becomes aware of an impairment in a Resident's skin integrity. LPN-G informed Surveyor the staff would tell her or she reviews the skin assessments and progress notes. Surveyor informed LPN-G there isn't any documentation in R2's progress notes regarding the skin tear on his right buttocks. LPN-G informed Surveyor this is where she would get the information and nothing was brought to her attention. LPN-G informed Surveyor R2 refused to have her look at his buttocks today.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview, record review and observation, the facility did not ensure that a resident who entered the facility without a Pressure Injury (PI) did not develop a PI and received appropriate care, treatment and preventative measures to promote healing for 2 (R3 & R6) of 3 Residents reviewed for pressure injuries. R3 was admitted to the facility on [DATE] for short term rehab without any pressure injuries. On 2/7/21, R3 was identified with a small open area. There was no assessment of this open area. The weekly skin review dated 2/11/21 noted R3 had a previously existing pressure injury to the coccyx but no other open areas. There was no assessment of R3's pressure injury on 2/11/21. On 2/15/21, 8 days later, NP (Nurse Practitioner)- K was made aware of coccyx open area and a nurses notes indicates NP-K would refer to wound team and wound doctor. There was no weekly skin review completed during the week of 2/14/21 through 2/20/21. A wound assessment was not completed by Facility staff or WD (Wound Doctor)-M until 2/26/21 at which time R3's pressure injury was unstageable and had a foul odor. This assessment was 19 days after being identified as a small open area. WD-M informed Surveyor it was a significant injury when he saw the pressure injury on 2/26/21 and was not aware of R3's pressure injury until 2/26/21. R3's pressure injury declined and on 3/5/21 the Facility's wound evaluation documented Stage 4. WD-M's wound assessment on 3/8/21 documents R3's sacrum pressure injury as Stage 4. R3's skin integrity care plan was not revised when the pressure injury was identified and when there was a decline in the pressure injury. R3's nurses note dated 3/10/21 documents R3 was placed on antibiotic therapy for the coccyx wound. On 3/20/21 R3's lab showed R3 was positive for C-diff and was started on Vancomycin. The Facility's failure to assess R3's small open area for 19 days, at which time it was assessed as unstageable with 5% slough and 55% necrotic wound bed and a foul odor, failure to implement appropriate interventions to facilitate healing and prevent further deterioration of the pressure injury, and the failure to consult with the Physician when the pressure injury was first identified, created a finding of Immediate Jeopardy (IJ) which began on 2/7/21. The Surveyor notified Administrator-A, Interim DON (Director of Nursing)-B, and Corporate RN (Registered Nurse)-H on 7/21/21 at 11:30 a.m. The immediate jeopardy was removed on 7/23/21. The deficient practice continues at a scope and severity of a G (harm/isolated) as the facility continues to implement its action plan and as evidenced by; * R6 developed a left heel pressure injury on 4/22/20. The facility did not assess R6's left heel Stage 4 pressure injury from 4/30/21 to 5/14/21, during which time the left heel pressure injury increased in size and went from an unstageable pressure injury to a Stage 4 pressure injury. The Wound Evaluation Tracker assessment dated [DATE] did not document the amount of Granulation or Slough in the wound bed. The facility did not assess R6's left heel during the week of 7/11/21 - 7/17/21. * R3 developed a blister to the right heel on 6/22/21. There was no description or measurement of the wound until 6/25/21. On that date, the wound nurse (LPN-G) incorrectly described the wound as unstageable. The facility did not assess the left heel from 7/11/21 - 7/17/21. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: The Pressure Ulcer/Injury, Prevention of policy and procedure with an original effective date of June 2017 under the section documentation guidelines indicates; Documentation may include: * Date, time, approaches to prevent pressure ulcer/injury development. * Prevention equipment used. * Condition of the resident's skin. * Physician notification when change in skin condition is observed. * If a pressure ulcer/injury is present, the Licensed Nurse is responsible to record condition of the skin, including stage, size, site, depth, color drainage and odor as well as the treatment provided. Notification of the physician is required when a new pressure ulcer/injury is identified as well as when treatment is not effective. * Signature and title. 1. R3 was admitted to the facility on [DATE] for short term rehab without any pressure injuries. R3 does not have an activated power of attorney. Diagnoses includes Congestive heart failure, coronary artery disease, hypertension, and atrial fibrillation. The admission evaluation dated 1/21/21 includes a Braden assessment with a score of 14. A score of 13-14 indicates moderate risk. Under the skin integrity section there is no documentation of any skin impairments. The admission MDS (Minimum Data Set) with an assessment reference date of 1/26/21 documents a BIMS (Brief Interview Mental Status) score of 15 which indicates cognitively intact. R3 requires extensive assistance with two plus person physical assist for bed mobility, is dependent with two plus person physical assist for transfer, is dependent with one person physical assist for toilet use, and does not ambulate. R3 is coded as having an indwelling catheter and is always incontinent of bowel. R3 is at risk for pressure injury development and is coded as not having any pressure injuries. The admission pressure injury CAA (Care Area Assessment) under analysis of findings documents; Skin is checked upon admission during cares, toileting and bathing. Skin audit upon admission shows no skin concerns. [R3] admitted to facility for therapy after recent hospitalization for CHF (congestive heart failure). Therapy is in place and [R3] plans to return to previous living arrangements upon completion. Extensive to total assistance with ADL's (activities daily living) as per POC (plan of care) documentation. [R3] remains at risk for development of pressure area due to his dependency on staff for cares. [R3] continues to have a Foley catheter in place and is incontinent of bowel. A toileting program has been implemented. Skin prevention interventions are currently in place. The weekly skin review dated 1/28/21 is checked for skin intact. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The At risk for Skin Integrity Condition or Pressure Sores r/t (related to) Impaired mobility, Incontinence Care Plan initiated & revised 2/1/21 documents the following interventions: * Apply pressure reduction chair cushion on wheelchair and pressure reduction mattress on the bed. Ensure cushion is properly placed, clean and dry. Initiated 2/1/21. * Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately. Initiated 2/1/21. * Avoid friction/shearing while repositioning: if Resident is unable to assist, use at least two staff members, use lift sheet, bed should be as flat as possible with lifting. Initiated 2/1/21 & revised 7/2/21. * Conduct pressure injury skin assessments (i.e. Braden scale) as indicated. Initiated 2/1/21. * Frequent repositioning in bed. Initiated 2/1/21 & revised 7/2/21. * Head to toe assessment by Licensed Nurse performed weekly at minimum. Initiated 2/1/21. * Keep Resident clean and dry. Use barrier cream after good peri-care. Apply proper incontinent products as indicated. Initiated 2/1/21 and revised 7/2/21. * Labs and antibiotics as ordered. Initiated 3/10/21. * Provide treatments as ordered. Initiated 3/10/21. * Encourage the use of pressure relieving boots while in bed. Initiated 5/6/21 & revised 7/2/21. The weekly skin review dated 2/4/21 includes documentation of no new open areas noted. The Braden assessment dated [DATE] has a score of 16 which indicates is at risk for pressure injury development. The daily skilled note by LPN-F dated 2/7/21 under summary documents, Resident is doing well. A small open area was found on the resident coccyx this AM (morning) it was cleansed and dressed. There was no assessment, including an RN (Registered Nurse) assessment, of the small open area including measurements and description of wound bed. R3's skin integrity care plan was not revised and there is no notification to the physician. On 7/21/21 at 7:47 a.m. Surveyor asked LPN-F what type of dressing did she apply on 2/7/21. LPN-F informed Surveyor if she was to guess just a bordered gauze at the time or foamy kind of. Surveyor asked if she notified anyone of the pressure injury. LPN-F replied, I'm sure I must have. I don't remember. Surveyor asked how she became aware of the pressure injury. LPN-F replied, I don't remember and then informed Surveyor she probably would have told the DON but doesn't remember what she did back in February. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated 2/8/21 documents, Isolation maintained throughout first and second shift as a covid precaution no fever cough or shortness of breath. Dressing on coccyx is CDI (clean dry intact). The nurses note dated 2/10/21 documents, Isolation precautions maintained during shift, no respiratory distress. Coccyx wound has no drainage during night, resident repositioned off coccyx. The NP progress note dated 2/10/21 under physical exam for skin documents, no rashes or lesions noted. This NP progress note does not address R3's pressure injury. The Braden assessment dated [DATE] has a score of 11 which indicates high risk for pressure injury development. The weekly skin review dated 2/11/21 documents, no new open areas aside from coccyx that is being treated. OA (open areas) and pre existing are checked. The nurses note dated 2/12/21 documents, Repositioned as PPOC (personal plan of care). Excoriation remains to buttocks. Incontinent care provided. [NAME] barrier cream applied f/b (followed by) abd (abdominal) pad. The nurses note dated 2/14/21 documents, Barrier cream applied to coccyx. Repositioned per protocol. The nurses note dated 2/15/21 documents, Writer spoke with NP -K regarding Dx. (diagnosis) for Foley cath (catheter), NP made aware of coccyx open area, will refer to wound team and wound Dr. NOR (new order received) for Tylenol 650 mg (milligram) PRN (as needed) pain/fever. Surveyor noted this notification is 8 days after R3 was identified as having a small open area. The daily skilled note dated 2/17/21 includes documentation of Skin turgor: Extremely dry - tenting 4+ (plus) sec. (seconds). Skin conditions: Pressure area(s). open area on coccyx. order was given to dress with hydra blue, abd (abdominal) and tape until the resident sees the wound Dr. on Friday Skin integrity/positioning devices: Heel Relief/Protector/Lift Chair/Seat Cushion. open area on coccyx. The nurses note dated 2/17/21 documents, Dressing was changed today per order from NP-K wound was cleansed with dakins and dressed with hydra blue, abd (abdominal) pads and tap (tape). dressing to remain in place until Friday when resident will be seen by wound Dr. The NP progress note dated 2/17/21 under new orders documents, 1. Labs order for tomorrow. 2. Wound care consult. Under physical exam for skin documents No rashes or lesions noted. This progress note does not include an assessment of R3's pressure injury. There was no weekly skin review dated 2/18/21 or at any other time during this week. The nurses note dated 2/18/21 documents, NP updated on labs. Cleansed coccyx area and applied dry bandage. Turned and repositioned from side to side. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses noted dated 2/19/21 documents, Dressing on coccyx was CDI throughout first and second shift wound Dr. will be here Monday to see resident. The nurses note dated 2/23/21 documents, Dressing on coccyx is clean dry and intact. No complaints of pain related to fall, MD (Medical Doctor) notified. The NP progress note dated 2/24/21 documents under physical exam for skin no rashes or lesions. This NP progress note does not address R3's pressure injury. The nurses note dated 2/25/21 documents, Necrosis noted coccyx open wound. Repositioned side to side. wet to dry dressing applied. Surveyor reviewed the February 2021 TAR (Treatment Administration Record) and noted a treatment with a start date of 2/26/21 and discontinued on 3/3/21 for the PM (evening) shift of Coccyx OA (open area) Remove packing material Skin prep peri wound, pack wound with Dakins' soaked gauze, cover with Bordered gauze, change q (every) day until healed. One time a day for wound healing. The next treatment listed on the February 2021 TAR with a start date of 2/27/21 and discontinued on 3/8/21 for the AM (morning) shift of Santyl Ointment 250 unit/gm (gram) (Collagenase) Apply to Coccyx topically one time a day for wound healing. Coccyx: Cleanse with Dakins', pat dry, skin prep peri wound, apply Santyl to wound base, pack wound with Dakins' soaked gauze, cover with Bordered gauze change q day until healed. Surveyor noted there are no other treatments on the February 2021 TAR. The wound evaluation for date of wound data collection is documented as 2/26/21. Site is documented as; 53) sacrum, type pressure, length 4.91, width 4.52, depth 2 and Stage is documented as Unstageable. For the question when was the wound identified documents 02/26/2021. Under the exudate section for color/type documents, seropurulent, consistency Thin, watery, Amount Large/copious, and Odor Foul. The Wound bed is 40% granulation, 5% slough and 55% necrotic. Date of treatment ordered documents 02/26/2021. Under current wound status/additional comments documents, debrided by wound MD (Medical Doctor) this shift. This assessment was signed on 4/27/21 by LPN (Licensed Practical Nurse)-G. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted this is the first assessment (2/26/21) of R3's pressure injury, and this assessment did not occur until 19 days after it was identified as a small open area on 2/7/21. There was no revision of R3's skin integrity care plan during that time period. The wound evaluation for date of wound data collection 03/05/2021 documents, length 6.33, width 7.85, and depth 3.3. Under staging documents, IV (4). Under the exudate section for color/type documents serous, consistency Thin, watery, Amount moderate, and Odor not present. The Wound bed is 45% granulation, 15% slough and 40% necrotic. Date of treatment ordered documents 02/26/2021. Under current wound status/additional comments is blank. This assessment was signed on 4/27/21 by an RN (Registered Nurse) who is no longer employed by the Facility. Although the measurements of R3's pressure injury have increased and is now a Stage 4, Surveyor noted there were no revisions in R3's skin integrity care plan. The Facility's next wound evaluation is dated 4/9/21. The Facility provided Surveyor with WD (wound doctor)-M's assessments dated 2/26/21, 3/8/21, 3/19/21 (11 days), 3/26/21, 4/2/21, 4/9/21, 4/16/21, 4/30/21 (14 days), 5/14/21 (14 days), 5/21/21, 5/28/21, 6/4/21 6/18/21, 6/25/21, and 7/9/21. Starting 3/8/21, WD-M began classifying R3's pressure injury as a Stage 4. The nurses note dated 3/8/21 documents, wound was cleaned by wound MD, IV (intravenous) started in L (left) hand for Rocephin (antibiotic), IV to be started in AM (morning). The nurses note dated 3/10/21 documents, Abt (antibiotic) therapy for coccyx wound prophylactic. PIV (peripheral intravenous line) left outer hand. Coccyx wound without odor. The nurses note dated 3/11/21 documents, Abt therapy prophylactic for coccyx wound. No redness or odor noted @ (at) site. The physician progress note dated 3/14/21 under assessment and plan documents, Coccyx Wound Infection - Started on Ceftriaxone (antibiotic) IV daily on 3/9, - followed by wound team, seen on 3/8, -dressing changes per wound MD. The nurses note dated 3/16/21 documents, Treatment to coccyx wound con't (continued). Positioned side to side in bed. IV abt therapy con't for coccyx wound. The nurses note dated 3/18/21 documents, Coccyx wound dressing changed per orders, IV antibiotics completed today no9 [sic] (no) adverse reaction to antibiotics. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated 3/19/21 documents, Post antibiotic therapy loose stool have obtained an order to collect a stool sample to test for c-diff (clostridium difficile). The nurses note dated 3/20/21 documents, Writer received confirmation from Wisconsin diagnostic laboratories of resident being positive for C Diff. [Physician-L] paged at this time to update on the positive result to receive ABT order awaiting return call to facility. The nurses note dated 3/20/21 documents, Coccyx wound, wound vac to be started today. Resident is positive for C-diff and will be started on Vanco (vancomycin - antibiotic) and probiotics. Surveyor compared LPN-G's wound evaluation with WD-M's wound evaluation dated 4/9/21. Surveyor noted the measurements are the same with Length 4.39, width 4.61, and depth 2.20 with the exception of undermining. LPN-G documents undermining at 9-3 o'clock 1.4 cm and MD-M documents undermining 0 cm (centimeters). LPN-G documents the wound bed as 100% granulation while WD-M documents the wound bed as 83% red tissue and 16% black tissue. Surveyor noted weekly Facility wound evaluations dated 4/16/21, 4/23/21, 4/30/21 and 5/7/21. The wound evaluation dated 5/7/21 shows R3's Stage 4 pressure injury declined with length documented, 7. 6 (previous week 5.93), width 6.4 (previous week 3.66) and depth 2(previous week 1.2). The wound bed is 76% granulation, 20% slough, and 4% necrotic. The previous week the wound bed was 10% epithelial and 90% granulation. Surveyor noted there was no revision in R3's plan of care. Surveyor noted weekly Facility wound evaluations for R3's stage 4 sacrum pressure injury dated 5/14/21, 5/21/21, 5/28/21, 6/4/21, 6/11/21, 6/18/21, 6/25/21, 7/2/21, and 7/9/21. Surveyor noted there are no assessments documented for the week of 7/11/21 through 7/17/21. Surveyor also noted the facility is now interchangeably referencing the coccyx pressure injury as the sacrum pressure injury. The nurses note dated 4/30/21 documents, Resident monitored for coccyx and buttocks open areas. Dressing remains clean and intact. Resident repositioned during the night. No complaints of pain noted will continue to monitor. Surveyor noted this is the first nurses note regarding a buttocks open area. The nurses note dated 5/13/21 documents, Resident monitored for coccyx and right buttocks wound. The nurses note dated 5/17/21 documents, Resident monitored for coccyx and right buttocks wound. The nurses note dated 5/20/21 documents, Resident monitored for coccyx and right buttock wounds. Dressing remains clean and intact. Resident position on side to side. Encouraged to stay off back to improve wound healing. Foley catheter patent with yellow urine in tubing and bag. Resident denies pain or discomfort. Will continue to monitor. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated 5/26/21 documents, Resident monitored for coccyx and right buttock wounds. Dressing remains clean and intact. Resident position on side to side. Encouraged to stay off back to improve wound healing. Foley catheter changed prior shift due to no output and complaints of abdomen discomfort. Resident denies pain or discomfort. Will continue to monitor. The nurses note dated 5/31/21 documents, Resident monitored for coccyx and right buttock wounds. Dressing remains clean and intact. Resident position on side to side. Encouraged to stay off back to improve wound healing. Foley catheter patent with yellow urine in tubing and bag. Resident denies pain or discomfort. Will continue to monitor. Surveyor noted this is the last nurses note regarding right buttock wound and did not note any wound assessment for R3's right buttocks. Surveyor was unable to locate any weekly skin reviews completed in May 2021. The weekly skin review dated 6/9/21 under other documents, bilateral feet dryness lotioned daily. Surveyor was unable to locate any further weekly skin reviews in June 2021. On 7/20/21 at 11:03 a.m., Surveyor spoke with R3 who informed Surveyor they told him he needs to go to the hospital and have a new catheter put in. Surveyor observed R3 was on his left side in bed laying on an air mattress and wearing bilateral pressure relieving boots. Surveyor asked R3 if he has any open areas on his buttocks. R3 informed Surveyor he does and the nurse makes sure it is medicated. Surveyor asked R3 how he developed the open area on his buttocks. R3 informed Surveyor the reason they said was because he is on his back side. R3 informed Surveyor the reason he is on his back side is because he is in bed and if someone doesn't move him he can't move himself. Surveyor asked R3 if staff moves him around in bed. R3 replied, just from one side to the other. Surveyor asked R3 how often staff moves him from side to side. R3 replied, I'd say three times a day. Surveyor asked R3 why he wears the boots on his feet. R3 replied, They insisted I wear them because I have a sore on my leg. Surveyor asked if the pressure injuries on his buttocks or heel hurts. R3 informed Surveyor sometimes they put spray on them which irritates the skin. On 7/20/21 at 12:15 p.m., Surveyor observed R3 on a stretcher being wheeled out of his room by ambulance staff. On 7/20/21 at 1:54 p.m., Surveyor asked CNA (Certified Nursing Assistant)-J if she has provided cares to R3. CNA-J replied, yes. Surveyor asked CNA-J if she had any idea how R3 developed the pressure injury on his buttocks. CNA-J replied, no. Surveyor asked CNA-J if R3 would allow staff to reposition him. CNA-J replied, yes and he is turned from one side to the other. Surveyor asked how long R3 has had the air mattress. CNA-J informed Surveyor R3 had the air mattress since he was on another unit. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/20/21 at 3:04 p.m. Surveyor spoke with LPN-G to inquire about pressure injury assessments. LPN-G informed Surveyor she assesses Residents every week on Friday. Surveyor asked what should happen if a CNA reports a pressure injury. LPN-G informed Surveyor the nurse should be going in measuring the area, notify the doctor, get orders and open up a wound tracker. LPN-G informed Surveyor the nurses were also letting her know and notify the family. LPN-G informed Surveyor WD-M comes in the Facility once a week and she does rounds with him. Surveyor asked if the assessments are completed with WD-M. LPN-G informed Surveyor sometimes she'll get a head start before he comes in or if WD-M can't come then she will do the wound rounds herself. Surveyor asked if she completes the assessments herself does she review the assessments with anyone. LPN-G informed Surveyor she'll talk with RN (Registered Nurse)-N who is the night nurse but mostly updates RN Corporate-H. LPN-G informed Surveyor she will call or email RN Corporate-H. LPN-G informed Surveyor she places the information into a flow sheet for RN Corporate-H so she will know who has pressure injuries in the building. Surveyor asked how would RN-N or RN Corporate-H verify the assessment is correct. LPN-G informed Surveyor they could come in and measure to double check. Surveyor asked LPN-G if she knows how R3 developed the pressure injury on his sacrum. LPN-G replied No, that was before I was here. Surveyor asked LPN-G if she knew why R3 was placed on an antibiotic in March. LPN-G replied no. Surveyor asked who is responsible for revising the care plan. LPN-G replied, DON (Director of Nursing) unless she told me to. On 7/21/21 at 8:26 a.m. Surveyor asked Corporate RN (Registered Nurse)-H why R3 was started on an antibiotic IV in March and if there was any lab work. At 8:28 a.m. RN-H informed Surveyor she was unable to locate any lab work for the antibiotic and thinks R3 was placed on an antibiotic for his CRP (C-Reactive Protein) levels. Corporate RN-H also informed Surveyor there is a MD progress note dated 3/14/21 which references coccyx wound infection. On 7/21/21 at 9:01 a.m., Surveyor spoke with WD -M on the telephone regarding R3's sacrum pressure injury. Surveyor informed WD-M according to his & the Facility's assessment R3's pressure injury on 2/26/21 was identified as unstageable. Surveyor informed WD-M this is the first assessment Surveyor located. WD-J replied 2/26 was when I was informed of the wound. Surveyor informed WD-M the next assessment dated [DATE] by the Facility and his assessment 3/8/21 documents the pressure injury is now a Stage 4. Surveyor asked how the pressure injury declined to a Stage 4. WD-M informed Surveyor looking at his notes the depth was 2 cm (centimeters) and there was a lot of necrotic tissue on 2/26/21. WD-M informed Surveyor on 2/26 he wrote an order for Santyl with border gauze as he wanted the pressure injury to be debrided. WD-M informed Surveyor when he saw the pressure injury on 3/8 it was mostly cleaned out and post debridement the depth was 3.3 cm. WD-M explained R3 doesn't have much meat on his backside and it was past the fascia at that point and opted to call the pressure injury a Stage 4. WD-M explained to Surveyor there were a few challenges here and there but the wound is doing better. At this point believes the depth is 1 cm and is not as deep as before. WD-M informed Surveyor he did have a wound vac on for a short period but the wound vac was challenging depending on the skill of the nurses and he was worried R3 might develop osteomyelitis. WD-M informed Surveyor he was having CRP levels done as he was concerned for osteomyelitis. WD-M informed Surveyor It was a significant injury when I saw it on 2/26. WD-M informed Surveyor there were a lot of challenges with staffing and the Facility tried to get staff. On 7/21/21 at 12:51 p.m., Surveyor asked LPN-G if she was working at the Facility last week (7/11/21 to 7/17/21). LPN-G replied no and explained she was on vacation. Surveyor informed LPN-G of not being able to locate any skin assessments when she was on vacation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/23/21 Surveyor received an email from Administrator-A with the additional information: * Director of Nursing timeline * Critical event dated 3/8/21 which Surveyor had previously reviewed * Training log/inservice sheet dated 3/9/21 which documents for objectives Review wound policy and sign that you understand. If you have any questions see DON. Surveyor noted there are 4 LPN (Licensed Practical Nurse) signatures and 13 CNA (Certified Nursing Assistant) signatures. * Pressure Ulcer/Injury, prevention of policy and procedure which Surveyor had previously reviewed. * Skin sweep dated 3/8/21 & 3/9/21. * A quality team visit summary not dated. * Emails dated 6/8/21 & 6/9/21 between Corporate RN-H and Previous DON-R * Approximately 43 Resident shower/bath check sheets dated 6/8/21 & 6/9/21. Surveyor noted R3 is included with a shower/bath check. The facility submitted a skin review for R3 dated 7/14/21 and signed on 7/22/21. Under site documents 53 sacrum and under description documents, Peri wound skin appears macerated c (with) small skin tear like spots. No odor noticed, tissue is pink with small areas of yellow. Measures 7 x 5 x . (sic) Surveyor noted this is not a comprehensive assessment as there there is no percentage of slough and does not include the depth of the pressure injury. There is no documentation of exudate. The facility's failure to ensure R3 received care consistenent with professional standards of practice to prevent pressure injuries, to promote healing and to provide appropriate care and treatment of R3's sacral pressure injury led to a finding of immediate jeopardy. The immediate jeopardy was removed on 7/23/21 when the facility implemented the following action plan: * Initiated a review of care planning on all Residents with pressure injuries to ensure appropriate interventions were in place to decrease the risk of pressure injuries based on the risk assessment and scoring. * Initiated a review of current weekly skin assessments to ensure an accurate comprehensive wound assessments completed by a Registered Nurse. * Initiated a review of all other Residents to ensure at risk care planning is in place based on risk assessment and scoring. * Initiated full house skin review audit on all Residents. * Re-educated all licensed and non licensed staff on the policy and procedure for intervention and treatment of skin injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* All licensed staff will complete return demonstration training on completion of the skin assessment and review upon admission. * All licensed staff were be re-educated on the process of timely notification to the physician when a new skin injury event is identified. * All licensed staff were re-educated on the process of timely treatment and care planning when a new skin injury is identified. * All certified nursing assistants received re-education on the policy and procedure related to prevention for pressure related skin injuries. * Reviewed the Policy and Procedure on Pressure Ulcer care and intervention. * DON and/or designee will review progress notes daily during morning meeting to identify new skin events. The IDT will ensure a comprehensive assessment and care plan review is completed at that time of identification to ensure appropriate interventions and orders for treatment are in place. * DON and/or designee will conduct 5 random audits of wound documentation weekly to treatments and interventions are completed per the recommended plan of care. * The center will conduct a monthly QAPI (Quality Assessment Perfomance Improvement) meeting to review findings with any additional recommendations. Following the implementation of their action plan, the deficient practice continues as evidenced by the following two examples. R6 is being cited at a scope and severity level of G (harm/isolated). 36161 2. R6 was readmitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis, Diabetes Mellitus Type II, Dementia without Behavioral Disturbance. R6's Quarterly MDS (Minimum Data Set) dated 3/30/21 documents a BIMS (Brief Interview of Mental Status) score of six, indicating that R6 is severely cognitively impaired. Due to R6's mental status, Surveyor was unable to interview R6. The MDS Section G (Functional Status) documents that R6 requires extensive assistance and two person physical assist for his bed mobility needs. Section G also documents that R6 has total dependence on staff and requires a two person physical assist for his transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R6 has impairment to one of both his upper and lower extremities. Section M (Skin Conditions) documents that R6 had one unhealed unstageable pressure injury at the time of the MDS. Section M also documents that R6 is at risk for the development of pressure injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R6's left heel pressure injury documentation and noted that a pressure injury on the left heel was first discovered on 4/22/20 and that the area was followed by the wound physician and that the following interventions were in place since 2020: Offloading heels, turning and repositioning every 2 hours, the implementation of an air mattress and wearing of heel boots. R6's Pressure Injury CAA (Care Area Assessment) dated 7/27/20 documents under the Care Plans considerations section, Resident has actual wound, unstageable pressure area to plantar foot near heel, measuring 5.0 x 2.2 x 0 cm (centimeters) with 40 % necrosis and 60% epithelial skin. Wound care is performed daily as ordered. Wound MD (Medical Doctor) making virtual visits every 2-3 weeks. Wound is much improved in last 30 days. Remains at risk for impaired skin integrity r/t impaired mobility, incontinence. Bed and WC (wheelchair) are fitted with pressure relieving devices. Staff provide assistance with frequent repositioning and provide incontinence cares prn (as needed). Skin is monitored daily and assessed weekly. Will continue to care plan. R6's Tissue Analytics wound assessment completed by the [TRUNCATED]

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F 0727 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36161 Based on record review and staff interview, the facility did not ensure an RN (Registered Nurse) worked at the facility for at least eight consecutive hours a day, seven days a week, on 1 of 20 days reviewed. Additionally the facility did not have a full time Director of Nursing for 28 days. * The facility did not have an RN (Registered Nurse) working in the facility for at least eight consecutive hours on 7/7/21. * The facility did not have a full time Director of Nursing from 6/22/21 through 7/19/21 (28 days). A full time interim Director of Nursing started on 7/20/21. This deficient practice had the potential to affect all of the residents residing at the facility from 6/22/21 through 7/19/21. Findings include: On 7/21/21 at 9:54 a.m., Surveyor interviewed Scheduler-C regarding staffing hours from 2/5/21 to 2/10/21 and from 7/4/21 to 7/17/21. Scheduler-C informed Surveyor that the facility should have an RN working for at least 8 hours per day. On 7/21/21 at 11:40 a.m., Scheduler-C reviewed the actual staffing schedules for the facility from 2/5/21 to 2/10/21 and from 7/4/21 and 7/17/21 with Surveyor. Surveyor asked Scheduler-C if the facility had an RN working for at least 8 hours a day on 7/7/21, as Surveyor was unable to locate an RN working on the schedule provided to Surveyor. Scheduler-C and Surveyor reviewed the schedule and Scheduler-C informed Surveyor that on 7/7/21 the facility did not have an RN working for at least 8 hours. Scheduler-C informed Surveyor that the facility did not have a full time DON (Director of Nursing) at the time and that she was unable to schedule an RN to work on 7/7/21. Scheduler-C informed Surveyor that the facility was without a full time DON from 6/22/21 until 7/20/21, when the facility obtained an interim DON. Scheduler-C informed Surveyor that although the facility did not have a full time DON, there were several corporate RNs who were overseeing the facility during that time. Surveyor observed the arrival of the facility's interim DON on 7/20/21, when Surveyor initially entered the building to begin the survey. On 7/21/21 at 1:20 p.m., Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. (continued on next page)

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F 0727 Level of Harm - Potential for minimal harm Residents Affected - Many	NHA-A informed Surveyor that he did not have any additional information to provide to Surveyor. No additional information was provided as to why the facility did not ensure an RN worked at the facility for at least eight consecutive hours on 7/7/21.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 20483 Based on observation and interview the Facility did not ensure Resident's medical records were safeguarded against loss, destruction, or authorized use. Resident's medical records were observed in a cardboard box under the desk, an uncovered box on top of the desk, and in cardboard boxes on top of file cabinets in the medical record office Multiple card board boxes were observed stacked in the resident storage room along with items for dietary, activities, therapy, and maintenance departments. This has the potential to affect all Residents residing in the Facility. Findings include: On 7/27/21 at 2:47 p.m. Surveyor met with MR (Medical Records)-P to discuss storage of Resident's paper medical records. MR-P informed Surveyor the file cabinets in her office contain discharge Resident's records from 2018 to present. Resident's records prior to 2018 are stored in banker boxes in the resident storage room and will be sent to Name of Location for storage. Surveyor inquired when they would be sent to Name of Location. MR-P indicated she didn't know. At 2:50 p.m. Surveyor observed a large card board box approximately three feet in length and approximately 2 feet high on the floor under the desk filled with papers. Surveyor asked MR-P about the papers in this box. MR-P informed Surveyor they are Resident's assessments and records that have to be sorted and filed. Surveyor then asked about a box on top of MR-P's desk filled with papers. MR-P informed Surveyor they are Resident's therapy records that need to be scanned and uploaded. MR-P informed Surveyor she started in medical records in November 2020 and the position had been vacant for about six months. MR-P informed Surveyor when she came the medical records office was horrible and has gotten better. MR-P informed Surveyor HR (Human Resource)-Q helps her when she has the chance. At 2:52 p.m. Surveyor observed 5 card board boxes on top of the file cabinets and inquired what was in these boxes. MR-P informed Surveyor they are MARs (medication administration records) and TARs (treatment administration records). Surveyor informed MR-P if there was a fire or the sprinkler were activated these records could be destroyed. MR-P replied that's for sure. At 2:54 p.m. Surveyor accompanied MR-P to the Resident Storage room located in the basement. After MR-P unlocked the door, Surveyor entered the Resident Storage room with MR-P. Surveyor asked other than herself is there anyone else who has access to this room. MR-P informed Surveyor maintenance, dietary, and activities. MR-P informed Surveyor this room is where the older discharge records are stored. Surveyor noted there were approximately 12 card board boxes marked 2015 stacked together. In another section in the storage room there were approximately 15 card board boxes marked 2017 stacked together in rows. On top of donated brief boxes were approximately 18 card board banker boxes stacked together. Surveyor observed adjacent to the Resident's medical record boxes were cushions, oxygen carriers, walkers, broda chairs, activities and dietary supplies. Surveyor noted although the door to the storage room is locked staff from other departments once inside the storage room would have access to these confidential Resident's medical records. (continued on next page)

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	525415	A. Building B. Wing	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menomonee Falls Health Services	N84 W17049 Menomonee Ave Menomonee Falls, WI 53051

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

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Many	On 7/27/21 at 4:18 p.m. Administrator-A, Interim DON (Director of Nursing)-B and Corporate RN (Registered Nurse)-H were informed of the above.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 20483 Based on observation, interview and record review, the Facility did not establish and maintain an infection control program designed to help prevent the development and transmission of disease and infection for 2 (R2 & R3) of 2 Residents observed. During observations of wound treatment for R2 and R3, Licensed Practical Nurse (LPN)-D and LPN-G did not practice hand hygiene according to professional standards of practice. Findings include: The Handwashing/Hand Hygiene Policy & procedure from 2001 Med-Pass Inc (Revised August 2019) under policy interpretation and implementation for #2 documents, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. #7 Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: k. After handling used dressings, contaminated equipment, etc.; and After removing gloves. 1. R2 was admitted to the Facility with surgical wounds on his left lateral and medial calf. On 7/20/21 at 11:44 a.m., Surveyor entered R2's room with LPN (Licensed Practical Nurse)-D. Surveyor observed R2 was sitting on the edge of his bed. LPN-D cleaned off the over bed table and placed treatment supplies on the over bed table. R2 placed a pillow behind his head, took off his shirt stating he has shortness of breath. LPN-D informed R2 when he (R2) was set to hit his button, as he (LPN-D) was going to get someone to help lift his (R2's) leg and left R2's room. At 11:51 a.m. R2 placed his call light on. At 11:55 a.m., LPN-D, CNA (Certified Nursing Assistant)-I and CNA-J entered R2's room and placed gloves on. CNA-I & CNA-J assisted R2 with moving his lower extremities further onto the bed. CNA-J then held up R2's left leg while LPN-D started to unwrap the ace bandage from R2's left lower leg. At 11:58 a.m., CNA-I started to hold up R2's left leg up and LPN-D removed the kerlix from R2's left lower leg. LPN-D removed the tape and abdominal pads from R2's left medial and lateral surgical wounds. LPN-D removed his gloves, moved the over bed table closer, and placed gloves on. LPN-D did not perform hand hygiene. LPN-D removed the gauze from R2's medial and lateral surgical wounds. LPN-D cleansed the medial and lateral surgical wound with Dakins 0.25%, removed his gloves and placed gloves on. LPN-D did not wash or cleanse his hands prior to placing gloves on. LPN-D poured Dakins into three gauze sponge packages, pressed on the dressings to disperse the Dakins, and then placed the Dakins soaked gauze over R2's left medial surgical wound. LPN-D opened gauze sponge packages and poured Dakins into the packages. LPN-D placed an abdominal pad over R2's medial surgical wound, pressed on the gauze sponge packages with Dakins to disperse the Dakins and placed the gauze sponge over R2's left lateral surgical wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-D placed two abdominal pads over R2's left lateral surgical wound, wrapped R2's left lower leg with kerlix and then wrapped the leg with ace wrap. CNA-I & CNA-J removed their gloves and performed hand hygiene. LPN-D picked up treatment papers from the floor, removed his gloves, and placed gloves on. LPN-D did not wash or cleanse his hands prior to placing the new gloves on. R2 was trying to sit up in bed. LPN-D informed R2 let me put your bed down so you don't fall out and lowered the bed. LPN-D then gathered up the garbage, tied the bag, and left R2's room. On 7/21/21 at 3:03 p.m., Surveyor asked Interim DON (Director of Nursing)-B during a treatment after the nurse removes a dressing should the nurse remove their gloves & wash or cleanse their hands. Interim DON-B replied yes. Surveyor then asked if after staff removes their gloves should they wash or cleanse their hands. Interim DON-B replied yes. Surveyor informed Interim DON-B of the observation with LPN-D during R2's treatment. 2. R3 has a pressure injury on the sacrum. On 7/21/21 at 11:58 a.m., Surveyor observed R3 in bed on his right side with a pillow under R3's upper left side. CNA-E washed her hands and placed gloves on. LPN (Licensed Practical Nurse)-G informed R3 she was going to be doing the treatment on his bottom, washed her hands, and placed gloves on. LPN-G informed R3 she was going to his heel first, removed the prevlon boot from R3's right foot and asked if he had any pain. R3 replied nope. LPN-G sprayed skin prep on R3's right heel pressure injury and placed the prevlon boot back on. At 12:03 p.m., CNA-E and LPN-G repositioned R3 towards the right side of the bed and then positioned R3 on his left side with CNA-E holding onto R3. LPN-G moved the urinary collection bag closer towards the head of the bed attaching the collection bag to the bed frame. LPN-G then removed her gloves and placed new gloves on. LPN-G did not wash or cleanse her hands after touching the urinary collection bag and removing her gloves. LPN-G poured Dakins on gauze and cleaned R3's wound bed on the sacrum. LPN-G informed Surveyor she's switching out her glove, removed the glove from her right hand and placed a new glove on. LPN-G did not perform any hand hygiene. LPN-G cleaned the wound bed again with Dakins on a piece of gauze, sprayed skin prep around the peri wound and removed her gloves. LPN-G did not wash or cleanse her hands. LPN-G picked up a piece of paper from the floor and placed gloves on. LPN-G did not wash or cleanse her hands prior to placing gloves on. LPN-G opened dermablue foam and cut the foam to the approximate size of R3's pressure injury. LPN-G packed the dermablue into the pressure injury informing Surveyor there's not much of undermining at this point. LPN-G dated a border gauze dressing and placed the border gauze dressing over R3's pressure injury. LPN-G and CNA-E positioned R3 on his right side, CNA-E placed a pillow under R3's left side, and a pillow was placed under R3's lower legs. LPN-G attached the call light to R3's gown. At 12:12 p.m. CNA-E removed her gloves and washed her hands. LPN-G then removed her gloves and washed her hands. On 7/21/21 at 12:17 p.m. Surveyor asked LPN-G after she removed her gloves why didn't she wash or cleanse her hands. LPN-G replied because I didn't bring sanitizer with me. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/21 at 3:03 p.m. Surveyor asked Interim DON (Director of Nursing)-B during a treatment after the nurse removes a dressing should the nurse remove their gloves & wash or cleanse their hands. Interim DON-B replied yes. Surveyor then asked if after staff removes their gloves should they wash or cleanse their hands. Interim DON-B replied yes. Surveyor informed Interim DON-B of the observation with LPN-G during R3's treatment.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 20483 Based on interview and record record the Facility did not ensure 3 of 5 CNAs (Certified Nursing Assistant) received dementia management training & resident abuse prevention training and completed a performance review. * CNA-T was hired on 4/30/19. During the time period 4/30/20 to 4/30/21 CNA-T did not receive resident abuse prevention training and did not have a performance review. * CNA-U was hired on 6/3/20. During the time period 6/3/20 to 6/3/21 CNA-U did not have dementia management training and did not have a performance review. * CNA-S was hired on 11/13/17. During the time period 11/13/19 to 11/13/20 CNA-S did not have resident abuse training and did not have a performance review. CNA-S & CNA-U work on all units which would have the potential to affect all 44 Residents residing in the Facility. Findings include: On 7/27/21 at approximately 11:00 a.m., Surveyor asked Administrator-A for inservice training & performance reviews for CNA-T during the time period of 4/30/20 to 4/30/21, CNA-U during the time period of 6/3/20 to 6/3/21, CNA-V for 6/8/21 to present, CNA-S during the time period of 11/13/19 to 11/13/20 and CNA-J during the time period 8/27/19 to 8/27/20. On 7/27/21 at 2:05 p.m. Surveyor reviewed the information provided for CNA-T, CNA-U, CNA-V, CNA-S and CNA-J. Surveyor was unable to locate Resident abuse training or a performance review for CNA-T. Surveyor was unable to locate dementia management training or a performance review for CNA-U. Surveyor was unable to locate resident abuse training or a performance review for CNA-S. On 7/27/21 at 2:30 p.m. Surveyor informed Administrator-A, Interim DON (Director of Nursing)-B and Corporate RN (Registered Nurse)-H of the missing items for CNA-T, CNA-U, & CNA-S. On 7/27/21 at 4:02 p.m. Surveyor asked Administrator-A and Corporate RN-H if there are any performance reviews. Corporate RN-H informed Surveyor they do not have performance evaluations. Surveyor asked if there is any more inservice records for Surveyor to review. Administrator-A informed Surveyor they do not have any information.