STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36161 Based on observation, interview and record review, the facility did not ensure that 1 (R80) of 22 residents reviewed had a clean, comfortable, sanitary, orderly and homelike environment. * R80's room was observed to have brown stains at the base of his feeding pole. R80's room heating and cooling unit was observed to have the front plastic cover off, exposing wires and internal components. Findings include: On 11/29/21 at 10:20 a.m., Surveyor observed R80's room to have brown stains at the base of his feeding pole. Surveyor noted that the stains, brown in color, appeared to be from R80's enteral feeding formula. Surveyor also observed the heating and cooling unit to have front plastic cover off, exposing wires and internal components. On 11/29/21 at 3:40 p.m., Surveyor observed R80's room to have brown stains at the base of his feeding pole. Surveyor noted that the stains, brown in color, appeared to be from R80's enteral feeding formula. Surveyor also observed the heating and cooling unit to have front plastic cover off, exposing wires and internal components. On 11/30/21 at 8:53 a.m., Surveyor observed R80's room to have brown stains at the base of his feeding pole. Surveyor noted that the stains, brown in color, appeared to be from R80's enteral feeding formula. Surveyor also observed the heating and cooling unit to have front plastic cover off, exposing wires and internal components. On 11/30/21 at approximately 3:10 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/1/21 at 8:46 a.m., NHA-A informed Surveyor that housekeeping had cleaned R80's feeding pole and that maintenance had reattached the face of R80's heating and cooling unit No additional information was provided as to why the facility did not not ensure that R80 had a clean, comfortable, sanitary, orderly and homelike environment.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure that 2 (R118, R119) of 2 Residents reviewed for involuntary discharge received a 30 day involuntary discharge notice and or a discharge notice containing specific regulatory requirements. * The involuntary discharge notice provided to R118 on 6/22/21 did not include: The location to which R118 was to be discharged to or transferred to, the email address for the entity receiving appeals to the 30 day involuntary discharge notice, the email address for the Office of the Long-term Care Ombudsman and the mailing and email address and telephone number for the protection and advocacy of individuals with a mental disorder, even though R118 was admitted with a diagnosis of Major Depressive Disorder. On 10/14/21, R118 was transferred to the hospital for a change in condition. As of 11/30/21, R118 remains in the hospital awaiting placement. The facility denied R118 readmission without providing R118 with an updated or revised involuntary discharge notice with appeal rights. * On 10/23/21 R119 requested to be sent out to the emergency room (ER). R119's Nurse Practitioner was made aware however did not give an order for R119 to be sent out. In order for R119 to be purse further treatment outside of the facility, R119 was presented with a form titled Leaving Nursing Center Against Advice. R119 made a mark on this form. On 10/23/21, R119 was then sent to the emergency room and was admitted into the hospital. As of 11/30/21, R119 was still in the hospital waiting for discharge. As of 12/01/21, the facility has refused to take R119 back. The facility did not provide R119 with an involuntary discharge notice with appeal rights. Cross Reference F626 Findings include: Surveyor reviewed 2 facility policies and procedures in regards to R118's discharges to the hospital and being denied re-admission to the facility, which included; 1. Transfer or Discharge Notice-revised October 2016 Our facility shall provide a Resident and/or Resident's representative with a 30 day written notice of an impending transfer or discharge. Policy Interpretation and Implementation (states in part) 3. The Resident and/or representative will be notified in writing of the following information: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the Resident is being transferred or discharged d. A statement of the Resident's rights to appeal the transfer or discharge, including: 1. Name, address, email and telephone number of entity which receives such requests 2. Information about to obtain, complete, and submit an appeal form 3. How to get assistance completing the appeal process e. The facility bed-hold policy f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman g. The name, address, email and telephone number of the agency responsible for the protection and advocacy of Residents with intellectual and developmental(or related) disabilities h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of Residents with a mental disorder or related disabilities i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices 4. A copy of the notice will be sent to the Office of the State Long-term Care Ombudsman. 5. The reasons for the transfer or discharge will be documented in the Resident's medical record. 6. If the information in the notice changes prior to the transfer or discharge, the recipients of the notice will be updated as soon as practicable. 11. In determining the transfer location for a Resident, the decision to transfer to a particular location will be determined by the needs, choices, and best interest of that Resident. 2. Transfer or Discharge, Preparing a Resident for-revised December 2016. Residents will be prepared in advance for discharge. 1) R118 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Type 2 Diabetes Mellitus, Neuromuscular Dysfunction of Bladder, Other Psychoactive Substance Abuse, and Major Depressive Disorder. R118 is his own person. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R118's Quarterly Minimum Data Set (MDS) dated [DATE] documents R118's Brief Interview for Mental Status (BIMS) score of 15 which indicates R118 is cognitively intact for daily decision making skills. R118 has a Patient Health Questionnaire (PHQ-9) score of moderate depression. There are no behaviors documented. Surveyor reviewed R118's comprehensive care plan and noted the following focused problem: R118 requires discharge planning related to R118's preference to return to the community. Initiated 5/8/20. Revised 9/22/20 Surveyor notes R118's discharge planning focused problem was not updated when R118 was issued the 30 day involuntary discharge notice on 6/22/21. Surveyor reviewed the 30 day discharge notice given to R118 on 6/22/21. Surveyor notes the reason for discharge is for the safety of the individuals in the facility is endangered. A discharge meeting was scheduled for 7/1/21. There is no documentation in R118's EMR the discharge meeting occurred. Surveyor notes the 30 day discharge notice given to R118 on 6/22/21 does not contain the following required information; 1. The location to which R118 was to be discharged to or transferred to. 2. The email address is not provided for the entity receiving appeals to the 30 day involuntary discharge notice. 3. The email address is not provided for the Office of the Long-term Care Ombudsman. Further, the name of the designated Ombudsman is incorrect on the 30 day involuntary discharge notice. 4. The 30 day involuntary discharge notice did not contain the contact information (mailing and email address and telephone number) responsible for the protection and advocacy of individuals with a mental disorder, even though R118 was admitted with a diagnosis of Major Depressive Disorder. Surveyor notes upon review, there is no documentation in R118's EMR that R118 was given the 30 day involuntary discharge notice on 6/22/21 and that it was explained to R118 in a language and manner that R118 could understand. Further, there is no documentation that R118 was explained how to appeal the involuntary discharge notice and that assistance was offered to help with the appeal process. R118's EMR does not contain documentation the state ombudsman was notified of the 30 day involuntary discharge notice. R118's EMR did not contain documentation from R118's primary physician of the specific needs that could not be met, facility attempts to meet those needs, and the service available at the receiving facility to meet R118's needs. Surveyor reviewed R118's medical record which documents; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/21 3:42 AM Nurses Note Text: [R118] has orders to collect urine specimen to rule out UTI (Urinary Tract Infection). Assisted nurse with replacing suprapubic catheter due to poor urinary output. Foley tubing noted with large amounts of sediment clogging urinary flow. Multiple attempts made to reinsert the suprabubic catheter, all unsuccessful. Unable to get a urinary return. [R118] has a history of obstruction. Bladder scan shows no large volume residual -- 50-100cc noted. [R118] is screaming. [R118's] mentation is also changed. [R118] is alert x 4 but presents with hysteria. Called on call MD from .Health and orders given to send to ER. Paramedics arrived to send the ER. [R118] continues to scream and attempting to throw self into floor. [R118] is yelling I'm drunk and high. Called (name of Hospital) and gave report. Vitals stable upon departure. Declines family update. All documentation sent with [R118]. No updated transfer or discharge notice with appeal rights was provided to R118 upon his discharge to the hospital on 10/14/21. The facility provided Surveyor with a transfer/bed hold document for [R118] and [R118] requested a bed hold. A written note on this document indicated the document was reviewed with R118 at the hospital by an un-named case manager on 10/15/21 and signed by the facility. This document does not indicate any information pertaining to an involuntary discharge. This notice indicated: Effective date discharge/transfer:10/14/21,(name of facility) is transferring/discharging R118 to (name of hospital) for the following reasons:(this part Surveyor notes was left blank) The document lists the state agency and the state long -term care ombudsman information if R118 wanted to appeal the transfer/discharge. On 11/30/21 at 1:04 PM, Surveyor spoke to hospital social worker (HSW-Q) for R118. HSW-Q stated the facility stopped returning calls. HSW-Q stated the Administrator (NHA-A) informed HSW-Q the facility would not take R118 back because of R118's behaviors. HSW-Q called Ombudsman (O-R) and was told by O-R that R118's 30 day involuntary discharge notice was not valid because there was no discharge destination listed on it. HSW-Q validated that as of 11/30/21 R118 remains in the hospital awaiting placement at this time. On 12/01/21 at 12:52 PM, Surveyor interviewed NHA-A in regards to R118's discharge. NHA-A gave a 30 day involuntary discharge notice to R118, but does not have documentation R118 received the 30 day notice or understood the 30 day involuntary discharge notice. NHA-A stated the facility originally denied re-admission because R118 had an expensive IV. NHA-A stated then R118 ran out of bed hold days and informed the hospital the facility would not allow R118 to return to the facility because of behaviors. Surveyor noted however, R118's EMR did not document R118 as having behavioral issues from May 2021 through October 14, 2021. NHA-A stated NHA-A did not offer to assist HSW-Q with R118's discharge planning from the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/02/21 at 1:57 PM, Surveyor spoke to O-R in regards to R118. O-R does not remember having any contact directly with R118. O-R did speak to HSW-Q on 10/26/21 and informed HSW-Q R118's 30 day discharge notice was not valid due to it not containing documentation of a discharge location. O-R did speak to R118 on 10/29/21 who indicated R118 may not want to return to the facility. On 12/2/21 at 3:16 PM, Surveyor shared the concern with Administrator (NHA-A), Director of Nursing (DON-B), and Regional Nurse Consultant (RNC-C) that R118's 30 day involuntary discharge notice did not contain the required information per regulation. Surveyor's concern was acknowledged and no further information was provided at this time. 2) R119 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Neuromuscular Dysfunction of Bladder, Bipolar Disorder, and Attention Deficit Hyperactivity Disorder. R119 is her own person. R119's Quarterly Minimum Data Set (MDS) dated [DATE] documents R119's Brief Interview for Mental Status (BIMS) score to be a 15, indicating R119 was cognitively intact for daily decision making. R119 had a PHQ-9 score of 3, indicating minimal depression. The MDS documented R119 had verbal behavioral symptoms and rejection of care 1-3 days during the assessment period. Surveyor reviewed R119's medical record and noted the following nurses notes: 10/23/2021 9:41 AM Nurses Note Text: [R119] is requesting to be sent out to the emergency room (ER). [R119] tells writer she just doesn't feel good. [R119] says she feels like [R119] has a Urinary Tract Infection (UTI) and will not be cared for in the facility as [R119] feels she needs to. [R119] states, I think they don't even care and I'm leaving. Vitals taken and stable. NP (Nurse Practitioner) gives orders for Bactrim x 3 days and a repeat UA (urinalysis) with C&S (culture and sensitivity). Explained new orders to [R119]. [R119] declines treatment and states, I am leaving. NP aware. Explained AMA to the [R119]. Paperwork prepared and ready. 10/23/2021 9:41 AM Nurses Note Late Entry: [R119] tells writer [R119] isn't coming back. Tells writer watch my things, after I'm better I'll be back to get them and I'm not coming back here again. I'm getting out of this place. [R119] declines bed hold or alternatives to cares and signed AMA paperwork with Emergency Medical Technician (EMT) as witness, Certified Nursing Assistant (CNA), and this writer. 10/23/2021 9:45 AM Nurses Note Text: Called to get non- emergent transport - cannot get transport- called 911 to send to emergency room (ER) for evaluation and treat. [R119] aware and will update family on own per her statement. 10/23/2021 11:29 AM Nurses Note Text: [R119] departed via EMT transfer. Report given to EMT and paperwork given upon departure. [R119] declined cares before departure as [R119] wanted to leave right now no medications given. 10/23/2021 9:53 PM Nurses Note Text: Writer called (name of hospital) ER-[R119] was admitted for UTI and Aspiration Pneumonia at 4:00 PM. [R119] is her own person. Management aware. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/21 at 1:06 PM, Surveyor spoke to Hospital Social Worker (HSW)-Q who stated that HSW-Q does not know how [R119] could have signed an AMA form being a quadriplegic and that [R119] was very sick and confused when [R119] arrived to the ER. HSW-Q stated [R119] was admitted to Intensive Care Unit(ICU). HSW-Q contacted the facility seeking readmission for R119. HSW-Q does not remember on what date HSW-Q spoke with a representative at the facility or with whom. HSW-Q was informed at this time, the facility would not allow R119 to return to the facility due to behaviors. HSW-Q stated that [R119] was still in the hospital waiting for discharge. Surveyor reviewed documentation dated 10/23/21 from the hospital record and notes [R119's] chief complaint was coughing and respiratory failure, and [R119] required up to 8 liters of Oxygen (O2) on admission. Surveyor reviewed the the AMA document dated 10/23/21. The AMA document is titled, Leaving Nursing Center Against Advice. The document indicates, I [R119] am leaving this nursing center against the advice of my attending physician and this nursing center's administration. By signing below, I acknowledge that I have been informed of the risk involved and hereby release the attending physician and nursing center staff from responsibility for an ill effects or damages which may result from my choosing to leave the center. Surveyor notes R119 signed an AMA document with a squiggly line dated 10/23/21 with 1 witness signature. Surveyor was unable to contact the witness. On 12/1/21 at 11:05 AM, Surveyor interviewed Registered Nurse (RN-G) who was the RN involved with R119's AMA discharge. RN-G stated that RN-G had [R119] sign AMA because there was no physician order to leave. [R119] came to the desk stating [R119] had an UTI. Called the NP who ordered a collection of urine, and wanted to treat [R119] in house. RN-G stated the NP would not give an order to go to the ER. Tried to explain what the NP had stated to [R119], but [R119] kept calling RN-G the grim [NAME]. RN-G gave [R119] the AMA form to sign and [R119] said I don't have use of my hands. So RN-G told [R119] even a dot would work as a signature. RN-G does not know who the witness is. Surveyor noted R119 signed the AMA document in order to obtain treatment outside of the facility. On 12/01/21 at 12:57 PM, Surveyor spoke to NHA-A about R119's AMA discharge. NHA-A stated, I don't even know if we got a phone call to take [R119] back. NHA-A stated the facility would not take [R119] back into the facility due to [R119's] behaviors. NHA-A stated [R119] refused to let the facility care for [R119] at times .[R119] would sit in the chair for days . Had bad wounds and was noncompliant with the treatments. NHA- A stated [R119] would not use the electric chair on low mode and would vape in [R119's] room. On 12/2/21 at 8:18 AM, Surveyor interviewed RN-G again and asked RN-G who instructed RN-G to have [R119] sign the AMA form. RN-G stated, no one did, I just knew that working in management at another facility; if you don't have an order it would be AMA. There is no documentation that RN-G consulted with facility management to discuss options for R119. Further, there is no documentation in R119's EMR that options to discharging AMA was discussed with R119. There is no evidence in R119's medical record that the facility provided R119 with an involuntary discharge notice. The AMA form was presented to R119 in order to obtain outside treatment. On 12/2/21 at 9:50 AM, Surveyor left a message for the NP who did not give an order for discharge. No return call was received. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of 12/2/21, R119 has not been readmitted back into the facility.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure that 2 (R118 and R119) of 4 Residents reviewed were permitted to return back to the facility to the first available bed after a hospitalization . As of 11/30/21, both R118 and R119 remain in the hospital waiting for placement. As of 12/2/21, R118 and R119 have not been readmitted into the facility. *R118 was given a 30 day discharge notice on 6/22/21 that was not valid. R118 discharged to the hospital on 10/14/21 and requested a bed hold. The facility informed the hospital they would not allow R118 to return to the facility. *R119 requested to go to the hospital on 10/23/21 and the facility had R119 sign an Against Medical Advice (AMA) document. The facility informed the hospital they would not allow R119 to return to the facility. Findings include: Surveyor reviewed 3 facility policy and procedures in regards to R118 and R119's discharges to the hospital and being denied re-admission to the facility, which included; 1. Discharging a Resident Without a Physician's Approval-revised October 2016 A physician's order should be obtained for all discharges, unless a Resident or representative is discharging himself or herself against medical advice. 2. Transfer or Discharge Notice-revised October 2016 Our facility shall provide a Resident and/or Resident's representative with a 30 day written notice of an impending transfer or discharge. 3. Transfer or Discharge, Preparing a Resident for-revised December 2016 Residents will be prepared in advance for discharge. 1) R118 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Type 2 Diabetes Mellitus, Neuromuscular Dysfunction of Bladder, Other Psychoactive Substance Abuse, and Major Depressive Disorder. R118 is his own person. R118's Quarterly Minimum Data Set (MDS) dated [DATE] documents R118's Brief Interview for Mental Status (BIMS) score of 15 which indicates R118 is cognitively intact for daily decision making skills. R118 has a Patient Health Questionnaire (PHQ-9) score of moderate depression. There are no behaviors documented. Surveyor reviewed R118's comprehensive care plan and noted the following focused problems: (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. R118 has depression due to admission, disease process, and medication side effects. Initiated 10/30/19, Revised 7/17/20 2. R118 has behavior problem, self mutilation, attention seeking due to self-physical abuse, self inflicting injuries. Initiated 10/30/12, Revised 1/19/21 3. R118 has an active use of alcohol. R118 becomes intoxicated and displays decreased control of social behavior/function. Initiated 1/8/20, Revised 1/12/21 4. R118 smokes/vapes. R118 has been vaping in room daily with disregard for facility's policy. Initiated 11/4/19; Revised 10/12/20 5. R118 requires discharge planning related to R118's preference to return to the community. Initiated 5/8/20. Revised 9/22/20 Surveyor notes R118's discharge planning focused problem was not updated when R118 was issued the 30 day discharge notice on 6/22/21. Surveyor reviewed the 30 day discharge notice given to R118 on 6/22/21. Surveyor notes the reason for discharge is for the safety of the individuals in the facility is endangered. A discharge meeting was scheduled for 7/1/21. There is no documentation the discharge meeting occurred. There is no indication the 6/22/21 reason for discharge remained a current reason for discharge when the facility decided not to have accept R118 back into facility when R118 was hospitalized on [DATE]. Surveyor notes the 30 day discharge notice given to R118 on 6/22/21 does not identify a location to which R118 was to be discharged to or transferred to. Surveyor notes on the discharge notice the the name of the ombudsman to be contacted is incorrect. Surveyor notes the 30 day discharge notice did not contain the contact information responsible for the protection and advocacy of individuals with a mental disorder, even though R118 was admitted with a diagnosis of Major Depressive Disorder. (Cross Reference F623) Surveyor reviewed R118's electronic medical record (EMR) progress notes starting with 5/21 forward. Surveyor was not able to locate any documentation of R118's behaviors while at the facility until 9/18/21. The following was documented: (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/18/2021 1:59 PM Nurses Note Text: [R118] came down on Wing 2 without a mask and entered another Resident's room at approximately 9:00 AM. Writer told [R118] he must wear a mask in facility. [R118] became very angry and began calling writer many foul names repeatedly. Writer asked [R118] to stop using that language and [R118] intensified. Several other Residents came out of their rooms to see what was going on. Writer called Charge Nurse to report incident. Instructed to call [NAME] Police, which was done. Police arrived and found [R118] on another Wing. They reprimanded [R118] and left. Immediately after leaving, [R118] came back down Wing 2 towards writer and again began a barrage of insults and foul names. Also stated ha! ha! That didn't do you any good did it? No further problems after that. Continue to observe. 09/18/2021 2:30 PM Nurses Note Text: [R118] very agitated during this shift. [R118] yelling at staff through out this shift. Writer talked with [R118] multiple times regarding [R118's] behavior and [R118] was able to be redirected for short periods of time. Writer notified that [R118] was at middle nurses station with behaviors hitting [R118's] head on the nurses desk multiple times. Writer did get [R118] to come back to [R118's] unit. [R118] did admit to writer that [R118] had smoked marijuana. Upon attempting to assess [R118], became verbally agitated with writer then said [R118] was leaving to go to the store and left down the hallway and out the door. 09/18/2021 3:58 PM Nurses Note Text: [R118] found outside on sidewalk by patio area on ground. writer unable to complete assessment of [R118] due to [R118] thrashing around on the ground. Staff unable to use Hoyer sling to get [R118] off ground due to thrashing. R118 admitted to use of marijuana and drinking four loko. 911 called for assistance, paramedics and police. arrived. resident whites of eyes had a tint of yellowing. resident taken to ER (emergency room) for further medical evaluation. Nurse Practitioner (NP) and Assistant Director of Nursing (ADON) aware of above. 10/14/21 3:42 AM Nurses Note Text: [R118] has orders to collect urine specimen to rule out UTI (Urinary Tract Infection). Assisted nurse with replacing suprapubic catheter due to poor urinary output. Foley tubing noted with large amounts of sediment clogging urinary flow. Multiple attempts made to reinsert the suprabubic catheter, all unsuccessful. Unable to get a urinary return. [R118] has a history of obstruction. Bladder scan shows no large volume residual -- 50-100cc noted. [R118] is screaming. [R118's] mentation is also changed. [R118] is alert x 4 but presents with hysteria. Called on call MD from .Health and orders given to send to ER. Paramedics arrived to send the ER. [R118] continues to scream and attempting to throw self into floor. [R118] is yelling I'm drunk and high. Called (name of Hospital) and gave report. Vitals stable upon departure. Declines family update. All documentation sent with [R118]. The facility provided Surveyor with a transfer and bed hold document for [R118] and [R118] requested a bed hold. A written note on this transfer/bedhold notice indicated the document was reviewed with R118 at the hospital by a un-named case manager on 10/15/21 and signed by the facility. This transfer and bed hold document does not reference any information pertaining to an involuntary discharge. It reads as follows: Effective date discharge/transfer: 10/14/21,(name of facility) is transferring/discharging R118 to (name of hospital) for the following reasons:(this part Surveyor notes was left blank) The document lists the state agency and the state long -term care ombudsman information if R118 wanted to appeal the transfer/discharge. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document contains the facility's bed hold policy. It details the right of a bed hold when leaving the facility for a temporary stay in an acute care hospital or elsewhere. It outlines the charges for bed hold if private pay or Medicare. The document states if a Resident's hospitalization or therapeutic leave exceeds the bed hold period, the Resident will be readmitted to the first appropriate Semi-Private bed if the Resident requires the services provided by the facility and is eligible for Medicaid nursing facility services. Surveyor notes R118 chose to have R118's bed hold by checking, Yes I would like a bed hold. Surveyor notes upon review, there is no documentation in R118's EMR, that R118 was given the 30 day discharge notice and that it was explained to R118 in a language and manner that R118 could understand. R118's EMR does not contain documentation the state ombudsman was notified of the 30 day discharge notice. R118's EMR did not contain documentation from R118's primary physician of the specific needs that could not be met, facility attempts to meet those needs, and the service available at the receiving facility to meet R118's needs. Surveyor notes R118 was being treated by a psychologist who last saw R118 on 6/15/21 and documented R118 affect and demeanor appeared fairly stable. On 11/30/21 at 12:10 PM, Surveyor interviewed Social Worker (SW-E) in regards to R118's behaviors. SW-E indicated SW-E did not know much about R118. SW-E stated, the rumor was [R118] was drinking a lot, buying alcohol for other Residents, throwing self on the floor, refusing cares, smoking in the building, noncompliant, running into doorways, noncompliant with smoking and drinking .The facility tried re-approaching. Surveyor requested any documentation of R118's behaviors. Surveyor reviewed R118's Treatment Administration Records (TARS) from May to October 2021. Surveyor notes the targeted behaviors are not R118 specific. Surveyor also notes that each month contains several days where no documentation is recorded on whether R118 displayed behaviors or not. May 2021 - no behaviors documented June 2021- 6/4/21 Sexually inappropriate, yelling/screaming,kicking/hitting July 2021- 7/25/21-yelling/screaming,abusive language 7/26/21-abusive language 7/27/21-yelling/screaming,abusive language, wandering 7/31/21-abusive language August 2021-no behaviors documented (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	September 2021 -no behaviors documented October 2021-no behaviors documented On 11/30/21 at 1:04 PM, Surveyor spoke to hospital social worker (HSW-Q) for R118. HSW-Q stated the facility stopped returning calls after HSW-Q first spoke to a representative at the facility. HSW-Q stated the Administrator (NHA-A) informed HSW-Q the facility would not take [R118] back because of [R118's] behaviors. HSW-Q does not recall the exact date NHA-A informed HSW-Q that [R118] could not return to the facility. HSW-Q called Ombudsman (O-R) and was told by O-R that [R118's] 30 day discharge notice was not valid because there was no destination listed on it. HSW-Q validated [R118] remains in the hospital awaiting placement at this time. On 12/1/21 at 12:21 PM, Surveyor interviewed Activities Director (AD-F) who is familiar with R118. AD-F stated [R118] had no behaviors with AD-F. AD-F stated AD-F had heard [R118] was caught smoking in the facility a couple of times with an e-cigarette, and had verbal altercations (be rude to other Residents). AD-F stated [R118] attended parties, and social activities. [R118] was never disruptive, and respected AD-F. AD-F stated [R118] helped gather Residents and remind Residents of activities. On 12/01/21 at 12:52 PM, Surveyor interviewed NHA-A in regards to R118's discharge. NHA-A gave a 30 day discharge notice to R118, but does not have documentation R118 received the 30 day notice or understood the 30 day discharge notice. NHA-A stated the facility originally denied re-admission because [R118] had an expensive IV. NHA-A stated then [R118] ran out of bed hold days and informed the hospital the facility would not allow [R118] to return to the facility because of behaviors. NHA-A stated [R118] was buying alcohol for other Residents, would get high and drunk and would run into things with [R118's] power wheelchair. NHA-A stated that [R118] was not able to be re-directed. NHA-A stated NHA-A did not offer to assist HSW-Q with [R118's] discharge planning from the hospital. On 12/02/21 at 1:57 PM, Surveyor spoke to O-R in regards to R118. O-R does not remember having any contact directly with [R118]. O-R did speak to HSW-Q on 10/26/21 and informed HSW-Q [R118's] 30 day discharge notice was not valid due to it not containing documentation of a discharge location. O-R did speak to [R118] on 10/29/21 who indicated [R118] may not want to return to the facility. As of 12/01/21, R118 has not been readmitted back into the facility. 2) R119 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Neuromuscular Dysfunction of Bladder, Bipolar Disorder, and Attention Deficit Hyperactivity Disorder. R119 is her own person. R119's Quarterly Minimum Data Set (MDS) dated [DATE] documents R119's Brief Interview for Mental Status (BIMS) score to be a 15, indicating R119 was cognitively intact for daily decision making. R119 had a PHQ-9 score of 3, indicating minimal depression. The MDS documented R119 had verbal behavioral symptoms and rejection of care 1-3 days during the assessment period. Surveyor reviewed R119's comprehensive care plan and noted the following focused problems: 1. R119 has a behavior problem due to refusal to get out of R119's motorized chair for staff to perform incontinence cares, catheter cares, repositioning, offloading, skin assessments, application of barrier cream, treatment to wounds, assist with meals/liquid intake. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Initiated 9/9/21, Revised 10/22/21 2. R119 displays socially inappropriate behaviors related to mental illness. Makes sexually inappropriate comments both to and about staff. Displays angry, aggressive behaviors as evidenced by swearing at staff and peers and threatening to hit staff and peers with electric wheelchair. Making false accusations about staff. Initiated 5/28/21; Revised 8/5/21 3. R119 does not require active discharge planning as R119 is accepting of R119's need for long term placement. Initiated 5/28/21 Surveyor reviewed R119's Electronic Medical Record (EMR) for documentation of behaviors. Surveyor was not able to locate any documentation of behaviors in the progress notes. Surveyor notes that discharge planning for R119 started on 9/21/21, however, on 10/8/21 it is documented that R119 stated R119 could not discharge home at this time. Surveyor notes R119's comprehensive care plan documenting the focused problem: discharge planning was not updated when discharge planning was initiated on 9/21/21. Surveyor reviewed R119's Treatment Administration Record (TARS) for behavior documentation. Surveyor was not provided with August 2021 TARS upon request. The behavior documentation below are the days R119 had refusal of cares, refusing repositioning, and refusing to lay in bed. Surveyor also notes that each month contains several days where no documentation is recorded on whether R119 displayed behaviors or not. The expectation is for behaviors to be documented on per shift, daily. September 2021- 9/10/21,9/11/21,9/12/21,9/13/21,9/15/21,9/16/21,9/17/21,9/25/21, 9/26/21 October 2021- 10/4/21,10/6/21,10/7/21,10/9/21,10/10/21,10/11/21,10/13/21,10/15/21,10/20/21 Surveyor notes the following was documented in regards to R119's Against Medical Advice (AMA) discharge: 10/23/2021 9:41 AM Nurses Note Text: [R119] is requesting to be sent out to the emergency room (ER). [R119] tells writer she just doesn't feel good. [R119] says she feels like [R119] has a Urinary Tract Infection (UTI) and will not be cared for in the facility as [R119] feels she needs to. [R119] states, I think they don't even care and I'm leaving. Vitals taken and stable. NP (Nurse Practitioner) gives orders for Bactrim x 3 days and a repeat UA (urinalysis) with C&S (culture and sensitivity). Explained new orders to [R119]. [R119] declines treatment and states, I am leaving. NP aware. Explained AMA to the [R119]. Paperwork prepared and ready. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/23/2021 9:41 AM Nurses Note Late Entry: [R119] tells writer [R119] isn't coming back. Tells writer watch my things, after I'm better I'll be back to get them and I'm not coming back here again. I'm getting out of this place. [R119] declines bed hold or alternatives to cares and signed AMA paperwork with Emergency Medical Technician (EMT) as witness, Certified Nursing Assistant (CNA), and this writer. 10/23/2021 9:45 AM Nurses Note Text: Called to get non- emergent transport - cannot get transport- called 911 to send to emergency room (ER) for evaluation and treat. [R119] aware and will update family on own per her statement. 10/23/2021 11:29 AM Nurses Note Text: [R119] departed via EMT transfer. Report given to EMT and paperwork given upon departure. [R119] declined cares before departure as [R119] wanted to leave right now no medications given. 10/23/2021 9:53 PM Nurses Note Text: Writer called (name of hospital) ER-[R119] was admitted for UTI and Aspiration Pneumonia at 4:00 PM. [R119] is her own person. Management aware. On 11/30/21 at 12:10 PM, Surveyor spoke to Social Work (SW)-E in regards to R119. SW-E was not present when R119 left for the hospital and did not have anything to do with R119 discharging AMA. On 11/30/21 at 1:06 PM, Surveyor spoke to Hospital Social Worker (HSW)-Q who stated that HSW-Q does not know how [R119] could have signed an AMA form being a quadriplegic and that [R119] was very sick and confused when [R119] arrived to the ER. HSW-Q stated [R119] was admitted to Intensive Care Unit(ICU). HSW-Q contacted the facility seeking readmission for R119. HSW-Q does not remember on what date HSW-Q spoke with a representative at the facility or with whom. HSW-Q was informed at this time, the facility would not allow R119 to return to the facility due to behaviors. HSW-Q stated that [R119] was still in the hospital waiting for discharge. Surveyor reviewed documentation dated 10/23/21 from the hospital record and notes [R119's] chief complaint was coughing and respiratory failure, and [R119] required up to 8 liters of Oxygen (O2) on admission. Surveyor reviewed the the AMA document dated 10/23/21. The AMA document is titled, Leaving Nursing Center Against Advice. The document indicates, I [R119] am leaving this nursing center against the advice of my attending physician and this nursing center's administration. By signing below, I acknowledge that I have been informed of the risk involved and hereby release the attending physician and nursing center staff from responsibility for an ill effects or damages which may result from my choosing to leave the center. Surveyor notes R119 signed an AMA document with a squiggly line dated 10/23/21 with 1 witness signature. Surveyor was unable to contact the witness. On 12/1/21 at 11:05 AM, Surveyor interviewed Registered Nurse (RN-G) who was the RN involved with R119's AMA discharge. RN-G stated that RN-G had [R119] sign AMA because there was no physician order to leave. [R119] came to the desk stating [R119] had an UTI. Called the NP who ordered a collection of urine, and wanted to treat [R119] in house. RN-G stated the NP would not give an order to go to the ER. Tried to explain what the NP had stated to [R119], but [R119] kept calling RN-G the grim [NAME]. RN-G gave [R119] the AMA form to sign and [R119] said I don't have use of my hands. So RN-G told [R119] even a dot would work as a signature. RN-G does not know who the witness is. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted R119 signed the AMA document in order to obtain treatment outside of the facility. On 12/01/21 at 12:57 PM, Surveyor spoke to NHA-A about R119's AMA discharge. NHA-A stated, I don't even know if we got a phone call to take [R119] back. NHA-A stated the facility would not take [R119] back into the facility due to [R119's] behaviors. NHA-A stated [R119] refused to let the facility care for [R119] at times .[R119] would sit in the chair for days . Had bad wounds and was noncompliant with the treatments. NHA- A stated [R119] would not use the electric chair on low mode and would vape in [R119's] room. On 12/2/21 at 8:18 AM, Surveyor interviewed RN-G again and asked RN-G who instructed RN-G to have [R119] sign the AMA form. RN-G stated, no one did, I just knew that working in management at another facility; if you don't have an order it would be AMA. There is no documentation that RN-G consulted with facility management to discuss options for R119. Further, there is no documentation in R119's EMR that options to discharging AMA was discussed with R119. On 12/2/21 at 9:50 AM, Surveyor left a message for the NP who did not give an order for discharge. No return call was received. On 12/2/21 at 3:16 PM, Surveyor shared the concern with Administrator(NHA-A), Director of Nursing(DON-B), and Regional Nurse Consultant(RNC-C) that R118 and R119 were not permitted to return to the first available bed in the facility. As of 12/2/21, R119 has not been readmitted back into the facility. Surveyor's concern was acknowledged and no further information was provided at this time.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on record review and interview, the facility did not ensure 1 Resident (R88) of 5 sampled residents reviewed, met the PASRR (Pre-Admission Screen and Resident Review) requirements. R88 was admitted to the facility on [DATE] and the Level 1 PASRR documented R88 had no diagnosis of a major mental disorder. On 1/3/20 a diagnosis of bipolar disorder was entered in R88's medical record, the PASRR was not completed with the change in diagnosis information. Findings include: R88 was admitted to the facility on [DATE] with diagnoses that included anxiety. On 1/3/20 the diagnosis of bipolar disorder was added to R88's medical record. On 12/1/21, R88's PASRR level 1 screen dated 1/2/20 was reviewed and indicated R88 was not suspected of having a serious mental illness but was on the medications Ativan (antianxiety), Seroquel (antipsycotic) and Zyprexia (Antipsycotic). The screen indicated that a PASRR level 2 was not indicated. On 12/1/21 R88's diagnosis list was reviewed and read: 1/3/20 Bipolar disorder. On 12/2/21 at 12:30 PM Admissions Coordinator-T was interviewed and indicated she completed R88's PASRR 1 on admission but bipolar was not on R88's discharge hospital paperwork. Admissions Coordinator-T indicated she only does the initial PASRR based on the paperwork the hospital provides and does not do any additional PASRR's after admission. On 12/2/21 at 1:00 PM Regional Nurse Consultant-C was interviewed and indicated R88's PASRR level 1 should have been completed again with his diagnosis of Bipolar disorder and was not. The above findings were shared with the Administrator and Director of Nurses on 12/2/21 at 1:00 PM. Additional information was requested if available. None was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure 6 of 7 Residents (R13, R23, R24, R41, R46, & R96) and/or responsible party participated in the development of their person centered plan of care and making decisions about his or her care. *R13's electronic medical record (EMR) had no documentation that a care conference has been scheduled or taken place to discuss R13's plan of care. *R23's EMR documents the last care conference held was 10/20 for R23. *R24's EMR documents the last care conference held was 10/1/20 for R24. *R41's electronic medical record (EMR) had no documentation that a care conference has been scheduled or taken place to discuss R41's plan of care. *R46's EMR documents the last care conference held was 1/7/20 for R46. *R96's electronic medical record (EMR) had no documentation that a care conference has been scheduled or taken place to discuss R96's plan of care. Findings Include: Surveyor reviewed the facility's Resident Participation-Assessment/Care Plans policy and procedure revised December 2016 and notes the following: Policy Statement The Resident and his/her representative are encouraged to participate in the Resident's assessment and in the development and implementation of the Resident's care plan. Policy Interpretation and Implementation 1. The Resident and his/her legal representative are encouraged to attend and participate in the Resident's assessment and in the development of the Resident's person-centered care plan. 4. The care planning process will: a. Facilitate the inclusion of the Resident and/or representative b. Include an assessment of the Resident's strengths and his/her needs c. Incorporate the Resident's personal and cultural preferences in establishing goals of care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. A 7 day advance notice of the care planning conference is provided to the Resident and his/her representative. Such notice is made by mail and/or telephone. 8. The Social Services Director or designee is responsible for notifying the Resident/representative and for maintaining records of such notices. Notices include: a. The date, time, and location of the conference b. The name of each person contacted and the date he/she was contacted c. The method of contact d. Input from the Resident or representative if they are not able to attend e. Refusal of participation, if applicable f. The date and signature of the individual making the contact 1) R13 was admitted to the facility on [DATE] with diagnoses of Diffuse Traumatic Brain Injury, Obesity, Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, and Schizoaffective Disorder. R13 is her own person and has a caseworker. R13's Annual Minimum Data Set (MDS) dated [DATE] documents R13's Brief Interview for Mental Status (BIMS) score of 15, indicating R13 is cognitively intact for daily decision making. R13 is independent for all activities of daily living (ADLS). Surveyor reviewed R13's EMR and was unable to locate documentation that a care conference had been scheduled or occurred for R13. On 12/2/21 at 8:24 AM, Surveyor confirmed with R13 that R13 has not had a care conference meeting. R13 stated R13 would like a meeting to express R13's concerns and get answers on medical questions. 2) R23 was admitted to the facility on [DATE] with diagnoses of Paraplegia, Other Psychoactive Substance Use, and Anxiety Disorder. R23 is her own person and has a caseworker. R23's Quarterly Minimum Data Set (MDS) dated [DATE] documents R23 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R23 is cognitively intact for daily decision making. R23's MDS also documents R23 requires limited assistance for bed mobility and transfers. R23 requires supervision for dressing and extensive assistance for toileting. Surveyor reviewed R23's EMR and notes there is documentation that R23 last had a care conference in October of 2020. Further, Surveyor notes there is no documentation in R23's EMR that R23 and/or representative were offered to, or participated in any form of review of R23's comprehensive care plan either by in person, video, or by phone since October of 2020. On 11/29/21 at 10:37 AM, Surveyor spoke to R23 who can't remember the last time there was ever a care conference meeting for R23. R23 stated having a meeting is important because I am very involved in my care and sometimes I do not know what is going on. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) R24 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Cerebral Infarction, Vascular Dementia, and Major Depressive Disorder. R24 has an activated Health Care Power of Attorney (HCPOA). R24's Quarterly Minimum Data Set (MDS) dated [DATE] documents R24 has a Brief Interview for Mental Status (BIMS) score of 5 indicating R24 demonstrates severely impaired skills for daily decision making. R24's MDS also documents R24 requires extensive assistance for bed mobility and transfers. Surveyor reviewed R24's EMR and notes there is documentation that R24 last had a care conference on 10/1/20. Further, Surveyor notes there is no documentation in R24's EMR that R24 and/or representative were offered to, or participated in any form of review of R24's comprehensive care plan either by in person, video, or by phone since 10/1/20. 4) R41 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease, Stage 3, Type 2 Diabetes Mellitus, and Unspecified Dementia. R41 has an activated Health Care Power of Attorney (HCPOA). R41's Admission MDS dated [DATE] documents R41 has a BIMS score of 3 indicating R41 demonstrates severely impaired skills for daily decision. The MDS also documents R41 requires extensive assistance for bed mobility and total dependence for toileting. Surveyor reviewed R41's EMR and was unable to locate documentation that a care conference had been scheduled or occurred for R41 since admission and no documentation that R41's activated HCPOA had any input into R41's comprehensive care plan. 5) R46 was admitted to the facility on [DATE] with diagnoses of Hyperlipidemia and Unspecified Dementia. R46 has an activated Health Care Power of Attorney (HCPOA). R46's Annual MDS dated [DATE] documents R46 has a BIMS score of 0, indicating R46 demonstrates severely impaired skills for daily decision. The MDS also documents R46 requires extensive assistance with bed mobility and transfers and requires total dependence for eating, toileting, and hygiene. Surveyor reviewed R46's EMR and notes there is documentation that R46 last had a care conference on 1/7/20. Further, Surveyor notes there is no documentation in R46's EMR that R46's HCPOA were offered to, or participated in any form of review of R46's comprehensive care plan either by in person, video, or by phone since 1/7/20. 6) R96 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Peripheral Vascular Disease, Delusional Disorders, Major Depressive Disorder, and Shared Psychotic Disorder. R96 is his own person. R96's Annual MDS dated [DATE] documents R96's BIMS score of 15 meaning R96 is cognitively intact for daily decision making. The MDS also documents R96 requires extensive assistance for bed mobility, and total dependence for transfers. Surveyor reviewed R96's EMR and was unable to locate documentation that a care conference had been scheduled or occurred for R96. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/29/21 at 2:49 PM, spoke with R96 who stated that R96 has not had a care conference in a long time, and thinks its been over 3 months. R96's friend has not been invited to a care conference and is usually invited. R96 feels it would benefit so staff is consistent with R96's cares. R96 remembers having a care conference where there was no warning it was being held and both R96 and R96's friend were not invited. On 12/1/21 at 12:47 PM, Surveyor spoke to Administrator (NHA-A) about care conferences not being held for Residents on a quarterly basis. NHA-A stated NHA-A was made aware there was an issue of care conferences not being held when NHA-A became employed at the facility in June of 2021. NHA-A stated that it has been hard to catch up with care conferences because the facility has had so many new admissions but the goal is to get caught up by the end of the year. NHA-A shared on 6/28/21 a plan for improved compliance was completed for care conferences not being done. On 12/2/21 at 3:16 PM, Surveyor shared the concern with Administrator (NHA-A), Director of Nursing (DON-B), and Regional Nurse Consultant(RNC-C) that R13, R23, R24, R41, R46, and R96 had not participated in the development of their person centered plan of care and making decisions about his or her care with in formal meeting on a quarterly basis. The concern was acknowledged. No further information was provided at this time.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 7) R87 was admitted to the facility on [DATE] with diagnosis that included Dementia. R87's Admission Minimum Data Set (MDS) dated [DATE] indicated R87 requires 1 person physical assist with part of bathing. The MDS indicates R87 requires extensive assistance of 1 staff member for bed mobility, transferring, dressing, toilet use, and personal hygiene. On 11/29/21 at 2:00 PM R87 was observed in his wheelchair in his room with hair growth observed on his face. On 11/30/21 at 10:00 AM R87 was observed in his wheelchair in his room with hair growth observed on his face that was longer than 11/29/21. On 12/1/21 at 1:00 PM R87 was observed in his wheelchair in his room with hair growth observed on his face that was longer than the day before. R87 indicated he would like to be shaved and would not say no if someone offered to shave him. On 12/1/21 R87's shower records were reviewed and indicated R87 should receive a shower every week. No documentation could be found that R87 received showers for the week of 10/3/21, 10/10/21, 11/15/21 and 11/22/21. On 12/1/21 at 3:00 PM Corporate Consultant-C was interviewed and indicated no further documentation could be found to prove R87 received his scheduled showers. On 12/2/21 at 10:00 AM R87 was observed in his wheelchair clean shaven. The above information was shared with the Administrator and Director of Nurses on 12/1/21 at 3:00 PM. Additional information was requested if available. None was provided. 38829 Based on interview and record review the facility did not ensure that 6 (R1, R13, R18, R23, R87, & R96) of 7 sampled Residents requiring assistance of staff for showers and/or unable to carry out activities of daily living received necessary services. *Weekly showers were not recorded as being provided to R1 while at the facility and R1 would prefer 2 showers a week. *Weekly showers were not recorded as being provided to R13 while at the facility and R13 would prefer 2 showers a week. *Weekly showers were not recorded as being provided to R23 while at the facility and R23 would prefer 2 showers a week. *Weekly showers were not recorded as being provided to R18 while at the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Weekly showers were not recorded as being provided to R87 while at the facility and R87 has not received shaving assistance. *Weekly showers were not recorded as being provided to 96 while at the facility and R96 would prefer 2 showers a week. Findings Include: Surveyor reviewed the facility's Activities of Daily Living(ADLs), Supporting policy and procedure revised March 2018 and noted the following: Policy Statement Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy Interpretation and Implementation 1. Residents will be provided with care, treatment, and services to ensure that their ADLs do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. 2. Appropriate care and services will be provided for Residents who are unable to carry out ADLs independently, with the consent of the Resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene(bathing, dressing, grooming, and oral care) 5. A Resident's ability to perform ADLs will be measured using clinical tools, including the Minimum Data Set (MDS). 6. Interventions to improve or minimize a Resident's functional abilities will be in accordance with the Resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The Resident's response to interventions will be monitored, evaluated, and revised as appropriate. 1) R1 was admitted to the facility on [DATE] with diagnoses of Epilepsy, Peripheral Vascular Disease, Unspecified Dementia with Behavioral Disturbance, Developmental Disorder of Scholastic Skills, and Major Depressive Disorder. R1 has a legal guardian. R1's Quarterly MDS dated [DATE] documents R1 has a Brief Interview for Mental Status (BIMS) score of 10, indicating R1 demonstrates moderately impaired skills for daily decision making. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS documents R1 is independent with ADLs but requires physical help in part of bathing activity with support provided. R1's Annual MDS dated [DATE] documents R1 feels it is very important to the question of: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. Surveyor reviewed R1's comprehensive care plan which documents the focused problem of self care deficit due to cognitive deficits, decreased mobility, and generalized weakness. Initiated 8/12/20 Intervention initiated on 9/24/20 documents R1 requires supervision for bathing. R1 is scheduled for a shower on Wednesday on PM shift. Surveyor requested R1's shower sheets for September, October, November of 2021. Surveyor was provided the following: 3 shower sheets for September dated 9/13/21, 9/17/21, 9/24/21-all documented that R1 received a shower on that date October-no completed shower sheets and treatment administration record (TAR) indicates R1 received 1 shower for the month-10/7/21 November-no completed shower sheets and treatment administration record (TAR) indicates R1 received 3 showers for the month-11/3/21, 11/10/21, 11/17/21. On 12/1/21 at 9:13 AM, R1 informed Surveyor that R1 can not remember the last time R1 had a shower. R1 stated R1 is upset about not getting a shower 2x a week. 2) R13 was admitted to the facility on [DATE] with diagnoses of Diffuse Traumatic Brain Injury, Obesity, Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, and Schizoaffective Disorder. R13 is her own person. R13's Annual Minimum Data Set (MDS) dated [DATE] documents R13's Brief Interview for Mental Status (BIMS) score of 15, indicating R13 is cognitively intact for daily decision making. R13 is independent for all activities of daily living (ADLS). The MDS also documents that bathing did not occur for R13. R13 feels it is very important to the question of: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. Surveyor reviewed R13's comprehensive care plan which documents the focused problem of self care deficit due to decreased mobility, and generalized weakness. Initiated 9/13/20 Intervention initiated on 9/3/20 documents R13 requires assistance of 1 for ADLs. R13 is scheduled for a shower on Friday on PM shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested R13's shower sheets for September, October, November of 2021. Surveyor was provided the following: September-no documentation of showers October- no completed shower sheets and treatment administration record(TAR) indicate R13 received 1 shower for the month-10/23/21 November- completed shower sheet for 11/12/21 and treatment administration record(TAR) indicate R13 received 2 showers for the month-11/5/21,11/12/21 On 12/1/21 at 9:13 AM, R13 informed Surveyor that R13 is pissed off about the change from 2 showers a week to 1 shower per week. R13 stated it feels like R13 has gone months without a shower. 3) R18 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, Major Depressive Disorder, and Anxiety Disorder. R18 is his own person. R18's Annual MDS dated [DATE] documents R18's BIMS score of 14, indicating R18 is cognitively intact for daily decision making. R18's MDS documents R18 is independent with ADLS and bathing did not occur. R18 feels it is very important to the question of: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. Surveyor reviewed R18's comprehensive care plan which documents the focused problem of self care deficit due to decreased mobility, and generalized weakness. Initiated 1/12/20 Intervention initiated on 5/5/20 documents R18 requires assistance of 1 for ADLs. R18 is scheduled for a shower on Monday on AM shift. Surveyor requested R18's shower sheets for September, October, November of 2021. Surveyor was provided the following: September-1 completed shower sheet-9/21/21 October- no completed shower sheets and treatment administration record(TAR) indicate R18 received 2 showers for the month-10/23/21,10/30/21 November- no completed shower sheet and treatment administration record(TAR) indicate R18 received 1 shower for the month-11/29/21 On 12/1/21 at 9:13 AM, R18 informed Surveyor R18 last had a shower about 3 wks ago. R18 stated R18 feels grubby and when R18 gets a shower R18 feels exhilarated and wants to do something for the day. 4) R23 was admitted to the facility on [DATE] with diagnoses of Paraplegia, Other Psychoactive Substance Use, and Anxiety Disorder. R23 is her own person. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23's Annual Minimum Data Set (MDS) dated [DATE] documents R23's Brief Interview for Mental Status (BIMS) score of 15, indicating R23 is cognitively intact for daily decision making. R23's MDS also documents R23 requires limited assistance for bed mobility and transfers. R23 requires supervision for dressing and extensive assistance for toileting. R23's MDS documents R23 needs physical help. R23's Annual MDS dated [DATE] documents R23 feels it is very important to the question of: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. Surveyor reviewed R23's comprehensive care plan and notes R23's ADL status and bathing are not documented. R23 is scheduled for a shower on Thursday on PM shift. Surveyor requested R23's shower sheets for September, October, November of 2021. Surveyor was provided the following: September-no documentation of showers October- completed shower sheets for 10/1/21, 10/8/21 and treatment administration record (TAR) indicate R23 received 1 showers for the month-10/4/21 November-no completed shower sheets and treatment administration record(TAR) indicate R23 received 0 showers for the month On 11/29/21 at 10:31 AM, R23 informed Surveyor that R23 used to receive 2 showers a week but it was changed to 1 shower per week. R23 stated the day and time switched for R23's shower. R23 stated R23 would prefer a shower 2x per week. R23 stated, I feel yucky without a shower. I'm young and want more showers. 5) R96 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Peripheral Vascular Disease, Delusional Disorders, Major Depressive Disorder, and Shared Psychotic Disorder. R96 is his own person. R96's Annual MDS dated [DATE] documents R96's BIMS score of 15 meaning R96 is cognitively intact for daily decision making. The MDS also documents R96 requires extensive assistance for bed mobility, dressing, personal hygien and total dependence for transfers. R96 requires physical help with 1 staff for bathing. R96 feels it is somewhat important to the question of: How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath. Surveyor reviewed R96's comprehensive care plan which documents the focused problem of self care performance deficit due to limited range of motion limited mobility, and musculosketal impairment Initiated 6/9/16 Intervention initiated on 1/18/19 documents R96 is to be given showers on Wednesday evening and Sunday morning. R96 is scheduled for a shower on Thursday on AM shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested R96's shower sheets for September, October, November of 2021. Surveyor was provided the following: September-no documentation of showers October- completed shower sheets for 10/4/2, and treatment administration record(TAR) indicate R96 received 2 showers for the month-10/10/21 and 10/24/21 November- completed shower sheet for 11/11/21 which states that the shower could not be given due to no linen and treatment administration record(TAR) indicate R96 received 1 shower for the month-11/25/21 On 11/29/21 at 2:41 PM, R96 informed Surveyor that R96 has not been getting showers 2x per week anymore and now its only 1x per week. R96 stated R96 would prefer 2x per week and stated R96 does not feel clean when R96 goes without a shower. 6) On 12/1/21 at 9:13 AM, Resident Council group informed Surveyor that showers went down from 2x to 1x a wk in October and all Residents are not happy. The 5 Residents in attendance (R18, R91, R1, R20 and R13) further stated that the days the showers are given were switched and do not know what day or shift the shower was switched to. All Residents in attendance stated they would prefer to receive 2 showers a week. Surveyor reviewed the Resident Council Minutes and notes on 10/26/21, Administrator(NHA-A) informed Residents of the new shower schedule of going to 1 shower a week. On 12/1/21 at 8:46 AM, Surveyor asked NHA-A, did you tell Residents they would only be getting 1 shower a week due to staff issues? NHA-A confirmed this statement and stated NHA-A informed the Residents at Resident council meeting. On 12/2/21 at 3:16 PM, Surveyor shared the concern with Administrator(NHA-A), Director of Nursing(DON-B), and Regional Nurse Consultant(RNC-C) about R1, R13, R18, R23, R96 not getting showers, not even 1x per week. RNC-C confirmed that the shower sheets should be completed by Certified Nursing Assistants everytime a Resident gets a shower.

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F 0684 Level of Harm - 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** 36161 2.) R93 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Diabetes Mellitus and Anxiety Disorder. R93's Admission MDS (Minimum Data Set) dated 11/5/21 documents a BIMS (Brief Interview for Mental Status) score of 11, indicating that R93 has moderate cognitive impairment. R93's Diabetes Mellitus management care plan dated as initiated on 11/1/21 documents under the Interventions section, Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. On 11/29/21 at 10:24 a.m., Surveyor interviewed R93 regarding the quality of care at the facility. R93 informed Surveyor that he had recently stubbed his right big toe on the dresser and that a nurse came and just put a Band-Aid on it. R93 informed Surveyor that he was concerned that since then, nursing staff had not come to evaluate the area and or change the Band-Aid. Surveyor reviewed R93's medical record, including R93's MAR (Medication Administration Record) and TAR (Treatment Administration Record) and was unable to locate any documentation that facility staff had assessed or treated R93's right toe and or that facility staff was inspecting R93's feet daily as documented in R93's diabetes management care plan. On 11/30/21 at 2:51 p.m., Surveyor observed CNA (Certified Nursing Assistant)-N remove R93's socks. Surveyor observed some dried blood on R93's left toe nail and a scab on his right toe. On 11/30/21 at 2:59 p.m., Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. NHA-A informed Surveyor that she would get nursing staff to assess R93's feet and would follow up with Surveyor. R93's nursing note dated 11/30/21 at 4:06 PM documents, Nurses Note Text: This writer was informed that resident complained that he bumped his toe on his dresser a few days ago and a nurse put on band aid on it. Writer went and talked to resident he states that maybe 5-6 days ago he bumped his right big toe un the dresser and he got a small cut he stated he told a nurse and she put a band aid on it. No band aid noted. Right great toe has a 1.5 x 1.5 (centimeter) scab on it no s/sx (signs or symptoms) of infection. Resident denies any pain. No treatment needed at this time. NP (nurse practitioner) aware NNO (no new orders). On 12/1/21 at 10:32 a.m., Surveyor informed DON (Director of Nursing)-B and RN (Registered Nurse) Consultant-C of the above findings. Surveyor asked RN Consultant-C if R93 should be getting daily foot checks as documented in R93's diabetes management plan of care. RN Consultant-C reviewed R93's medical record and informed Surveyor that R93 should be getting daily foot checks as documented in R93's plan of care. RN Consultant-C informed Surveyor that she had added daily foot checks to R93's TAR (Treatment Administration Record) so that it could be completed daily. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	No additional information was provided. 3.) R97 was admitted to the facility on [DATE] with diagnoses that included Quadriplegia, Bipolar Disorder, Schizophrenia, Diabetes Mellitus Type II and Sepsis. R97's Admission MDS (Minimum Data Set) dated 8/29/21 documents a BIMS (Brief Interview for Mental Status) score of 10, indicating that R97 is moderately cognitively impaired. Section G (Functional Status) documents that R97 requires extensive assistance and a two person physical assist for his bed mobility needs. Section G0400 (Functional Limitation in Range of Motion) documents that R97 has impairment to one side of his upper extremities and no impairment to either side of his lower extremities. Section M (Skin Conditions) documents that R97 was admitted to the facility with 1 surgical wound present upon admission to the facility. R97's Skin Integrity care plan dated as initiated on 8/23/21 documents under the Focus section, Resident has impaired skin integrity .surgical wound to RLE (right lower extremity)- resolved 11/23/21. Under the Interventions section it documents, Treatment as ordered. R97's wound assessment dated [DATE] documents, right lower extremity- surgical incision; measurements: 12.5 (centimeters) x 4.3 cm x 0; Description: scab; Treatment: betadine. Surveyor noted that R97 received weekly wound assessments and daily treatments for his Right lower extremity surgical wound from 8/24/21 to 9/14/21. R97's Tissue Analytics assessment as completed by Wound MD (Medical Doctor)-P and dated 9/14/21 documents, Location: Right shin; Length: 10.23 cm, Width: 2.67 cm, Depth 0.10 cm, Etiology: Trauma, Woundbed Assessment: Eschar: 76-100%, Plan of Care: Discussed with facility staff. Surveyor noted that per Wound MD-P's documentation, R97's right shin surgical wound was debrided by Wound MD-P on 9/14/21. R97's Tissue Analytics post debridement assessment as completed by Wound MD-P, dated 9/14/21 documents, Location: Right Shin; Length: 10.93 cm, Width: 3.20 cm; Depth 0.20 cm; Etiology: Trauma; Woundbed Assessment: Granulation 1-25%, Slough 51-75%; Orders: Cleanse wound with saline; protect periwound with skin prep, apply silver gel to wound bed, cover wound with ABD (Army Battle Dressing), secure dressing with Kerlix, change daily, Change PRN (as needed) for soiling and/or saturation. R97's Orthopedic Clinic Visit Notes dated 9/21/21 documents, RLE (Right Lower Extremity): Right lower extremity incision is open. Please put on wound vac (vacuum) on this incision that is okay today when patient arrives back to facility. Dressing changes need to bed 3 x (times) a week. R97's Physician Progress Notes from the orthopedic clinic dated 9/21/21 documents, Ortho trauma, Okay to shower/needs shower; cover right leg in shower. Please put wound vac on right leg today; please do dressing changes 3 times a week. Please call us with wound concerns. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor was unable to locate any documentation in R97's medical record that R97's physician or Wound MD-P was notified of the above orders. Surveyor was unable to locate any documentation that any facility staff followed up on R97's orthopedic clinic orders dated 9/21/21. Surveyor was unable to locate any documentation in R97's medical record that the above orders for a wound vacuum to be applied to R97's right lower extremity wound were followed and implemented by facility staff on 9/21/21. R97's wound assessment dated [DATE] documents, right lower extremity- surgical incision; measurements: 13.2 (centimeters) x 2.16 cm x 0.2; Description: 75% granulation 25% slough, small drainage; Treatment: change to skin prep. R97's Tissue Analytics wound assessment as completed by Wound MD-P, dated 9/28/21 documents, Location: Right Shin; Length: 6.05 cm, Width: 2.16 cm; Depth 0.20 cm; Etiology: Trauma; Woundbed Assessment: Granulation 51-75%, Slough 1-25%; Orders: Cleanse wound with saline; protect periwound with skin prep, apply santyl to wound bed, cover wound with bordered gauze, change daily, Change PRN (as needed) for soiling and/or saturation. Surveyor was unable to locate any documentation that R97's 9/21/21 wound vacuum orders were implemented by the facility. Surveyor was unable to locate any documentation from Wound MD-P that he was aware of R97's 9/21/21 wound vacuum orders or any documentation from Wound MD-P that stated why a wound vacuum was inappropriate for R97. R97's Tissue Analytics wound assessment as completed by Wound MD-P, dated 10/5/21 documents, Location: Right Shin; Length: 10.73 cm, Width: 3.28 cm; Depth 0.20 cm; Etiology: Trauma; Woundbed Assessment: Granulation 51-75%, Slough 1-25%; Orders: Cleanse with 1/2 strength Dakin's solution, protect periwound with skin prep, apply santyl to wound bed, apply alginate to wound bed, change daily, change PRN (as need) for soiling and/or saturation. Surveyor was unable to locate any documentation that R97's 9/21/21 wound vacuum orders were implemented by the facility. Surveyor was unable to locate any documentation from Wound MD-P that he was aware of R97's 9/21/21 wound vacuum orders or any documentation from Wound MD-P that stated why a wound vacuum was inappropriate for R97. R97's Tissue Analytics wound assessment as completed by Wound MD-P, dated 10/12/21 documents, Location: Right Shin; Length: 10.73 cm, Width: 3.28 cm; Depth 0.20 cm; Etiology: Trauma; Woundbed Assessment: Granulation 51-75%, Slough 1-25%; Orders: Cleanse with 1/2 strength Dakin's solution, protect periwound with skin prep, apply santyl to wound bed, apply alginate to wound bed, change daily, change PRN (as need) for soiling and/or saturation. Surveyor was unable to locate any documentation that R97's 9/21/21 wound vacuum orders were implemented by the facility. Surveyor was unable to locate any documentation from Wound MD-P that he was aware of R97's 9/21/21 wound vacuum orders or any documentation from Wound MD-P that stated why a wound vacuum was inappropriate for R97. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R97's Tissue Analytics wound assessment as completed by Wound MD-P, dated 10/12/21 documents, Location: Right Shin; Length: 9.82 cm, Width: 3.31 cm; Depth 0.10 cm; Etiology: Trauma; Woundbed Assessment: Granulation 76-100%; Orders: Cleanse wound with saline, protect periwound with skin prep, apply Xeroform gauze (cut to size) to wound bed, cover wound with ABD (Army Battle Dressing), Secure dressing with Kerlix, change daily, change PRN (as needed) for soiling and/or saturation. Surveyor was unable to locate any documentation that R97's 9/21/21 wound vacuum orders were implemented by the facility. Surveyor was unable to locate any documentation from Wound MD-P that he was aware of R97's 9/21/21 wound vacuum orders or any documentation from Wound MD-P that stated why a wound vacuum was inappropriate for R97. R97's Orthopedic Clinic Visit Notes dated 10/15/21 documents, RLE (Right Lower Extremity): Right lower extremity incision is open (orthopedics is following this wound). Please put on wound vac (vacuum) on this incision that is okay today when patient arrives back to facility. Dressing changes need to bed 3 x (times) a week; Plan: Doctor is following this wound as this is their incision from surgery so we will be providing instructions for wound care. Please continue to use of wound vac until we see him back in clinic on 10/26/21. Patient needs to see infectious disease team- Infectious Disease Clinic at 414- . R97's Physician Progress Notes from the orthopedic clinic dated 10/15/21 documents, See attached. Put wound vac on asap (as soon as possible); Keep on until our next visit. Change vac dressing 3 times a week. Surveyor was unable to locate any documentation in R97's medical record that the above orders for a wound vacuum to be applied to R97's right lower extremity wound were followed and implemented by facility staff on 10/15/21. Surveyor was also unable to locate any documentation from facility staff that the infectious disease clinic was contacted by facility staff for R97 as documented in R97's Orthopedic Clinic Visit Notes dated 10/15/21. R97's nursing note dated 10/15/21 documents, Type: Nurses Note Text: MD CONTACT: Staff Member contacted B@B (name of facility) today. Stated that this resident was to have a Wound Vac and wanted to know why it had not been started. Author could not answer that question; informed her that author would have to review the orders. Dr (doctors)'s office would like a supervisor to contact them regarding this issue. R97's nursing noted completed by LPN (Licensed Practical Nurse)-S and dated 10/15/21 documents, Type : Nurses Note Text: Writer received phone call from ortho office. Resident was seen and orders to have wound vac placed. Writer explained resident has been seen by wound doctor here in facility and Wound MD-P has stated wound vac is not appropriate this RLE wound. Writer gave ortho office Wound MD-P, phone number and faxed over wound assessment to ortho office. At this time wound vac is not ordered by Wound MD-P and continue treatment as ordered and wound is healing evidenced by assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/2/21 at 1:02 p.m., Surveyor interviewed Wound MD-P regarding R97's right shin surgical wound. Surveyor asked Wound MD-P if he was aware of R97's orthopedic recommendations dated 9/21/21 and 10/15/21 for a wound vacuum placement on R97's right lower extremity. Wound MD-P informed Surveyor that he was informed by LPN-S that the orthopedic clinic wanted a wound vacuum placed on R97's right lower extremity on 10/15/21 and not prior to that. Wound MD-E informed Surveyor that he was not aware that the wound vacuum recommendation was initially made on 9/21/21. Wound MD-P informed Surveyor that due to the granulation in R97's right lower extremity wound, he felt that a wound vacuum was inappropriate for R97. Surveyor asked Wound MD-P if he had been made aware that R97's right lower extremity wound was referred to the infectious disease clinic on 10/15/21. Wound MD-P informed Surveyor that he was not made aware that R97's right lower extremity wound was referred to the infectious disease clinic on 10/15/21. Surveyor asked Wound MD-P if he had spoken to the orthopedic clinic regarding the disagreement on the placement of a wound vacuum for R97, as Surveyor was unable to locate any documentation in R97's medical record that he (Wound MD-P) had documented a reason for disregarding the orthopedic surgeon's physician orders. Wound MD-P informed Surveyor that he never spoke to the orthopedic clinic regarding the disagreement on the placement of a wound vacuum for R97 as he assumed LPN-S had informed the clinic to contact him (Wound MD-P). Wound MD-P informed Surveyor that he felt the wound vacuum order was for another wound and not R97's right lower extremity, but informed Surveyor that he was not aware of R97's orthopedic clinic orders or recommendations. On 12/2/21 at 3:07 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided. On 12/6/21 at 2:47 p.m., Surveyor informed LPN-S of the above findings. Surveyor asked LPN-S if she had been aware that R97's orthopedic clinic had provided physician orders for the placement of a wound vacuum on R97's right lower extremity on 9/21/21. LPN-S informed Surveyor that she was not aware that R97's orthopedic clinic had provided physician orders for the placement of a wound vacuum on R97's right lower extremity on 9/21/21. Surveyor asked LPN-S if she had been made aware that R97's right lower extremity wound was referred to the infectious disease clinic on 10/15/21. LPN-S informed Surveyor that he was not made aware that R97's right lower extremity wound was referred to the infectious disease clinic on 10/15/21. Surveyor asked LPN-S if she had reached out to the orthopedic clinic to inform them that Wound MD-P did not want a wound vacuum placed on R97's right lower extremity on 10/15/21. LPN-S informed Surveyor that she only reached out to the orthopedic clinic to provide them with Wound MD-P's contact information and that she assumed Wound MD-P would clear up any confusion with the orthopedic clinic. No additional information was provided as to why the facility did not ensure that R97's right lower extremity wound received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 38253 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	4.) R18 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia, diabetes with peripheral angiopathy, chronic obstructive pulmonary disease, peripheral venous insufficiency, and congestive heart failure. R18's Annual Minimum Data Set (MDS) assessment dated [DATE] indicated R18 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and coded R18 as being independent with bed mobility and transfers. R18's Impaired Skin Integrity Care Plan was initiated on 1/4/2020. On 9/17/2021 at 2:57 AM in the progress notes, a Registered Nurse (RN) charted R18 had fluid draining down the right lower leg and two open areas were noted on the right lower lateral shin draining serous drainage with no signs of infection. Nursing charted the area appears to be opened blisters related to edema. Nursing notified the Nurse Practitioner. R18's Impaired Skin Integrity Care Plan was revised with interventions to elevate the legs to reduce edema and have the wound team monitor the wounds. On 9/17/2021, an Initial Wound Assessment was completed on both open areas of the right lower leg measuring 2.0 cm x 2.2 cm x 0.1 cm and 0.5 cm x 2.0 cm x 0.1 cm with the wound base 75% granulation and 25% slough for both areas. On 9/17/2021, an SBAR Communication Form was completed indicating R18 had a skin wound or ulcer in an area where a wound had been before, with edema and a blister. On 9/18/2021, a treatment was started of oil emulsion non-adhesive dressings to both areas followed by an ABD bandage and wrapped with rolled gauze and tubi grip daily. No documentation of weekly comprehensive assessments was found of the right lower leg wounds after the initial assessment on 9/17/2021. On 10/12/2021, R18 was transferred to the hospital. On 10/18/2021 at 11:03 PM in the progress notes, an RN charted R18 was readmitted to the facility at 5:30 PM and a skin assessment was completed. No skin assessment documentation was found on 10/18/2021. A treatment to the right lower leg was continued as prior to hospitalization . No Admit/Readmit Assessment was completed on 10/18/2021 when R18 returned to the facility. On 10/24/2021 an Admit/Readmit Assessment was completed and the Skin Integrity section of the form documented R18 had a vascular wound to the left lower leg measuring 4.0 cm x 3.2 cm with no depth and a description stating the wound was venous. The documentation of the location of the wound was incorrect: the wound was on the right lower leg. This assessment was six days after R18 had been readmitted to the facility. On 10/26/2021 on the Weekly Wound Assessment form, nursing documented the vascular wound to the right lower leg measured 4.0 cm x 3.2 cm x 0.1 cm with 100% granulation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The wound to the right lower leg was comprehensively assessed weekly from 10/26/2021 until the time of the survey. In an interview on 11/29/2021 at 3:06 PM, R18 stated there is a wound to the right lower leg that gets a treatment almost every day and R18 had no concerns with the wound treatment being completed. Surveyor verified that a treatment was ordered to be completed every three days. In an interview on 12/6/2021 at 12:27 PM, Surveyor shared with Director of Nursing (DON)-B and Regional Nurse Consultant-C the concerns R18 did not have weekly comprehensive assessments of the right lower leg wounds after the initial discovery on 9/17/2021 until R18 was admitted to the hospital on 10/12/2021, when R18 was readmitted to the facility on [DATE] a complete assessment was not done for six days until 10/24/2021, and the skin assessment was not completed until 10/26/2021. Regional Nurse Consultant-C stated the readmission assessment on 10/24/2021 should have been the right leg instead of the left leg. Surveyor asked when would the facility expect a readmission assessment to be completed. Regional Nurse Consultant-C stated it should have been done as soon as the resident got into the building. Regional Nurse Consultant-C agreed with Surveyor the wounds should have been assessed weekly and documented in R18's medical record. No further information was provided at that time. 40533 Based on interview and record review, the facility did not ensure that 4 (R59, R97, R93 and R18) of 22 residents reviewed for quality of care received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, that will meet each resident's physical, mental, and psychosocial needs. 1. R59 had orders for 2 Comprehensive Metabolic Panel (CMP) lab draws to be completed on 11/8/21 and 11/15/21. The labs were not ordered and never completed. There was no follow up from the facility to ensure the labs were completed as ordered. On 11/15/21 R59 was hospitalized for acute renal failure Stage 3, hypocalcemia with recent treatment of hypercalcemia, mild hyperkalemia and decreased bicarbonate. These changes and abnormal lab values could have been identified had the 11/8/21 and the 11/15/21 labs been drawn. 2. R97 had a surgical wound. The facility did not follow MD orders for care and treatment. 3. R93 sustained a toe injury and was not having diabetic foot checks or care to that area. 4. R18 had missing assessments of blisters to the right lower leg and R18 was not comprehensively assessed for six days when readmitted to the facility. The example involving R59 is being cited at a scope/severity of a G (actual harm/isolated). Findings include: 1. Surveyor reviewed facility's Lab Diagnostic Test Results - Clinical Protocol policy with a revision date of November 2018. Documented was: Assessments and Recognition (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility . R59 was admitted to the facility 9/2/21 with diagnoses that included Cyst of Pancreas, Chronic Kidney Disease Stage 3 and Severe Protein Calorie Malnutrition. Surveyor reviewed Progress Notes documented by Former Nurse Practitioner (NP)-D. Documented on 10/6/21 was: [History of Present Illness (HPI)]: The patient was admitted to the [facility] on 9/2/21 after a 2-week long hospital stay. The patient presented to the hospital with abdominal pain, nausea and vomiting. After further review, the patient recently underwent a pancreatic necrosectomy and a diverting colostomy with a GJ tube that was converted to a G-tube due to necrotizing infected pancreatitis with colonic pancreatic fistula. After further workup, the patient was found to have [acute kidney injury (AKI)]. She was started on IV fluids and given pain medications and antiemetics. Due to the patient's dementia, she is unable to contribute to historical health information. After further review, the patient's health history includes hypertensive heart failure, hyperlipidemia, coronary artery disease, anemia, and on a long-term anticoagulant. She has seasonal/environmental allergies, chronic obstructive pulmonary disease and obstructive sleep apnea. She has anxiety and depression and is followed by psych. The patient is malnourished, has dysphagia, gastro-esophageal reflux disease, and the presence of colostomy. She has hypothyroidism, diabetes mellitus type II, and chronic kidney disease stage 3 without the use of insulin. She has rheumatoid arthritis, osteoporosis and an unsteady gait with a history of falls . CARE PLAN / ASSESSMENT ICD 10 or [diagnosis (DX)]: Chronic kidney disease, unspecified -New order for repeat [Basic Metabolic Panel (BMP)] -Monitor intake and output -Monitor weight -Monitor BMP -Monitor vitals -Avoid nephrotoxic medications . Surveyor reviewed BMP labs ordered and drawn on 9/16/21. Results were reviewed by NP-D and no new orders were given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Lab results were: Potassium: 4.3 (normal reference range 3.4 - 5.1) Blood Urea Nitrogen (BUN): 35 High (normal reference range 6 - 23) Creatinine: 2.35 High (normal reference range 0.70 - 1.30) Calcium: 12.4 High (normal reference range 8.4 - 10.2) Surveyor reviewed BMP labs ordered and drawn on 9/24/21. Results were reviewed by NP-D and no new orders were given. Lab results were: Potassium: 3.8 (normal reference range 3.4 - 5.1) BUN: 29 High (normal reference range 6 - 23) Creatinine: 2.11 High (normal reference range 0.70 - 1.30) Calcium: 12.2 High (normal reference range 8.4 - 10.2) Surveyor reviewed BMP labs ordered and drawn on 10/1/21. Results were reviewed by NP-D and no new orders were given. Lab results were: Potassium: 3.8 (normal reference range 3.4 - 5.1) BUN: 36 High (normal reference range 6 - 23) Creatinine: 1.88 High (normal reference range 0.70 - 1.30) Calcium: 11.9 High (normal reference range 8.4 - 10.2) Surveyor reviewed BMP labs ordered and drawn on 10/6/21. Results were reviewed by NP-D and no new orders were given. Lab results were: Potassium: 4.1 (normal reference range 3.4 - 5.1) BUN: 32 High (normal reference range 6 - 23) Creatinine: 1.88 High (normal reference range 0.70 - 1.30) Calcium: 12.1 High (normal reference range 8.4 - 10.2) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R59's MD orders with a date of 10/12/21. Documented was discontinue Sodium Bicarbonate. There was no further BMP, CMP or other labs to monitor Potassium, BUN, Creatinine, Calcium or Sodium Bicarbonate from 10/12/21 through 11/5/21. NP-D was not employed at the facility after 10/18/21 and MD-L continued to follow R59 and write orders. Surveyor reviewed R59's MD-L's orders with an order date of 11/5/21. Documented with a start date of 11/8/21 was CMP, one time only for 1 Day. This order was documented Completed on 11/9/21. Documented with a start date of 11/15/21 was CMP and [Vitamin D], one time only for 1 Day. This order was documented Completed on 11/16/21. Surveyor reviewed R59's hard chart, Electronic Medical Record and lab results provided by the facility. There were no lab results from 11/8/21. The lab results from 11/15/21 included a stool sample lab and a blood test but did not include a CMP or Vitamin D lab test as ordered. Surveyor reviewed R59's Progress Notes with a date of 11/15/21. Documented at 3:35 PM was Patient transported to a local ED after discussing her condition with [NP]. Patient had been complaining of headache past several days . Surveyor reviewed Hospital Paperwork with an admitted [DATE] and discharge date of [DATE]. Documented was: Hospital Course . Acute renal failure on stage 4 chronic kidney disease Electrolyte derangements including Hypocalcemia with recent treatment for hypercalcemia, hyperkalemia, hypomagnesemia . -IV fluids per Nephrology. Creatinine on admission 3 (with baseline creatinine on 09/23/2021 2.1) -> improved 1.9 with fluids, at baseline. -calcium gluconate per nephrology -ionized calcium ordered -phosphorus normal -Vitamin-D ordered Mild hyperkalemia -no acute changes on [electrocardiogram (EKG)] -use IV fluids -nephrology on consult, started on Veltessa. Placed on 70 mEq per day oral potassium restriction. Continue oral sodium bicarbonate. Attached 5.9 -> 5.6. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-cleared for discharge and follow with Nephrology outpatient Severe Hypomagnesemia - replaced and corrected, replaced Decreased bicarbonate -likely secondary to her renal disease -has been on sodium bicarbonate . Laboratory values: 11/15/21 [4:05 PM] BUN: 56 High (normal reference range 6 - 23) Creatinine: 3.03 High (normal reference range 0.70 - 1.30) Calcium: 5.3 Low (normal reference range 8.4 - 10.2) . On 12/02/21 at 10:43 AM Surveyor interviewed Registered Nurse (RN)-G. Surveyor asked who puts lab orders in and the process followed. RN-G stated the nurse who takes the order is in charge of putting in the labs. RN-G stated they go in 2 places; first the order is entered into the patients Electronic Medical Record and second they are entered into the lab online system so lab comes out to draw it. RN-G stated this is done on the computer with a login and password. Surveyor asked if someone was in charge of checking to make sure the labs were completed and drawn. RN-G stated she was not sure and that would be above me noting someone in management. On 12/2/21 at 12:02 PM Surveyor interviewed anonymous Medical Professional (MP)-U. Surveyor asked MP-U why a medical professional would order labs. MP-U stated they would order labs on admission to get a baseline and then routinely as needed depending on the patient. Surveyor asked what labs would be monitored for R59. MP-U said BMP to include BUN and Creatinine and electrolytes. Surveyor asked if the labs on 11/8/21 and 11/15/21 were drawn, would it be possible to correct or possibly avoid the acute renal failure and electrolyte derangements that R59 needed to be hospitalized for . MP-U stated yes, by monitoring these labs you could have monitored and see if they were trending up. MP-U stated it certainly would have given an indication that something was going on with the resident that could have allowed a change in treatment and avoid hospitalization . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/02/21 at 2:04 PM Surveyor interviewed Regional Nurse Consultant (RNC)-C. Surveyor asked who puts lab orders in and the process followed. RNC-C stated the nurse who takes the order is in charge of putting in the labs. Surveyor asked how the lab receives the order. RNC-C stated the orders are entered into the labs online portal called Test Direct. Surveyor asked if the facility has any system to know what labs were completed. RNC-C stated the facility has a lab binder. Surveyor asked if that confirms labs were drawn per order. RNC-C stated no. Surveyor noted the CMP labs on 11/8/21 and 11/15/21 that were not drawn. RNC-C stated she is not sure why they were not drawn. RNC-C checked the online portal system and those 2 labs were never put into the system to be drawn. RNC-C stated the nurse who took that order should have entered them into the online portal. Surveyor asked if there was any other documentation noting why these labs were not completed. No additional information was provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 6. R80 was admitted to the facility on [DATE] with a diagnosis that included Blindness in Right Eye and Left Eye, Developmental Disorder, Cerebral Palsy and Symptomatic Epilepsy and Epileptic Syndromes. R80's Quarterly MDS (Minimum Data Set) dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 1, indicating that R80 is severely cognitively impaired. Section G (Functional Status) documents that R80 requires limited assistance and one person physical assist for his bed mobility needs. Section G also documents that R80 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 R80 has impairment to both sides of his lower extremities. Section M (Skin Conditions) documents that R80 is at risk for the development of pressure injuries. R80's Pressure Ulcer/Injury CAA (Care Area Assessment) dated [DATE] documents under the Analysis of Findings section, R80 is at risk for pressure ulcers and plan of care is needed in this area. R80's Braden Scale for Predicting Pressure Injuries dated [DATE] documents a score of 15, indicating that R80 is at moderate risk for the development of pressure injuries. R80's Skin Integrity care plan dated as initiated [DATE] documents under the Interventions section, Encourage to float heels in bed. On [DATE] at 10:20 a.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 3:40 p.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 8:53 a.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 11:46 a.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 1:02 p.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 2:35 p.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. (continued on next page)

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	525482	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:37 a.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 10:07 a.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 1:10 p.m., Surveyor observed R80 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R80's plan of care. On [DATE] at 8:59 a.m., Surveyor informed DON (Director of Nursing)-B and RN (Registered Nurse) Consultant-C of the above findings. Surveyor asked RN Consultant-C if R80 should have his heels offloaded as documented in R80's plan of care. RN Consultant-C informed Surveyor that R80 should have his heels offloaded per his plan of care. No additional information was provided. 7. R97 was admitted to the facility on [DATE] with a diagnosis that included Quadriplegia, Bipolar Disorder, Schizophrenia, Diabetes Mellitus Type II and Sepsis. R97's Quarterly MDS (Minimum Data Set) dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 8, indicating that R97 is moderately cognitively impaired. Section G (Functional Status) documents that R97 requires extensive assistance and a one person physical assist for his bed mobility needs. Section G also documents that R97 has total dependence on staff and a two person physical assist for his transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R97 has impairment to one side of his upper extremities and no impairment to either side of his lower extremities. Section M (Skin Conditions) documents that R97 has stage 3 pressure injury that was present upon admission to the facility. Section M also documents that R97 is a risk for the development of pressure injuries. R97's Pressure Injury CAA (Care Area Assessment) dated [DATE] documents under the Analysis of Findings section, R97 is at risk for pressure ulcer due to poor diet, very limited mobility and existing stage 2 on R heel from laying in hospital bed for a few months. R97 was in MVA (motor vehicle accident) and cannot roll over in bed without extensive assist of to staff at times. Plan of care is necessary in this area. R97's Braden Scale for Predicting Pressure Injuries dated [DATE] documents a score of 13, indicating that R97 is at moderate risk for the development of pressure injuries. R97's Skin Integrity care plan dated as initiated on [DATE] documents under the Interventions section, Encourage to float heels in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R97's pressure injury assessment dated [DATE] documents, Right heel- Date Acquired: [DATE], Stage III, Measurements: 0.5 cm (centimeters) x 0.6 cm, Description: Covered, pale and black; treatment: Betadine and Skin Prep. On [DATE] at 10:18 a.m., Surveyor observed R97 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R97's plan of care. On [DATE] at 3:37 p.m., Surveyor observed R97 laying supine in bed with both heels resting directly on the mattress and not floated as documented in R97's plan of care. On [DATE] at 1:10 p.m., Surveyor observed R97 laying supine in bed with his left heel resting directly on the mattress and not floated as documented in R97's plan of care. On [DATE] at 8:58 a.m., Surveyor informed DON (Director of Nursing)-B and RN (Registered Nurse) Consultant-ADD of the above findings. Surveyor asked RN Consultant-C if R97 should have his heels offloaded as documented in R97's plan of care. RN Consultant-C informed Surveyor that R80 should have his heels offloaded per his plan of care. No additional information was provided. 38253 Based on observation, record review, and interview, the facility did not provide treatment and services, consistent with professional standards of practice, to promote healing of pressure injuries for 7 (R43, R98, R117, R70, R28, R80, and R97) of 8 residents reviewed with pressure injuries. R43 developed an Unstageable pressure injury to the left heel on [DATE]. No treatment was put in place until [DATE]. Assessments of the wound base did not equal 100% of the tissue type. Treatments were not consistently signed out on the Treatment Administration Record. R98 was admitted with a Stage 2 pressure injury to the ball of the right foot, a Stage 3 pressure injury to the right heel, and an Unstageable pressure injury to the sacrum that, once it was able to be staged, was a Stage 4 pressure injury. The pressure injury to the ball of the foot was not documented on when the area healed. The pressure injuries to the right heel and sacrum were not comprehensively assessed weekly and the treatments were not always signed out as being completed on the Treatment Administration Record. R117 developed an Unstageable pressure injury to the coccyx on [DATE] that was determined to be a Stage 3 pressure injury on [DATE]. R117 was admitted to hospice services on [DATE]. R117 did not have comprehensive weekly assessments documented in the medical record of a Stage 3 pressure injury to the coccyx after [DATE]; R117 died on [DATE] on hospice services while a resident at the facility. F70 was admitted with a Stage 3 pressure injury to the right gluteal fold/buttock that developed into a Stage 4 pressure injury and a Stage 4 pressure injury to the sacrum. The pressure injuries were not comprehensively assessed weekly, percentages of the wound base did not equal 100%, and treatments were not always signed out as being completed on the Treatment Administration Record. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R28 was readmitted from the hospital on [DATE] with an Unstageable pressure injury to the right heel. The pressure injury was not comprehensively assessed on readmission on [DATE], percentages of the wound base did not equal 100%, and the Care Plan was not implemented or revised when the pressure injury was discovered. R80 was observed during the survey process to have heels not floated as care planned due to risk of pressure injury development. R97 was observed during the survey process to have heel boots not in place as care planned with presence of pressure injury to the heel. Findings: 1. R43 was admitted to the facility on [DATE] after fusion of the cervical spine. R43 had diagnoses of myelodysplastic syndrome, coronary artery disease, myelopathy, and anemia. R43 had limited mobility due to wearing a cervical collar at all times post cervical spine fusion. R43's Admission Minimum Data Set (MDS) assessment dated [DATE] indicated R43 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 12 and coded R43 needing extensive assistance with bed mobility, hygiene and bathing. R43 did not have any pressure injuries on admission to the facility. R43's Impaired Skin Integrity Care Plan was created on [DATE] with an initiation date of [DATE]. The following interventions were put in place on [DATE]: -Encourage to float heels when in bed -Pressure redistribution mattress -Assist to reposition approximately every ,d+[DATE] hours and as needed -Apply cushion to wheelchair -Barrier cream after each incontinent episode and as needed -Compete Braden scale upon admission, weekly times four, quarterly, with significant change of condition, and as needed -Lotion skin with cares -Weekly skin assessment -Monitor skin with all cares; report an changes to nurse -Update physician as needed -Refer to dietician as needed -Refer to therapy as needed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LEFT AND RIGHT BUTTOCKS On [DATE] on the Weekly Skin Check, a Stage 2 pressure injury was found on the left buttock measuring 3.0 cm x 3.0 cm and a Stage 2 pressure injury to the right buttock measuring 3.5 cm x 3.5 cm. The physician was notified and a treatment for zinc oxide was initiated. R43's Impaired Skin Integrity Care Plan was revised on [DATE] with the intervention of an alternating pressure mattress. On [DATE], the left and right buttock Stage 2 pressure injuries had healed. LEFT HEEL On [DATE] on the Admit/Readmit Assessment form, nursing documented R43 had a corn on the left heel. No other descriptors or measurements of the area were documented. On [DATE] on the Initial Wound Assessment form, nursing documented R43 had an Unstageable pressure injury to the left heel measuring 1.7 cm x 3.5 cm with no depth. The wound base was 100% eschar. On the treatment section of the form, nursing documented an APM (alternating pressure mattress) ordered, float heels while in bed. Resident is in cervical collar due to compressed vertebrae. Unable to move bilateral feet and has impaired mobility. The form indicated the physician and wound physician had been notified of the new area on [DATE] at 2:00 PM. No treatment order was obtained. On [DATE] on the Treatment Administration Record (TAR), an order was initiated for the left heel pressure injury: apply betadine to eschar every day and evening shift. The left heel pressure injury did not have a treatment in place for two days after discovery. The wound treatment was not signed out on the TAR by nursing staff indicating the treatment had been completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], seven times. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 2.1 cm x 3.82 cm with no depth with a wound base of 100% eschar. The wound was assessed by the wound physician. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 2.4 cm x 4.1 cm with no depth with the wound base of 100% eschar. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 3.4 cm x 4.2 cm with no depth with 1% granulation, 27% slough, 40% eschar, and 4% epithelialization. The total percentage of the tissue in the wound base should equal 100%; 72% of the wound base was accounted for. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 3.4 cm x 4.0 cm x 0.1 cm with 1% granulation, 4% slough, and 95% eschar. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 1.7 cm x 2.1 cm x 0.1 cm with 19% granulation, 68% eschar, and 9% epithelialization. The total percentage of the wound base assessed was 96%. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The left heel Unstageable pressure injury was comprehensively assessed weekly from [DATE] through the time of the survey. On [DATE] at 1:36 PM, Surveyor observed R43 in R43's room in a wheelchair. R43 had just transferred into the wheelchair and therapy staff was helping R43 put heel boots on. On [DATE] at 10:05 AM, Surveyor observed Licensed Practical Nurse (LPN)-S complete the treatment to R43's left heel. R43 was observed to be in bed on an air mattress with heel boots on both feet. LPN-S removed the left heel boot and applied betadine to the left heel pressure wound. The wound measured approximately 1.5 cm x 2.5 cm with black eschar covering 100% of the wound. The betadine was left open to air to dry and then the heel boot was replaced. R43 stated there was no pain to the left heel. In an interview on [DATE] at 12:40 PM, Surveyor met with Director of Nursing (DON)-B and Regional Nurse Consultant-C to discuss the concern with R43's Unstageable pressure injury to the left heel. Surveyor shared no treatment was put in place on [DATE] when the pressure injury was first discovered; the treatment was not initiated until [DATE], two days later. Surveyor shared the wound base percentages did not equal 100% on [DATE] and [DATE]. Surveyor shared the treatments in the TAR were not consistently signed out by nursing staff as completing the wound treatment. Regional Nurse Consultant-C agreed the treatment to the left heel wound should have been initiated when the wound was discovered on [DATE] and the percentages of the wound base descriptors should equal 100%. Regional Nurse Consultant-C stated the wound physician uses a program when assessing the wounds and the nurse uses the percentages from that program; the program does not give percentages that equal 100% and Regional Nurse Consultant-C stated the nurse should discuss with the wound physician to determine what the wound base is so the total would be 100%. Regional Nurse Consultant-C stated the nurses should be signing out all treatments in the TAR. No further information was given at that time. 2. R98 was admitted to the facility on [DATE] with diagnoses of toxic encephalopathy, diabetes, intellectual disabilities, and pressure ulcers. R98's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R98 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 9 and coded R98 as needing extensive assistance with all activities of daily living including bed mobility, toilet use, and hygiene. The Pressure Ulcer Care Area Assessment for that MDS assessment stated R98 was admitted with three pressure ulcers, see initial wound assessment for more details. Plan of care with treatment to be developed with goal that ulcers heal without complication. R98's Actual Impaired Skin Integrity Care Plan was initiated on [DATE] on admission with the following interventions: -Wound physician consult -assist to reposition approximately every ,d+[DATE] hours and as needed -Apply cushion to wheelchair -Barrier cream after each incontinent episode and as needed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Complete Braden scale upon admission, weekly times four, quarterly, with significant change of condition and as needed -Specialty mattress -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 while lifting -Monitor skin with all cares; report any changes to nurse -Update physician as needed -Refer to dietician as needed -Refer to therapy as needed RIGHT BALL OF FOOT On [DATE] on the Initial Wound Assessment form, nursing documented R98 was admitted with a Stage 2 pressure injury to the ball of the right foot that measured 1.2 cm x 1.8 cm with no depth and appeared as a flattened blister. The physician was notified at that time. No assessments were documented after the initial assessment on [DATE]. In an interview on [DATE] at 12:30 PM, Regional Nurse Consultant-C stated the wound on the ball of the right foot had healed the next time the foot was looked at after the initial wound assessment. Regional Nurse Consultant-C stated the nurse should have documented the area had healed. RIGHT HEEL On [DATE] on the Initial Wound Assessment form, nursing documented R98 was admitted with a Stage 3 pressure injury to the right heel that measured 1.8 cm x 3.6 cm x 0.1 cm with 90% granulation and 10% slough. The physician was notified at that time. No treatment to the right heel was initiated on [DATE]. On [DATE] on the Treatment Administration Record (TAR), an order was initiated to the right heel wound: clean with normal saline, dab dry, apply derma blue foam followed by bordered gauze then apply rolled gauze around the foot and place in foam boot daily. R98's Actual Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: treatment as ordered. R98's Actual Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: both heels to float while in bed. On [DATE] on the TAR, the treatment was changed to cleanse right heel with half-strength Dakins, pat dry, apply skin prep and bordered foam every Tuesday, Thursday, and Saturday. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No documentation was found in R98's medical record of a comprehensive assessment from [DATE] until [DATE], 19 days. On [DATE] on the Weekly Wound Assessment form, nursing documented R98's right heel Stage 3 pressure injury measured 1.28 cm x 3.03 cm x 0.1 cm with 100% granulation. The right heel Stage 3 pressure injury was comprehensively assessed weekly from [DATE] until [DATE] when the wound healed. The treatment to the right heel was not signed out by the nurse indicating the treatment was completed on [DATE]. SACRUM On [DATE] on the Initial Wound Assessment form, nursing documented R98 was admitted with an Unstageable pressure injury to the sacrum measuring 4.0 cm x 5.6 cm x 1.5 cm with 50% granulation and 50% slough. The physician was notified at that time. A treatment was started at that time with a wound vac and an alternate treatment if the wound vac was unavailable or not functional. No documentation was found in R98's medical record of a comprehensive assessment from [DATE] until [DATE], 19 days. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 3.65 cm x 4.22 cm x 2.2 cm with 90% granulation and 10% slough. The definition of Unstageable pressure injury is a wound that has the majority of the wound base covered by slough and therefore unable to determine the extent of the wound. With the wound having 90% granulation tissue, the wound should have had enough exposed base in order to stage the wound. On [DATE], ProSource 30 ml twice daily were ordered to increase protein intake. The Unstageable pressure injury was comprehensively assessed weekly from [DATE] through [DATE]. R98's Actual Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: turn and reposition every ,d+[DATE] hours and as needed. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 3.0 cm x 2.4 cm x 1.9 cm with 60% granulation and 40% slough with undermining of 3 cm from 7 o'clock to 5 o'clock. R98's wound was assessed weekly by the wound physician. R98 was hospitalized from [DATE] until [DATE]. The hospital discharge summary dated [DATE] indicated the sacral wound was surgically debrided while in the hospital due to an abscess. On readmission on [DATE], ProSource was not ordered as prior to hospitalization . On [DATE] on the Weekly Wound Assessment form, nursing documented the Stage 4 pressure injury measured 11.2 cm x 14.6 cm x 3.3 cm with 80% granulation, 10% slough, 5% eschar, and 15% epithelialization, totaling 110%. Tunneling was present measuring 13 cm in length. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Stage 4 pressure injury was comprehensively assessed weekly from [DATE] until the time of the survey. R98's Actual Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: new order for wound vac to sacrum. On [DATE] on the Weekly Wound Assessment form, nursing documented the Stage 4 pressure injury measured 9.4 cm x 10.3 cm x 3.1 cm with 98% granulation, 1% eschar, and 1% epithelialization with tunneling of 2.1 cm from 7 o'clock to 8 o'clock. The wound treatment was changed as the wound progressed as assessed by the wound physician. The treatment was not signed out on the TAR as being completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], a total of 7 treatments. On [DATE] at 10:11 AM, R98 was observed to be in bed with an air mattress in place. R98 was lying on the left side and did not respond verbally when interacted with by Surveyor. In the daily exit meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Regional Nurse Consultant-C on [DATE] at 3:04 PM, Surveyor requested to observe R98's wound care the following day. Regional Nurse Consultant-C stated R98 has a wound vac and was not sure what days the dressing change was done and would get back to Surveyor to arrange a day and time. On [DATE] at 10:35 AM, Regional Nurse Consultant-C stated R98's wound vac was due to be changed that day, but the wound vac had malfunctioned and was changed on the previous night shift and was not due to be changed until [DATE]. Surveyor was unable to observe R98's wound treatment. In an interview on [DATE] at 12:30 PM, Surveyor shared with DON-B and Regional Nurse Consultant-C the concerns with R98's pressure injuries: no documentation was found from [DATE] through [DATE] and treatments were not always signed out as being completed by nursing staff. Regional Nurse Consultant-C stated the Unstageable pressure injury to the sacrum on admission was a Stage 4 at that time and should have been documented that way. Regional Nurse Consultant-C agreed there was no documentation in R98's medical record for those dates and treatments should have been signed out when the treatment was completed. No further information was provided at that time. 3. R117 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, post polio syndrome, diabetes, coronary artery disease, and peripheral vascular disease. R117 admission Minimum Data Set (MDS) assessment dated [DATE] indicated R117 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and coded R117 needing extensive assistance with bed mobility and hygiene and frequently incontinent of bladder and always incontinent of bowel. R117's Impaired Skin Integrity Care Plan was initiated on [DATE] with the following interventions: -Pressure redistribution mattress -Complete Braden scale upon admission, weekly times four, quarterly, with significant change of condition and as needed -Weekly skin assessment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor skin with all cares; report any changes to the nurse -Update physician as needed -Refer to dietician as needed -Refer to therapy as needed On [DATE] on the Initial Wound Assessment form, nursing documented R117 had an Unstageable pressure injury to the coccyx that measured 1.0 cm x 1.0 cm with 100% slough. No depth was documented. In the comments section nursing charted: Resident cannot express need to be turned. Staff encourages resident to lay on side and staff assists resident to turn, but resident moves onto his back. Staff will re-approach every 2 hours and PRN (as needed) to assist resident with proper positioning. The Nurse Practitioner was notified of the new area. A treatment was started at that time. On [DATE] at 10:29 AM in the progress notes, nursing charted a consent was sent to R117's Power of Attorney (POA) for R117 to be seen by the wound physician. R117's Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: specialty air mattress; monitor for inflation every shift. R117's Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: assist to reposition approximately every ,d+[DATE] hours and as needed. R117's Impaired Skin Integrity Care Plan was on [DATE] with the following intervention: consult with wound physician. R117's Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: treatments as ordered. R117's Impaired Skin Integrity Care Plan was revised on [DATE] with the following intervention: bed rest. The Unstageable pressure injury was comprehensively assessed weekly from [DATE] through [DATE]. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 1.53 cm x 1.19 cm x 0.3 cm with 100% slough. On [DATE] on the Weekly Wound Assessment form, nursing documented the pressure injury was a Stage 3 that measured 1.52 cm x 0.47 cm x 0.1 cm with 90% granulation and 10% slough. The Stage 3 pressure injury was comprehensively assessed weekly from [DATE] through [DATE]. On [DATE] at 10:49 AM in the progress notes, nursing charted R117's POA had given verbal consent for R117 to have hospice provide services. On [DATE] on the Weekly Wound Assessment form, nursing documented the Stage 3 pressure injury measured 1.1 cm x 0.62 cm x 0.1 cm with 75% granulation and 25% slough. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No wound documentation was found in R117's medical record after [DATE]. Review of hospice documentation indicated the wound was being followed by facility staff. R117 passed away on hospice care at the facility on [DATE]. In an interview on [DATE] at 12:32 PM, Surveyor shared the concern with Director of Nursing (DON)-B and Regional Nurse Consultant-C no documentation of R117's Stage 3 pressure injury to the coccyx was found in R117's medical record after [DATE]. Surveyor asked DON-B and Regional Nurse Consultant-C if the facility had a policy that stated wounds were not assessed after the election of hospice services. Regional Nurse Consultant-C stated the nursing staff should have continued to assess and treat the pressure injury and document the comprehensive assessment in the medical record. No further information was provided at that time. 4. R70 was admitted to the facility on [DATE] with diagnoses of paraplegia, chronic obstructive pulmonary disease, osteomyelitis, and heart failure. R70's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R70 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and coded R70 needing extensive assistance with bed mobility. R70 had an indwelling urinary catheter and a colostomy. R70's Impaired Skin Integrity Care Plan was initiated on [DATE] with the following interventions: -Complete Braden scale upon admission, weekly times four, quarterly, with significant change of condition and as needed -Encourage to float heels in bed -Encourage to turn and reposition every ,d+[DATE] hours -Measure area weekly -Monitor for signs/symptoms of infection -Monitor for signs/symptoms of worsening skin tissue -Monitor pain and offer analgesic as needed as ordered -Monitor skin with all cares; report any changes to nurse/physician -Refer to dietician as needed -Soft boots on in bed -Specialty air mattress; monitor for inflation every shift -Weekly skin assessment -Wound doctor to evaluate and treat (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wound team to follow -Treatment as ordered -Update physician with changes in wound status as needed R70's Impaired Skin Integrity Care Plan was revised on the following dates with interventions: -[DATE]: ensure ROHO cushion is inflated and bring to therapy if not, and R70 to be up in chair a maximum of 1.5 hours. -[DATE]: resident was seen by the wound physician. -[DATE]: treatment changed to right buttock, bed rest for one week, and labs to be drawn. -[DATE]: may be up in chair twice per week for one hour. -[DATE]: discontinue peripherally inserted central catheter (PICC) line, wound vac order changed. On [DATE] on admission, R70 had a Stage 3 pressure injury to the right gluteal fold/buttock and a Stage 4 pressure injury to the sacrum. RIGHT GLUTEAL FOLD/BUTTOCK On [DATE] on the Initial Wound Assessment form, nursing documented R70 had a Stage 3 pressure injury to the right gluteal fold that measured 1.5 cm x 1.0 cm x 0.1 cm with 60% granulation and 40% slough. The physician and wound physician were notified. The Stage 3 pressure injury was comprehensively assessed and documented weekly from [DATE] through [DATE]. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 0.9 cm x 1.4 cm x 0.1 cm with 80% granulation and 20% epithelialization. The definition of an Unstageable pressure injury is the majority of the wound bed is covered with slough and the wound base is unable to be observed; the wound had a visible wound bed and should have been staged. On [DATE] on the Weekly Wound Assessment form, nursing documented the Unstageable pressure injury measured 0.9 cm x 1.4 cm x 0.1 cm with 80% granulation and 20% epithelialization. The wound had a visible wound bed and should have been staged. On [DATE] on the Weekly Wound Assessment form, nursing documented the wound was measured on [DATE] and had the same measurements that had been documented on the [DATE] Weekly Wound Assessment form: 0.9 cm x 1.4 cm x 0.1 cm. The wound bed had the following percentages: 0% granulation and 0% epithelialization. No other tissue types were documented. The assessment was not comprehensive and the date indicated the measurements were not current. No documentation was found in R70's medical record of a weekly comprehensive assessment from [DATE] through [DATE], for 28 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] on the Weekly Wound Assessment form, nursing documented the Stage 3 pressure injury measured 1.6 cm x 1.5 cm x 0.1 cm with 90% granulation. No other tissue type was documented. The Stage 3 pressure injury was comprehensively assessed and documented weekly from [DATE] through [DATE]. On [DATE] on the Weekly Wound Assessment form, nursing documented the Stage 3 pressure injury measured 1.33 cm x 1.32 cm x 0.3 cm with 75% granulation and 25% slough. No documentation was found in R70's medical record of a weekly comprehensive assessment on [DATE]. The Stage 3 pressure injury was comprehensively assessed and documented on weekly from [DATE] through [DATE]. On [DATE] on the Weekly Wound Assessment form, nursing documented the Stage 3 press [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, interview, and record review, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents for 2 (R23 and R88) of 4 Residents reviewed for smoking and 1 (R80) of 8 Residents reviewed for falls. R23 and R88 did not have smoking assessments for safety completed quarterly per facility policy. In addition R88 did not have a care plan for smoking. R80 was observed not to have his call light in reach. Findings include: On 12/1/21, the facility policy titled, Smoking Policy Residents dated 7/2017 was reviewed and read: A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change and as determined by staff. 1. R88 was admitted to the facility on [DATE] with diagnoses that included anxiety. On 11/30/21 R88's smoking assessment dated [DATE] was reviewed and indicated R88 was safe to smoke independently. No additional assessments for R88's safety with smoking were found. On 11/30/21 R88's care plan was reviewed and no care plan was found to address safety measures for smoking. On 12/02/21 at 12:21 PM Director of Nurses-B was interviewed and indicated R88 did not have a care plan for smoking and did not have any additional smoking assessments other than the 7/12/20 smoking assessment. On 12/1/21 at 1:30 PM R88 was observed out in the courtyard and appeared to be smoking safely. The above findings were shared with the Administrator and Director of Nurses on 12/2/21 at 1:00 PM Additional information was requested if available. None was provided. 36161 3. R80 was admitted to the facility on [DATE] with a diagnosis that included Blindness in Right Eye and Left Eye, Developmental Disorder, Cerebral Palsy and Symptomatic Epilepsy and Epileptic Syndromes. R80's Quarterly MDS (Minimum Data Set) dated 11/2/21 documents a BIMS (Brief Interview for Mental Status) score of 1, indicating that R80 is severely cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section G (Functional Status) documents that R80 requires limited assistance and one person physical assist for his bed mobility needs. Section G also documents that R80 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 R80 has impairment to both sides of his lower extremities. R80's Falls CAA (Care Area Assessment) dated 8/3/21 documents under the Analysis of Findings section, R80 is at high risk for falls. Plan of care to be developed for safety and to reduce chance of falls. R80's Falls Risk assessment dated [DATE] documents a score of 19, indicating that R80 is at high risk for falls. R80's Falls care plan dated as initiated on 7/30/21 documents under the Interventions section, Place call light or other communication device within reach at all times. On 11/29/21 at 10:20 a.m., Surveyor observed R80 laying supine in bed. Surveyor observed R80's call light to be on the chair at the foot of R80's bed and not within reach of R80 as documented in R80's falls plan of care. On 11/29/21 at 3:40 p.m., Surveyor observed R80 laying supine in bed. Surveyor observed R80's call light to be on the chair at the foot of R80's bed and not within reach of R80 as documented in R80's falls plan of care. On 11/30/21 at 8:53 a.m., Surveyor observed R80 laying supine in bed. Surveyor observed R80's call light to be on the chair at the foot of R80's bed and not within reach of R80 as documented in R80's falls plan of care. On 11/30/21 at 11:46 a.m., Surveyor observed R80 laying supine in bed. Surveyor observed R80's call light to be on the chair at the foot of R80's bed and not within reach of R80 as documented in R80's falls plan of care. On 11/30/21 at 1:02 p.m., Surveyor observed R80 laying supine in bed. Surveyor observed R80's call light to be on the chair at the foot of R80's bed and not within reach of R80 as documented in R80's falls plan of care. On 11/30/21 at 2:35 p.m., Surveyor observed R80 laying supine in bed. Surveyor observed R80's call light to be on mattress at the foot of R80's bed and not within reach of R80 as documented in R80's falls plan of care. On 12/2/21 at 8:59 a.m., Surveyor informed DON (Director of Nursing)-B and RN (Registered Nurse) Consultant-C of the above findings. No additional information was provided as to why R80 did not have his call light in reach per his falls care plan intervention. 38829 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R23 was admitted to the facility on [DATE] with diagnoses of Paraplegia, Other Psychoactive Substance Use, and Anxiety Disorder. R23 is her own person. R23's Quarterly Minimum Data Set (MDS) dated [DATE] documents R23 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R23 is cognitively intact for daily decision making. Surveyor reviewed R23's comprehensive care plan and notes R23 has a focused problem of R23 being an independent smoker and has no known history of inappropriate or hazardous smoking behaviors. Initiated 2/7/19 and revised 6/16/21. Surveyor reviewed R23's electronic medical record (EMR) and notes 2 progress notes documented in regards to R23's smoking which indicated: 1. 9/19/21 Smoking materials to be kept at nurses cart every shift for smoking policy, refused. 2. 10/3/21 Smoking material to be kept and nurses cart every shift for smoking policy. Surveyor notes R23's last smoking assessment completed is dated 12/4/19 and documents that R23 was caught smoking in room, explained safety concerns, staff is keeping cigarettes and lighter. Surveyor notes per the facility's policy and procedure, smoking assessments are to be completed quarterly. On 11/29/21 at 10:37 AM, Surveyor notes R23 has R23's own smoking materials and an E-cigarette charging at bedside. On 12/2/21 at 3:16 PM, Surveyor shared the concern with Administrator (NHA-A), Director of Nursing (DON-B), and Regional Nurse Consultant(RNC-C) that R23's smoking assessment had not been completed since 12/4/19. RNC-C validated the smoking assessment should have been updated. No further information was provided by the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and interview, the facility did not comprehensively assess 1 (R63) of 1 Residents reviewed for the use of urinary catheters. R63 had a urinary catheter placed on 6/17/21 without having a comprehensive bladder assessment completed for care and services. Findings Include: Surveyor reviewed the facility's Urinary Continence and Incontinence-Assessment and Management policy and procedure revised September 2010 and noted the following: Policy Statement: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. 2. Management of incontinence will follow relevant clinical guidelines. 3. The physician and staff will provide appropriate services and treatment to help Residents restore or improve bladder function and prevent urinary tract infections to the extent possible. 4. Indwelling urinary catheters will be used sparingly, for appropriate indications only. Policy Interpretation and Implementation states impart: 1. As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary continence. 3. Periodically (as required and when there is a change in voiding), staff will define each individual's level of continence, referring to the criteria in Minimum Data Set(MDS), as follows: Not Rated: The Resident has an indwelling catheter, condom catheter, ostomy, or no urine output(dialysis). 15. If a Resident is admitted from the hospital with a newly placed indwelling catheter, the physician and staff will evaluate the potential for removing it, depending on the current condition and the rationale for its original placement 22. The staff and physician will evaluate the effectiveness of interventions and implement additional pertinent interventions as indicated. 24. The physician will identify situations in which an indwelling urethral or suprapubic catheter are indicated, and will document why other alternatives are not feasible. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Indwelling catheters shall not be used as a substitute for nursing care of the Resident with urinary incontinence. b. If an indwelling catheter is needed, staff will monitor for and report complications such as evidence of a symptomatic infection. R63 was admitted to the facility on [DATE] with diagnoses of Encephalopathy, Aphasia, Dyspagia, Anoxic Brain Damage, and Flaccid Neuropathic Bladder. R63 currently has a legal guardian. R63's Quarterly Minimum Data Set (MDS) dated [DATE] documents R63's long and short term memory to be impaired and R63's cognitive status was unable to be assessed. R63 requires total dependence for bed mobility, transfers, dressing, toileting, and hygiene. R63's MDS also documents that R63 has a catheter. Surveyor noted R63 was not interviewable. Surveyor notes there is a focused problem for catheter use for urinary retention and neurogenic bladder initiated on 6/17/21 for R63. Surveyor notes the following on R63's current physician orders: 1. Foley catheter care 3x a day for retention-order start date-7/14/21 2. Ensure catheter securement device in place every shift- order start date-8/5/21 3. Insert 16F Foley catheter with 10CC bulb as needed for occlusion as needed-order start date-10/20/21 Surveyor reviewed R63' electronic medical record (EMR) and was unable to locate any documentation of an assessment for R63's indwelling catheter. On 11/30/21 at 1:24 PM, Surveyor observed R63 to have an indwelling catheter. On 12/2/21 at 8:14 AM, Surveyor shared the concern with Regional Nurse Consultant (RNC-C) that Surveyor was unable to locate a catheter assessment for R63's Foley catheter that was inserted on 6/17/21. On 12/2/21 at 12:15 PM, RNC-C confirmed a catheter assessment had not been completed when R63's catheter was placed on 6/17/21. RNC-C stated that a Foley catheter assessment should have been completed at this time and further stated, there is one there now. On 12/2/21 at 3:16 PM, Surveyor shared the concern with Administrator (NHA-A), Director of Nursing (DON-B), and Regional Nurse Consultant(RNC-C) that R63 did not have a Foley catheter assessment completed when R63 had the catheter inserted on 6/17/21. The concern was acknowledged and no further information was provided at this time.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not ensure residents were monitored for weight loss and comprehensively assessed when a weight loss occurred for 1 (R91) of 6 residents reviewed for weight loss. R91 was admitted on [DATE] with a weight of 221.4 pounds. On 11/11/2021, R91 weighed 172.4 pounds, a 49-pound weight loss or 22.13%. The physician and dietician were not notified of the weight loss and R91 was not reweighed to determine if the weight was accurate. Findings include: The facility policy and procedure entitled Weight and Hydration Management Practice Guidelines dated 2/2016 states: Obtaining Weight: . 2. Weigh all residents upon admission and readmission, weekly for four weeks and then monthly or as indicated by physician orders and/or the medical status of the resident. Admission weight will be input in (electronic charting system) to establish baseline weight. 4. As residents are weighed, staff can compare current weight to previous weight. Residents with weight variance are reweighed within 24 hours. Weight variance include and require reweight: a. Weight change of 5 lbs. 8. Residents identified as significant weight loss will have a SBAR completed and physician and family will be notified. 10. Registered dietician will be informed of any residents with significant weight loss for assessment and recommendations. R91 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, anxiety, and depression. Admission weight was 221.4 pounds. R91's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R91 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and coded R91 being independent with eating. The Nutrition Care Area Assessment (CAA) documented R91 had morbid obesity. The hospital discharge summary documented R91 weighed 220 pounds on 10/28/2021. R91's diet order on admission was a regular diet with thin liquids. No restrictions were ordered. On 11/4/2021, Registered Dietician (RD)-K initiated a Nutritional Assessment on R91. RD-K documented R91 was morbidly obese and on a restricted diet. RD-K documented R91's intake had been good and remained a moderate risk due to R91 not liking pork, having no bottom teeth with top dentures, and Speech Therapy was consulted to determine the best consistency of food for R91. The Nutritional Assessment was signed 11/10/2021. On 11/8/2021, R91's diet was downgraded to a low fat, low cholesterol diet of mechanical soft texture with regular thin consistency liquids. On 11/9/2021 at 11:22 AM in the progress notes, nursing charted R91 was tolerating the downgraded mechanical soft diet with a good appetite and no issues with chewing or swallowing. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 11/9/2021 at 8:01 PM in the progress notes, nursing charted R91 did not have any issues related to the recent diet change and appetite is good consuming 100% of the meal without difficulty chewing or swallowing. On 11/10/2021 at 10:40 AM in the progress notes, nursing charted R91 was being monitored for recent abdominal pain; no gastrointestinal upset that shift with no complaint of nausea, vomiting, or loose stools. Nursing charted no issues were noted from the recent downgrade to mechanical soft diet. A Nutritional Care Plan was initiated on 11/10/2021 for R91 being on a low fat, low cholesterol mechanical soft diet with interventions to encourage diet compliance, provide diet per order, a speech therapy evaluation, and weigh R91 per orders. On 11/11/2021, R91 weighed 172.4 pounds. No documentation was found indicating the physician was notified, the Registered Dietician was notified, or a re-weight was completed to verify the accuracy of the 49-pound weight loss in thirteen days, a 22.13% weight loss. On 11/29/2021 at 1:50 PM, Surveyor observed R91 in a wheelchair in the common area participating in activities. On 11/30/2021 at 8:11 AM, Surveyor observed R91 sleeping in bed. On 12/1/2021 at 2:24 PM in the progress notes, RD-K charted a weight loss of approximately 50 pounds was noted from 10/29/2021 and a reweight was requested. RD-K noted R91 was eating very good and was awaiting a reweight. On 12/1/2021 at 8:04 PM in the progress notes, nursing charted R91 was upset with the mechanical soft diet. Nursing charted therapy was consulted and R91 had issues with pocketing food, having a bolus of food in the back of the throat, and a wet voice after eating. On 12/2/2021 at 4:42 PM in the progress notes, the physician documented a routine visit note. The physician documented R91 had a history of alcoholism with alcoholic liver disease and lab values form 11/15/2021 were reviewed. Significant lab values included high glucose 197, high bilirubin 2.8, high alkaline phosphate 191, and low albumin 2.8. (High glucose, high bilirubin, high alkaline phosphate, and low albumin can be attributed to liver disease. Low albumin may also show malnutrition.) The physician documented R91's weight was labile and difficult to determine a trend but appeared to be down ten pounds from the average 180 pounds and was on diuretics to control edema. The physician documented R91 was concerned about the diet and wants to eat pizza, but the low fat, low cholesterol diet was not giving R91 many options due to the soft mechanical diet. The physician documented no concerns were reported by nursing staff. The physician documented R91 had a good appetite and wanted more food and had no significant weight change. The Assessment/Plan section of the physician note stated: Severe protein caloric malnutrition: alb 2. 6. Start protein supplement. On 12/3/2021, R91's diet order was changed to regular mechanical soft diet; the restrictions had been lifted. A protein supplement, as stated in the physician note, was not added to R91's orders. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R91's Nutrition Care Plan was not revised with the change in diet order. In an interview on 12/2/2021 at 4:31 PM, RD-K stated RD-K saw R91 for the first time on 11/4/2021 because RD-K was new to the facility at that time. RD-K stated Speech Therapy had decreased R91's diet to a mechanical soft due to difficulty chewing and swallowing. Surveyor asked RD-K if the facility had notified RD-K when R91 had a 49-pound weight loss. RD-K stated no, the facility had reached out to RD-K regarding other residents but did not say anything about R91's weight loss. Surveyor asked RD-K if RD-K would have expected to be notified of R91's weight loss. RD-K stated yes, it would be an expectation to be notified when there was that much of a weight loss. RD-K stated the facility should have done a re-weight at the time the drastic weight loss was recognized, but RD-K stated that had not been done. RD-K stated RD-K looked at R91 on 12/1/2021 and requested a re-weight to be completed. RD-K looked in R91's electronic record during the interview and stated R91 still had not been re-weighed. On 12/3/2021, R91 weighed 180.6 pounds. In an interview on 12/6/2021 at 12:23 PM, Surveyor shared with Director of Nursing (DON)-B and Regional Nurse Consultant-C the concerns regarding R91's weight loss. R91 weighed 221.4 pounds on admission on 10/29/2021 and weighed 172.4 pounds on 11/11/2021, a loss of 49 pounds, or 22.13%. Surveyor shared the hospital had documented R91 weighing 220 pounds just prior to admission to the facility which was similar to the facility admission weight. R91 was not weighed weekly as per the facility policy for new admissions, a re-weight was not obtained on 11/11/2021 when the weight was significantly less than the previous reading, and the physician and dietician were not notified of the significant weight loss.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation, interview, and record review the facility did not have an updated comprehensive assessment for enabler bars for 1 (R24) of 1 Residents observed with enabler bars during the survey process. Further, the facility did not have evidence of Interdisciplinary Team (IDT) involvement, no documentation of side rails being reviewed at care conference, and side rails were not documented on R24's Minimum Data Set (MDS) or comprehensive care plan. Findings include: Surveyor reviewed the facility's Side Rail Policy-Quarter/Assist rail issued October 2016 and notes the following: Purpose: To ensure safety of Resident utilizing side rails/Assist rail on their bed Procedure: Resident will utilize, upon request a quarter side rail or U(Assist rail) when in bed to assist with turning and positioning and getting out of bed. An Assist bar or quarter rail is not considered a restraint. 1. On implementation or request for a side rail and with change in functional status, the Resident will have a safety device assessment completed(located in PCC). 6. The Minimum Data Set(MDS) Coordinator will ensure care plan is implemented. R24 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Cerebral Infarction, Vascular Dementia, and Major Depressive Disorder. R24 has an activated Health Care Power of Attorney (HCPOA). R24's Quarterly Minimum Data Set (MDS) dated [DATE] documents R24 has a Brief Interview for Mental Status (BIMS) score of 5 indicating R24 demonstrates severely impaired skills for daily decision making. R24's MDS also documents R24 requires extensive assistance for bed mobility and transfers. Surveyor notes R24's MDS does not document that R24 has enabler bars. Surveyor reviewed R24's comprehensive care plan for enabler bars and notes there is no documented focus problem for R24's enabler bars. Surveyor reviewed R24's current physician orders and notes enabler bars x2 to aide with repositioning was obtained by phone on 3/27/21 with no start date. Surveyor reviewed R24's physical therapy(PT) discharge summary and notes R24 met the goal of safely performing bed mobility tasks without use of siderails on 3/16/20. Surveyor also notes there was not a PT assessment for enabler bars completed before the enabler bars were ordered on 3/27/21. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes R24 has an enabler bar assessment completed 3/31/20 that documents the following was completed: 1. a physician's order reflecting the enabler bar, time frame to be used 2. consent form completed 3. update long term(IDT) care plan to reference use 4. review at minimum quarterly and as needed(PRN) Surveyor notes that an assessment has not been completed on a quarterly basis, a physician's order was obtained on 3/27/21, 1 year after an enabler bar assessment was completed with no new assessment, and no current consent form was located in R24's electronic medical record (EMR). On 11/29/21 at 10:28 AM, Surveyor observed R24 had enabler bars on both the right and the left side of R24's bed. On 12/1/21 at 8:46 AM, Surveyor spoke to Licensed Practical Nurse (LPN-M) who is familiar with R24. LPN-M states that R24 does use the enabler bars for turning in bed. On 12/2/21 at 3:16 PM, Surveyor shared the concern with Administrator (NHA-A), Director of Nursing (DON-B), and Regional Nurse Consultant (RNC-C) that R24 did not have evidence of Interdisciplinary Team (IDT) involvement, no documentation of side rails being reviewed at care conference, side rails was not documented on R24's Minimum Data Set (MDS) or comprehensive care plan, and the enabler bar assessment had not been updated since 3/31/21. The concern was acknowledged and no further information was provided at this time.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 21855 Based on observation, record review and staff interview, the facility did not ensure the required Nurse Staffing information was displayed daily and maintained for the past 18 months. This had the potential to effect all residents and visitors. The facility did not have the Nurse Staffing posted, nor the last 18 months readily available for review. Findings include: On 11/30/21 at 08:36 AM Surveyor spoke with Administrator-A regarding the Nurse Staffing information that was not observed posted in the facility. Administrator-A indicated they will find out who oversees Nurse Staff postings. This has not been observed posted in the lobby/entrance area. On 11/30/21 at 09:44 AM Surveyor spoke with Scheduler-E who is in charge of the Nurse Staff posting. Scheduler-E indicated they were busy this morning and just posted it. Scheduler-E shared it is in a standing hard plastic frame at the receptionist desk. Scheduler-E indicated they will provide 18 months of staffing and indicated the PM staffing for nurses needs to be changed for today due to a call-in. On 11/30/21 at 02:38 PM Surveyor spoke with Scheduler-E in their office. Surveyor had not yet received the 18 months of Nurse Staff posting's. Scheduler-E indicated they are also the Social Worker and will be getting more training. They have been doing resident discharge's. Scheduler-E shared they do not have Nurse Staff Posting's for 2021 and was filling them out now. Scheduler-E was filling out Nurse Staff forms from 2020 and was starting on 2021's. There was no daily information regarding nurse/staff postings to review regarding staffing accuracy in the facility. On 11/30/21 at 3:07 PM at the facility exit meeting. Surveyor shared the concerns with the Staff Posting availability. There was no further information provided.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure that 5 (R7, R49, R66, R77, & R113) of 5 residents reviewed were provided medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being. Based on resident council minutes and group interview conducted 12/1/21, Residents are in agreement that medically-related social services have not been provided. *A self-report submitted to the state agency on 9/24/21 documents R7 was involved in a Resident/Resident altercation. The summary documented the social worker would meet with R7 weekly to follow-up on concerns. R7 received no psychosocial follow-up. *A self-report submitted to the state agency on 9/24/21 documents R49 was involved in a Resident/Resident altercation. The summary documented the social worker would meet with R49 weekly to follow-up on concerns. R49 received no psychosocial follow-up. *A self-report submitted to the state agency on 10/7/21 documents R66 was involved in a Resident/Resident altercation. The summary documented the social worker would follow-up to ensure R66's psychosocial needs are met. R66 received no psychosocial follow-up. *A self-report submitted to the state agency on 10/19/21 documents R77 reported an allegation of abuse. The summary documented the social worker would meet with R77 weekly to follow-up on concerns. R77 received no psychosocial follow-up. *A self-report submitted to the state agency on 10/7/21 documents R113 was involved in a Resident/Resident altercation. The summary documented the social worker would follow-up to ensure R113's psychosocial needs are met. R113 received no psychosocial follow-up. Findings Include: Per facility Social Services policy and procedure revised October 2010 the following is required in order to provide medically-related social services to assure that each Resident can maintain his/her highest practicable physical, mental, or psychosocial well-being: 2. Medically-related social services is provided to maintain or improve each Resident's ability to control everyday physical needs, and mental and psychosocial needs. 4. The social services department is responsible for: a. Obtaining pertinent social data about personal and family problems related to the Resident's illness and care b. Identifying individual social and emotional needs (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R7's comprehensive care plan and notes that R7 has a history of Resident to Resident altercations-6/19/21, 9/18/21,&11/4/21. R7's care plan also documents R7 takes Lorazepam due to anxiety disorder and Citalopram for depression. Surveyor reviewed a self-report submitted to the state agency on 9/24/21 which documents R7 was involved in a Resident/Resident altercation. The summary documented the social worker would meet with R7 weekly to follow-up on concerns. Surveyor reviewed R7's electronic medical record (EMR) and noted there were no documented social service follow-up. 2) R49 was admitted to the facility on [DATE] with diagnoses of Quadriplegia. R49 is his own person. R49's Quarterly MDS dated [DATE] documents R49's BIMS score of 15, meaning R49 is cognitively intact for daily decision making. R49's PHQ-9 score of 4 reflects minimal depression and R49 demonstrated verbal behaviors 1-3 days. Surveyor reviewed R49's comprehensive care plan and notes R49's care plan was updated on 9/21/21 to reflect a psychosocial well-being problem due to peer to peer altercation. Intervention applicable initiated on 9/21/21 is to allow to share thoughts and feelings. Off support through listening in 1:1 situation, Surveyor reviewed a self-report submitted to the state agency on 9/24/21 which documents R49 was involved in a Resident/Resident altercation. The summary documented the social worker would meet with R49 weekly to follow-up on concerns. Surveyor reviewed R49's electronic medical record(EMR) and notes there was no documented social service follow-up. 3) R66 was admitted to the facility on [DATE] with diagnoses of Morbid Obesity, Type 2 Diabetes Mellitus, and Chronic Kidney Disease. R66 is his own person. R66's Quarterly MDS dated [DATE] documents R66's BIMS score of 10 indicating R66 demonstrates moderately impaired skills for daily decision making. R66's PHQ-9 score of 7 indicates mild depression and R66 had rejection of care 1-3 days. R66's Admission MDS dated [DATE] documents R66 had a PHQ-9 score of 4 and verbal behaviors 1-3 days. Surveyor reviewed R66's comprehensive care plan and notes that R66 has a focused mood state problem due to repetitive verbalizations, persistent anger with self or others, manipulative behaviors, swearing and making racial slurs towards staff. Initiated 8/7/21. R66's focused problem was updated on 10/7/21 to reflect Resident to Resident altercation that occurred 10/1/21. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Intervention applicable was initiated 8/7/21 and documents to arrange for consult with social services or other counseling services. Surveyor reviewed R66's self-report submitted to the state agency on 10/7/21 which documents R66 was involved in a Resident/Resident altercation. The summary documented the social worker would follow-up to ensure R66's psychosocial needs are met. Surveyor reviewed R66's electronic medical record(EMR) and notes there was no documented social service follow-up. 4) R77 was admitted to the facility on [DATE] with diagnoses of Major Depressive Disorder, Acute and Chronic Respiratory Failure, and Type 2 Diabetes. R77 is her own person. R77's Admission MDS dated [DATE] documents R77's BIMS score to be a 15, meaning R77's cognitive skills are intact. R77's PHQ-9 score is a 7 indicating mild depression. Surveyor reviewed R77's comprehensive care plan and notes that R77 has been prescribed an antidepressant for a persistent diagnosis of depression initiated 10/28/21. Surveyor reviewed a self-report submitted to the state agency on 10/19/21 which documents R77 reported an allegation of abuse. The summary documented the social worker would meet with R77 weekly to follow-up on concerns. Surveyor reviewed R77's electronic medical record(EMR) and notes there was no documented social service follow-up. 5) R113 was admitted to the facility on [DATE] with diagnoses of Alcohol Dependence with Withdrawal Delirium and Hepatic Failure. R113 has an activated Health Care Power of Attorney(HCPOA). R113 discharged from the facility on 11/8/21. R113's Quarterly MDS dated [DATE] documents R113 has a BIMS score of 13, meaning R113 is cognitively intact, and a PHQ-9 score of 7 meaning R113 has mild depression. No behaviors are documented. R113's Admission MDS dated [DATE] documents R113 PHQ-9 score to be 0. Surveyor reviewed R113's comprehensive care plan and notes there was no applicable focused problem addressing R113's psychosocial needs. Surveyor reviewed R113's self-report submitted to the state agency on 10/7/21 which documents R113 was involved in a Resident/Resident altercation. The summary documented the social worker would follow-up to ensure R113's psychosocial needs are met. Surveyor reviewed R113's electronic medical record(EMR) and notes there was no documented social service follow-up. Surveyor reviewed Resident council minutes and noted Residents had communicated concern about social services not being available and lack of concerns being addressed and resolved. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 24, 2021-suggestion for a locked box by social services door so Residents could communicate when social worker was not in or to leave information Resident need follow-ups on. June 29,2021-has not seen anyone from Social Services July 27, 2021-do we even have Social Services October 26, 2021-concerns discharge planning and setting up for ancillary services was not getting followed up on On 12/1/21 at 9:13 AM, Surveyor conducted a Resident Council meeting. All Residents were in agreement that sufficient and appropriate social services were not being provided to Residents at the facility. Surveyor was informed Residents keep getting told 2 people are available but no one is following up on concerns. Surveyor was also informed that social services is very unavailable and not helping with anything. On 12/6/21 at 9:50 AM, Surveyor shared the concern with Administrator(NHA-A) that medically related social services has not been provided to Residents at the facility in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each Resident. NHA-A acknowledged the concern and no further information was provided at this time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on interview and record review, the facility did not ensure 1 (R59) of 6 resident's drug regimen was free from unnecessary medications. R59 had an physician (MD) order to obtain and test a stool sample for Clostridioides difficile (C-diff) and to start an antibiotic for the potential infection on 11/11/21. The lab test was delayed and not completed until 11/15/21. R59's delayed results came back negative for C-diff. R59 received 10 doses of Vancomycin in the time frame of 11/11-11/15/21 that were not necessary; the doses within that 5 day time frame would not not have been administered if the results were obtained timely. Findings include: Surveyor reviewed facility's Lab Diagnostic Test Results - Clinical Protocol policy with a revision date of November 2018. Documented was: Assessments and Recognition 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility . Surveyor reviewed facility's Administering Medications policy with a revision date of April 2019. Documented was: .4. Medications are administered in accordance with prescriber orders, including any required timeframes . 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the [Medication Administration Record (MAR)] space provided for that drug and dose . R59 was admitted to the facility 9/2/21 with diagnoses that included Cyst of Pancreas, Chronic Kidney Disease Stage 3 and Severe Protein Calorie Malnutrition. Surveyor reviewed R59's MD orders with a start date of 11/11/21. Documented was Collect stool specimen to [rule out] C-diff related to diarrhea one time only. Documented with a start date of 11/11/21 was Vancomycin HCl Suspension. Give 125 mg by mouth four times a day for C- diff take 125mg [4 times daily orally] for c-diff. Surveyor reviewed shipping manifest from facility pharmacy that documented Vancomycin medication shipped to facility on 11/11/21 at 9:02 PM. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed MAR for R59. Documented was: Date: 11/11/21 Time: PM; Administered: 4 [Other / See nurse's notes] Date: 11/11/21 Time: Eve; Administered: 4 [Other / See nurse's notes] Date: 11/11/21 Time: Night; Administered: 4 [Other / See nurse's notes] Date: 11/12/21 Time: AM; Administered: yes Date: 11/12/21 Time: AM; Administered: yes Date: 11/12/21 Time: Eve; Administered: 4 [Other / See nurse's notes] Date: 11/12/21 Time: Night; Administered: 4 [Other / See nurse's notes] Date: 11/13/21 Time: AM; Administered: yes Date: 11/13/21 Time: AM; Administered: yes Date: 11/13/21 Time: Eve; Administered: 4 [Other / See nurse's notes] Date: 11/13/21 Time: Night; Administered: 1 [Hold / See nurse's notes] . The medication was administered 11/14/21 and 11/15/21 per order. The resident was hospitalized on [DATE]. Surveyor reviewed Nurse's notes for R59. There was no documentation stating why the medication was not given for the 7 missed doses between 11/11/21 and 11/13/21. The nurses who did not administer the medications were unavailable for interview. Surveyor reviewed R59's lab test results for stool sample to rule out C-diff. Documented under Collection Date/Time was 11/15/2021 1:38:00 PM. This was 4 days after the order date of 11/11/21. There was no documentation of why the stool sample was not collected for 4 days. On 12/02/21 at 2:04 PM Surveyor interviewed Regional Nurse Consultant (RNC)-C. Surveyor asked who puts lab orders in and ensures the process is followed. RNC-C stated the nurse who takes the order is in charge of putting in the labs. Surveyor asked how the lab receives the order. RNC-C stated the orders are entered into the labs online portal called Test Direct. RNC-C stated the nurse would enter into the portal that the stool sample was ready for pickup. Surveyor asked what timeframe should be followed for stool samples to be picked up. RNC-C stated as soon as possible after the resident has a bowel movement. Surveyor noted that R59 had a colostomy bag. RNC-C stated then the sample as soon as the order was received and a nurse was able to access the resident's bag for a sample. RNC-C reviewed the online portal and noted there was no pick-up scheduled for 11/11/21. On 12/6/21 at 2:38 PM RNC-C reported to Surveyor that the sample was collected on 11/11/21 but not sent out until 11/15/21. RNC-C was unsure why there was a delay and noted the sample should have been picked up on 11/11/21. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R59's lab report from the 11/15/21 collection documented the stool sample was negative for C-diff. Surveyor noted R59 received 10 doses of the Vancomycin due to the delay in sending out the stool samples.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and staff interview, the facility did not ensure a residents psychotropic medication was monitored for indications for use. This was observed with 1 (R61) of 5 residents reviewed for medications. R61 is receiving psychotropic medications without identified, measureable targeted behaviors. Findings include: The facility's policy and procedures titled Behavioral Assessment, Intervention and Monitoring , revised March 2019, was reviewed by Surveyor. The procedures include documentation of specific targeted behaviors and expected outcomes. It also indicates other approaches and interventions tried prior to the use of antipsychotic medications. R61's medical record was reviewed for unecessary medications. R61 started on Hospice on 10/4/21 and has disgnoses of Traumatic Brain Injury, Anxiety, Depression and behavorial disorder. R61 currently is receiving the following medications: - Buspirone 10 mg twice a day for anxiety with a start date of 6/26/2019. - Lexapro 20 mg every day for depression with a start date of 8/15/2018. - Lorazepam 0.5 mg every 4 hours as needed for restlessness/anxiety with a start date of 9/8/2021. - Risperidone 2 mg everyday and 3 mg at bedtime for traumatic brain injury with behaviors with a start date of 7/13/2019. - Trazadone 75 mg at bedtime for depression with a start date of 4/19/2018. R61's Medication Administration Record and Treatment Administration Record for the current, and last month, were reviewed. There is no documented targeted behavior(s) identified with these medications. Surveyor reviewed R61's medical record and the physician progress note on 11/3/2021 for a Routine Visit indicates the following: This is a [AGE] year-old Caucasian male who is a resident since 2017 with past medical history significant for traumatic brain injury with associated seizure disorder, dysphagia, depression, anxiety with behavioral disorder, history of COVID-19 infection in December 2020 who has been experiencing a steady decline and transitioned to hospice. He continues to have frequent yelling out episodes which is his baseline. On arrival for exam he is calm however does not converse much at baseline. He appear a bit calmer today and RN (Registered Nurse) states yelling out behaviors stable w/o (without) much change. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 10/4/21 Psych Nurse Practitioner progress note indicates: medications and behaviors reviewed. No change in medication. Has had failed dose reductions in the past. Resident is stable on medication regimen. R61 plan of cares were reviewed and had behaviors and detailed interventions. On 12/01/21 at 10:51 AM Surveyor spoke with the RNC-C (Regional Nurse Consultant). Surveyor requested the facility's policy and procedures for behavior monitoring with psychotropic medications. Surveyor shared that R61 did not have did not have any behavior monitoring documented. On 12/01/21 at 11:50 PM RNC-C supplied Surveyor with a blank behavior charting documentaion for R61. There was no additional documentation of resident's behavior monitoring. There was no documentation to monitor the type, and frequency, of R61 behabiors that require the use of psychotropic medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40533 Based on interview and record review, the facility did not maintain medical records on each resident that are complete, accurately documented, readily accessible and systematically organized in accordance with accepted professional standards and practices for 3 (R43, R59 and R200) of 4 residents reviewed. 1. R43 had conflicting documentation of pressure injuries. Skin assessments documented a pressure injury to buttocks when there was no pressure injury on R43's buttocks on 3 weekly assessments. 2. R43 and R59 did not have all lab results scanned into her electronic medical record (EMR). There was no documentation that the physician was made aware of the lab results. There was no reference in the progress notes pertaining to R43 and R59's labs on 1/10 or 1/17/22. 3. R200 refused a lab draw on 1/10/22. There was no documentation in his EMR that the Nurse Practitioner (NP) was notified. Findings include: 1. R43 was admitted to the facility 9/21/21 with diagnoses that included Dementia without Behavioral Disturbances, Myelopathy, Other Megaloblastic Anemia and Chronic Pain Syndrome. Surveyor reviewed R43's Care Area Assessments (CAA) with an assessment date of 9/28/21. Documented under Pressure Ulcer/Injury was Nature of the problem/condition: Risk for impaired skin integrity as evidenced by limited mobility and incontinence. Surveyor reviewed R43's Weekly Wound Assessment Form documented by Regional Nurse Consultant (RC)-C with a date of 12/28/21. Documented under Wound Description was Site: Left heel . There were no other pressure injuries documented. Surveyor reviewed R43's Weekly Skin Check Form documented by Licensed Practical Nurse (LPN)-V with a date of 12/31/21. Documented under Skin Check was Site: Coccyx. Description: open area, treatment in place. Site: Left heel. Description: Eschar . Surveyor reviewed R43's Weekly Wound Assessment Form documented by RC-C with a date of 1/4/22. Documented under Wound Description was Site: Left heel . There were no other pressure injuries documented. Surveyor reviewed R43's Weekly Skin Check Form documented by LPN-V with a date of 1/7/22. Documented under Skin Check was Site: Coccyx. Description: open area, treatment in place. Site: Left heel. Description: Eschar . Surveyor reviewed R43's Weekly Wound Assessment Form documented by RC-C with a date of 1/11/22. Documented under Wound Description was Site: Left heel . There were no other pressure injuries documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R43's Weekly Skin Check Form documented by LPN-V with a date of 1/14/21. Documented under Skin Check was Site: Right buttocks. Description: open areas, treatment in place. Site: Left heel. Description: Eschar, treatment in place . Surveyor reviewed R43's Weekly Wound Assessment Form documented by RC-C with a date of 1/18/22. Documented under Wound Description was Site: Left heel . There were no other pressure injuries documented. On 1/20/22 at 10:30 AM, Surveyor interviewed RC-C. Surveyor asked where R43's had pressure injuries. RN-C stated her left heel. Surveyor asked if she had any wounds on her coccyx or buttocks. RC-C stated no, that healed in October [2021]. Surveyor asked why on 3 separate Weekly Skin Check Forms, the coccyx/buttocks was documented. RC-C was unsure. On 1/20/22 at 12:45 PM, Surveyor interviewed LPN-V. Surveyor asked where R43's had pressure injuries. LPN-V stated her left heel. Surveyor asked if she had any wounds on her coccyx or buttocks. LPN-V stated no. Surveyor asked why on 3 separate Weekly Skin Check Forms he documented a coccyx/buttocks pressure injury with treatment in place. LPN-V was unsure and could not explain why he documented that. 2. Surveyor reviewed facility's Lab Policy with an implementation date of 12/3/20. Documented was: - When an order for a lab or specimen is received the nurse will put a one time order into [Point Click Care (PCC)] for the date that the lab will be drawn. - The nurse will enter the correct lab into the Test Direct system and print out the lab order form. - The nurse will take the order to the reception area and place it in the lab orders box. - The nurse will then write the ordered lab or specimen on the Daily Lab Flow Sheet for the date that it is to be completed . - At the beginning of each shift the nurse will check the lab book for labs to be completed that day and for lab results. - Once a lab is drawn the phlebotomist will hand the completed lab draw slip to the nurse for the residents unit. The unit nurse will then highlight or initial that it was drawn. - When the nurse begins the shift, they will check the faxes and or Test Direct for the lab results that are pending. Once lab results are received, they will be faxed to the MD/NP as soon as possible . - Once the MD has been notified the nurse will highlight or initial that it was completed and place the results in the medical record. - If a resident refuses a lab draw the nurse will document the refusal in PCC and schedule a redraw . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R43 was admitted to the facility 9/21/21 with diagnoses that included Dementia without Behavioral Disturbances, Myelopathy, Other Megaloblastic Anemia and Chronic Pain Syndrome. R59 was admitted to the facility 9/2/21 with diagnoses that included Cyst of Pancreas, Chronic Kidney Disease Stage 3 and Severe Protein Calorie Malnutrition. 1. Surveyor reviewed Daily Lab Flow Sheet with a date of 1/10/22. Documented was Resident: [R43]. Date to be Drawn: 1/10/22. Lab to be Completed: [Complete Blood Count with Differential (CBC w/ Diff)], [Comprehensive Metabolic Panel (CMP)]. Received Results: [yes]. MD Notified: Faxed 1/11. New Orders: [no new orders (NNO). Also documented was Resident: [R59]. Date to be Drawn: 1/10/22. Lab to be Completed: CBC w/ Diff, CMP. Received Results: [yes]. MD Notified: Faxed 1/11. New Orders: NNO. Surveyor reviewed EMR and hard chart for R43 and R59. Labs drawn on 1/10/22 were not able to be located. There was no highlight or initial on the form verifying that the MD/NP received the results, only noted that they were faxed. Surveyor reviewed Progress Notes for R43 and R59. There was no documentation regarding labs on 1/10/22. 2. Surveyor reviewed Daily Lab Flow Sheet with a date of 1/17/22. Documented was Resident: [R43]. Date to be Drawn: 1/10/22. Lab to be Completed: CBC w/ Diff, CMP. Received Results: [yes]. MD Notified: [yes]. New Orders: NNO. Also documented was Resident: [R59]. Date to be Drawn: 1/17/22. Lab to be Completed: CBC w/ Diff, CMP. Received Results: [yes]. MD Notified: [yes]. New Orders: NNO. R43's date to be drawn was dated 1/10/22. Surveyor reviewed EMR and hard chart for R43 and R59. Labs drawn on 1/17/22 were not able to be located. There was no highlight or initial on the form verifying that the MD/NP received the results, only noted that they were faxed. Surveyor reviewed Progress Notes for R43 and R59. There was no documentation regarding labs on 1/17/22. On 1/20/22 at 12:45 PM, Surveyor interviewed LPN-V. Surveyor asked how staff knows labs were verified received by the MD or NP. LPN-V stated he was unsure because they usually are received on 2nd shift and he works 1st shift. LPN-V stated he thinks staff check the results received box on the Flow Sheet. Surveyor asked where labs are kept after they are received. LPN-V stated most of the time they go in the chart. On 1/20/22 at 1:05 PM Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked how staff know the process with lab ordering, receiving and reviewing. DON-B stated there was a lab policy inservice on 12/3/21 will all nurses. On 12/20/21 there was another inservice on the policy as well because staff were not getting it. Surveyor asked how staff knows labs were verified received by the MD or NP. DON-B stated they place a checkmark next to the residents' name on the lab flow sheet and a Progress Note is written stating NNO or the new orders received. Surveyor asked where labs are kept after they are received. DON-B stated they are sent to Medical Records to get scanned in the chart. Surveyor noted that there were no labs from 1/10/22 and 1/17/22 in R43 or R59's chart. DON-B stated they are probably behind in scanning them in. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted on 1/20/22, LPN-V was unaware of the process for labs. Surveyor also noted there was no highlighted or initials on Flow Sheet documenting MD received results. Surveyor noted check mark next to name was not part of the policy. Surveyor also noted Progress Notes not completed for R43 or R59 on 1/10 or 1/17/22. Surveyor noted no labs in both charts verifying they were received. 20483 3. On 1/20/22 at 10:53 a.m. Surveyor noted a physician order for R200 which documents CBC (complete blood count), CMP (comprehensive metabolic panel), HgA1c (glycated hemoglobin) [measures the amount of blood sugar attached to hemoglobin], Iron Level on 1/10/22. Directions one time only for med monitoring until 1/10/22. On 1/20/22 at 11:12 a.m. Surveyor reviewed the Unit 5 & 6 lab book. For current month under tab 10 lab draw for day 1/10/22 under the section lab to be completed documents CBC, CMP, A1C, Iron Binding. Under the section received results documents No draw violently refused. Under the section MD notified, there is no documentation R200's MD (medical doctor) or NP (nurse practitioner) was notified. Under the new orders section documents NNO (no new orders). On 1/20/22 at 11:15 a.m. Surveyor reviewed R200's medical record and was unable to locate documentation R200's physician/NP was notified of R200's lab draw refusal on 1/10/22. On 1/20/22 at 11:29 a.m. Surveyor asked LPN (Licensed Practical Nurse)-J where Surveyor would be able to locate documentation a physician was notified of a Resident's refusal for a lab draw. LPN-J informed Surveyor it should be in the progress notes. On 1/20/22 at 1:29 p.m. Surveyor asked MA (Medical Assistant)-CC if she remembers any nurse telling her R200 refused his lab draw on 1/10/22 as Surveyor could not locate any documentation in R220's medical record. MA-CC informed Surveyor she doesn't remember off the top of her head and she hasn't had a lot of interaction with R200. MA-CC informed Surveyor the nurses are suppose to communicate with her if she is here or they will contact the NP (Nurse Practitioner)-Y if they can't find her. On 1/20/22 at 1:33 p.m. Surveyor spoke with NP-Y on the telephone. Surveyor informed NP-Y R200 refused his lab draw on 1/10/22 and Surveyor was unable to locate any documentation in R200's medical record she was notified of the refusal. NP-Y informed Surveyor she was looking at her notes, doesn't have anything written down but does remember them informing her of R200's refusal. NP-Y informed Surveyor she doesn't recall if she ordered further labs. NP-Y indicated she just recalls he wasn't going to allow the labs to be done and there is nothing that can be done. Through interview Surveyor was able to determine NP-Y was notified of R200's refusal of the lab draw on 1/10/22 but there is no documentation in R200's medical record of NP-Y notification.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on observation, record review and staff interviews, the facility did not ensure staff utilized PPE (personal protective equipment) effectively, handled medication in a sanitary manner, or maintained personal medical devices, to prevent the spread of infection, such as COVID-19. The incorrect PPE application was observed on 3 of 6 units/hallways potentially affecting 65 residents (300 unit has 24 residents, 400 unit has 21 residents, and the 600 unit has 20 residents). Licensed Practical Nurse (LPN) -J, Medication Techinician (MT) - I, and Registered Nurse (RN) - H were observed on resident units without facial masks covering their nose and mouth. The medication was observed with 1 of 1 Medication Technicians observed preparing medication, and 1 (R43) of 2 residents observed with Foley catheters. Medication Tech-I was observed handling a medication tablet for R63 with her bare hands and R43 was observed several times to have their Foley catheter bag exposed and resting on the floor. Findings include: The facility's policy and procedure for Infection Control, revised October 2018, was reviewed by Surveyor. The policy indicates the facility, through policies and practices, intend to facilitate a safe, sanitary and comfortable environment to help prevent and manage transmission of diseases and infections. 1. On 11/29/21 at 08:52 AM Surveyor observed LPN-J administer medications on the 600 unit. LPN-J's facial mask was not covering her nose. LPN-J indicated the facial mask falls off her nose. LPN-J indicated the facial mask doesn't cover her nose because she can't see otherwise. On 11/29/21 at 10:17 AM Surveyor observed MT-I on the 400 unit in the hallway passing medications. MT-I was observed wearing her facial mask under her nose. MT-I did not verbalize a reason why her facial mask was not covering her nose. On 11/29/21 at 11:01 AM Surveyor observed RN-H at the Nurses Station for both the 300/400 unit. RN-H did not have PPE on to cover their mouth, nose and eyes. When Surveyor approached RN-H they then placed a surgical mask on over their nose and mouth with a face shield. RN-H indicated they don't keep their face mask on because their eyeglasses fog up. On 12/01/21 at 09:00 AM Surveyor reviewed the facility's Infection Control program with RNC -C (Regional Nurse Consultant and DON-B (Director of Nurses). They indicated they will alert staff to wear PPE appropriately in the facility. This means eye protection with facial masks. The facility does have adequate supplies of PPE available. They did not know why staff was not utilizing it appropriately. 2. On 11/29/21 at 10:17 AM Surveyor observed MT (Medication Technician)-I administer medication to R63. MT-I pushed out medication from its individual pharmacy packaging into a dose cup. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R63 had a Zoloft 50 mg tablet that required to be 25 mg. MT-I used their bare hands to place the tablet in a pill splitter from the medication cart. MT-I did not perform hand hygiene, or utilize gloves with tablet handling. MT-I then split the tablet in the pill splitter and threw the other half of tablet in the garbage On 11/30/21 at 3:07 PM at the facility exit meeting. Surveyor shared the concerns with medication handling. There was no further information provided. 38253 staff not wearing PPE correctly nurse touching med when splitting pill catheter on floor and uncovered [NAME] based on - and determine scope Resident #43 Pressure Ulcer/Injury 12/01/21 09:28 AM [NAME] Resident # 43 RESDIENT NOTES 9/21/21 Entry no sig change 9/28/21 Admit MDS - BIMS 12, PHQ9 10, behaviors none bed mobility 3/3 transfer 4/3 walk 8/8 dressing 2/2 eating 3/2 toilet use 4/3 hygiene 2/2 bathing 4/3 impairment 0/0, catheter, always incontinent bowel, occasional pain 09, no falls, 58 136 #, mechanically altered therapeutic diet, surgical wound, AD x7, opioid x2, ST, OT, PT (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CAAs COGNITIVE - VISUAL - ADL - URINARY - PSYCHOSOCIAL - MOOD - FALLS - NUTRITIONAL - DEHYDRATION - DENTAL - PRESSURE - Risk for impaired skin integrity as evidence by limited mobility and incontinece PSYCHOTROPIC - PAIN - 11/29/21 01:36 PM 407-B [NAME] (complaint) agreed to have watch treatment, res in wheelchair being helped by staff to put boots on 10/1/21 new areas found Weekly Skin Check 32) Left buttock - 3cm round OA to inner buttock 31) Right buttock - 3.5cm round OA to inner buttock 10/2/21 new areas found Weekly Skin Check 32) Left buttock - 3.0 round OA to inner buttock reported 10/2 31) Right buttock - 3.5 round OA in inner buttock reported 10/2 11) Left scapula - 5.5 cm round excoriation to left scapula discovered this date 10) Right scapula - 3.0 cm round excoriated area to right scapula 10/4/21 new area found Initial Wound Assessment (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Left Heel LEFT BUTTOCK pressure Stage 2 10/1/2021 Zinc oxide tx started 10/1/2021 10/12/2021 - healed RIGHT BUTTOCK pressure Stage 2 10/1/2021 Zinc oxide tx started 10/1/2021 10/12/2021 - healed RIGHT SCAPULA trauma 10/2/2021 10/12/2021 - healed LEFT SCAPULA trauma 10/2/2021 weekly 10/12/2021 until 11/16/2021 - healed LEFT HEEL pressure Unstageable 10/4/2021 treatment started 10/6/2021 10/12/21 Unstageable 2.1 x 3.82 x 0, 100% eschar, followed by wound team and wound doctor, continue treatment as ordered 10/19/21 Unstageable 2.4 x 4.1 x 0, 100% eschar 10/26/21 Unstageable 3.4 x 4.2 x 0, 1% granulation, 27% slough, 40% eschar, 4% epithelialization (72%) 11/2/21 Unstageable 3.4 x 4 x 0.1, 1% granulation, 4% slough, 95% eschar 11/9/21 Unstageable 1.7 x 2.2 x 0.1, 19% granulation, 68% eschar, 9% epithelialization (96%) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/16/21 Unstageable 1.7 x 2.1 x 0.1, 25% granulation, 75% eschar 11/23/21 Unstageable 1.5 x 2.1, 100% eschar BRADEN 11/15/21 score 14 ORDERS RN TO INSPECT open areas to Bilateral Buttocks Q Shift with cares every shift -Start Date10/01/2021 2300 -D/C Date10/05/2021 1536 Supplement 2.0 three times a day 120ml -Start Date09/24/2021 1700 -D/C Date10/12/2021 1645 Supplement 2.0 with meals 240ml -Start Date10/12/2021 1700 Monitoring OA to bilateral scapulas every shift -Start Date10/02/2021 1500 -D/C Date10/26/2021 2051 MEPILEX Tx to Bilateral Scapulas every other day and PRN every evening shift every 2 day(s) -Start Date10/02/2021 1500 -D/C Date10/05/2021 1543 Left scapula Apply Betadine to scab every day and evening shift for wound care -Start Date10/06/2021 0700 -D/C Date10/18/2021 1022 Left scapula CLEANSE with dakins, pat dry, apply SKIN PREP to wound edges and surrounding skin, apply SANTYL to wound base and cover with bordered gauze every evening shift for wound care -Start Date10/18/2021 1500 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-D/C Date10/26/2021 2040 Cleanse wound to left scapula with saline, Protect periwound with Skin Prep, Cover wound with Foam, Change Tues/Thur/Sat and PRN every day shift every Tue, Thu, Sat -Start Date10/28/2021 0700 -D/C Date11/09/2021 1349 Right scapula cleanse w/ NS, pat dry, apply skin prep to peri wound and apply hydrocolloid every evening shift every 3 day(s) for wound care -Start Date10/06/2021 1500 -D/C Date10/26/2021 2030 ZINC OXIDE to OPEN AREAS discovered 10/1 bilateral buttocks every shift -Start Date10/01/2021 2300 -D/C Date10/05/2021 1544 LEFT BUTTOCK Cleanse with normal saline, pat dry, apply skin prep to peri-wound and apply hydrocolloid every evening shift every other day for wound care -Start Date10/06/2021 1500 -D/C Date10/26/2021 2032 RIGHT BUTTOCK Cleanse area with normal saline, pat dry, f/b skin prep to peri-wound and surrounding skin and apply hydrocolloid every evening shift every other day for wound care -Start Date10/06/2021 1500 -D/C Date10/26/2021 2032 LEFT HEEL apply betadine to eschar every day and evening shift for wound care -Start Date10/06/2021 0700 Skin Integrity Care Plan initiated 9/21/21 and created on 10/7/21 12/01/21 10:05 AM [NAME] LPN CRAB precautions for wound splints in place to both hands, neck collar on, signs on wall for schedule of when to wear splints and collar (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heel boots on, no pain, air mattress left heel 1.5 x 2.5 black escar, betadine applied and left open to air LPN - will get catheter bag cover - cath bag on floor trauma to scapula was from the sling in wheelchair. treatments not signed out No RN assessment of skin on admit. Who assessed on 10/4/21??? - LPN and RN signed off 12/06/21 12:40 PM 38829 3. R43 was admitted to the facility on [DATE] with diagnoses of Fusion of Spine, Cervical Region, Unspecified Osteoartritis, Myelodysplastic Syndrome, Unspecified Dementia, and Major Depressive Disorder. R43 has an activated Health Care Power of Attorney(HCPOA). R43's Admission Minimum Data Set (MDS) dated [DATE] documents R43's Brief Interview for Mental Status (BIMS) score to be a 12, meaning R43 demonstrates moderately impaired skills for daily decision making. R43's MDS also documents R43 requires extensive assistance for bed mobility and eating, total dependence for transfers and toileting. R43's MDS documents R43 has a Foley catheter. Surveyor reviewed R43's comprehensive care plan and notes that there is a focused problem for the indwelling catheter post surgical initiated on 9/24/21. Intervention applicable initiated on 9/28/21 stated to follow physician orders and policy protocol. Surveyor notes the current physician orders for R43's Foley catheter include to flush the Foley with 60cc of sterile water every 8 hours an needed On 11/29/21 at 11:16 AM, Surveyor observed R43 in bed. Surveyor was able to see the uncovered Foley catheter bag from the doorway. The Foley catheter bag was hanging on the left side of R43's bed. Surveyor also notes the Foley catheter bag was touching the ground. On 11/30/21 at 8:05 AM, Surveyor observed R43 in bed, the Foley catheter bag uncovered, can be seen from the doorway, and touching the ground. On 12/2/21 at 10:10 AM, Surveyor observed R43 in bed, the Foley catheter bag uncovered, can be seen from the doorway, and touching the ground. Surveyor reviewed the policy and procedure, Emptying a Urinary Drainage Bag revised October 2010 provided by the facility and noted the following: 9. Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. (continued on next page)

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	525482	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/3/21 3:15 PM, Surveyor communicated the concern to Administrator (NHA-A), Director of Nursing(DON-B), and Regional Nurse Consultant (RNC-C) of R43's Foley catheter bag being observed to be uncovered, seen from the doorway, and touching the ground. RNC-C stated that all Foley catheter bags should be covered and not laying on the ground.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation, interview and record review, the facility did not ensure that 1 (R93) of 22 toilets reviewed was in a safe operating condition. * R93's toilet was observed to be leaking water and waste when flushed. Findings include: R93 was admitted to the facility on [DATE] with a diagnosis that included Chronic Obstructive Pulmonary Disease, Urine Retention and Anxiety Disorder. R93's Admission MDS (Minimum Data Set) dated 11/5/21 documents a BIMS (Brief Interview for Mental Status) score of 11, indicating that R93 has moderate cognitive impairment. Section G (Functional Status) documents that R93 requires limited assistance and one person physical assist for his toileting needs. On 11/30/21 at 10:24 a.m., Surveyor interviewed R93 regarding the quality of life at the facility. R93 informed Surveyor that the toilet in his room was not working and leaking water. R93 informed Surveyor that when he uses the toilet, water, urine and feces water would leak onto the floor when the toilet was flushed. R93 informed Surveyor that he had informed facility staff but that all that facility staff would do was put towels underneath the toilet to catch the leaking water. Surveyor observed R93's toilet bowl to be filled with clear water and observed a towel underneath R93's toilet that was soaked in water and what appeared to be urine. On 11/30/21 at 1:05 p.m., Surveyor observed R93's toilet bowel to be filled with clear water and observed a towel underneath R93's toilet that was soaked and water and what appeared to be feces On 11/30/21 at 2:48 p.m., Surveyor asked CNA (Certified Nursing Assistant)-N if she had been aware that R93's toilet was leaking water. CNA-N informed that she had observed R93's toilet to be leaking water when flushed since she started working at the facility approximately 3 weeks ago. On 11/30/21 at approximately 3:10 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided. On 12/1/21 at 8:46 a.m., NHA-A informed Surveyor that a plumber had been called to fix R93's leaking toilet. On 12/1/21 at 9:06 a.m., Surveyor interviewed Maintenance Director-O regarding R93's leaking toilet. Surveyor asked Maintenance Director-O if he had been aware that R93's toilet had been leaking when flushed. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maintenance Director-O informed Surveyor that he was told a couple of weeks ago that R93's toilet was leaking and that he had called a plumber to come fix it but that it had been postponed. No additional information was provided as to why the facility did not ensure that R93's toilet was in a safe operating condition.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation and interview, the facility did not provide a working call light system for 1 (R93) of 22 sampled residents. Findings include: R93 was admitted to the facility on [DATE] with a diagnosis that included Chronic Obstructive Pulmonary Disease, Urine Retention and Anxiety Disorder. R93's Admission MDS (Minimum Data Set) dated 11/5/21 documents a BIMS (Brief Interview for Mental Status) score of 11, indicating that R93 has moderate cognitive impairment. Section G (Functional Status) documents that R93 requires limited assistance and one person physical assist for his toileting needs. On 11/30/21 at 10:24 a.m., Surveyor interviewed R93 regarding the quality of life at the facility. R93 informed Surveyor that the call light in his room was not working. R93 informed Surveyor that he has pushed the call light multiple times to get help in going to the bathroom. R93 informed Surveyor that staff had previously told him that the call light outside his room did not light up and that it only flashed for assistance at the nursing station. R93 informed Surveyor that he did not know how long the call light had not been working but that it was longer than one week. On 11/30/21 at approximately 10:25 a.m., Surveyor pressed R93's call light. Surveyor observed the call light button light up in R93's room wall but observed the call light outside the door not to be on or flashing. Surveyor walked down to the nursing station and observed the call light flashing on the panel, indicating that R93's room required assistance. On 11/30/21 at 1:03 p.m., Surveyor observed R93's room call light flashing at the nursing station. Surveyor walked to R93's room and observed R93's call light panel inside of R93's room to be flashing and on, however the call light outside of R93's room was not on or flashing. On 11/30/21 at 2:47 p.m., Surveyor informed RN (Registered Nurse)-H of the above findings. RN-H informed Surveyor that he was just told that the call light in R93's room was not working and that he had notified maintenance of the issue. On 11/30/21 at 2:48 p.m., Surveyor asked CNA (Certified Nursing Assistant)-N if she had been aware that R93's call light outside of R93's room had not been working. CNA-N informed that she had observed R93's call light to not be working since she started working at the facility approximately 3 weeks ago. On 11/30/21 at approximately 3:10 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/1/21 at 8:46 a.m., NHA-A informed Surveyor that maintenance had fixed R93's outside call light and that it was now functioning. No additional information was provided as to why the facility did not provide a working call light system for R93.