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	03/21/2023

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 21855 Based on interviews, record reviews and facility document reviews, the facility did not implement measures to protect a resident from sexual abuse. This was discovered in 2 facility self reports involving (R23 & R76) of 9 facility self-report investigations. On 2/15/23 R23 touched R76 inappropriately in their genital area. R23 had a documented history of previously engaging in inappropriate activity with residents including kissing other residents. The facility had not assessed residents, including R76, for their ability to understand and consent to sexual activity/relations. The facility self report indicates the social worker sat down with R23 and R76 to clarify their relationship. The self report continues to indicate the power's of attorney for both R23 and R76 were contacted and stated they do not have an issue with their relationship but would prefer that the residents were not visiting in each others rooms. The consent for a relationship is not something that can be deferred to a responsible party. The facility did not take steps to prevent this incident from occurring as no assessment had been completed regarding R23's ability to understand what consent is from other parties/residents for sexual behavior. R23's care plan did not specify the level of supervision R23 required to prevent additional inappropriate behavior. On 2/15/23 it was reported that R23 was observed by other residents touching R76 in appropriately. The facility, through interview, expressed skepticism the 2/15/23 incident occurred. The facility stated R23 is in a relationship with R76 despite the lack of consent or assessment of R76 and awareness of R76's psychosocial history. Findings include: The facility's Abuse policy and procedure dated 10/24/22 was reviewed by Surveyor. The purpose is to provide protections for the health, welfare and rights of each resident residing in the facility. The Prevention section indicates: The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of needs and behaviors which might lead to conflict or neglect; this includes sexually aggressive behavior such a as saying sexual things, inappropriate touching/grabbing. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the Facility Self-Report investigation from 2/15/23 at 4:00 PM regarding R23 and R76. Another Resident reported to the Nurse that R23 and R76 were in the Dining Hall, and they saw R23 rubbing R76's vagina area over their clothes. R76 was wearing an incontinence brief and pants. R23 and R76 were separated and placed on 15-minute checks. R23 and R76 each have a Legal Representative. The investigation concluded R23 and R76 are in a relationship and their Legal Representatives are aware of the relationship and prefer them to visit in a common area. The facility final conclusion in their self report was that R76 and R23 are in a relationship despite R76 inconsistently understanding what a relationship is. R76 has diagnoses of Dementia, Bipolar disorder and borderline personality disorder. R76 on 2/21/22 was protectively placed with a court ordered Guardian. On 11/30/22 an Annual MDS (minimum data set) assessment indicates a 5 for BIMS (brief interview of mental status) which indicates severe cognitive impairment. A BIMS assessment was conducted on 2/17/23 that indicates a 3 for severe cognitive impairment. On 2/17/23 (Surveyor noted after the 2/15/23 incident with R23) a Trauma Informed Care Evaluation was completed for R76. This evaluation indicates R76 has had unwanted or uncomfortable sexual experiences by male resident, and this was reported to the State Agency by the facility; R76 does not recall any unwanted or uncomfortable sexual experiences by male resident; R76 has experiences with a life-threatening illness of severe neurocognitive disorder. On 2/20/23 a Recommendations for Addressing Resident Relationships Intimacy and Sexuality History. This assessment indicates R76 is not in a relationship; they currently are not involved in a relationship; is not currently interested in having a relationship. R76's plan of care indicates The resident has a psychosocial well-being problem related to inability to meet role expectations initiated 2/1/23. Indicates on 2/1/23 resident chooses to be in a relationship with a peer. The plan of care does not define or have interventions related to this peer relationship. R76's plan of care indicates 2/15/23 Resident has experienced trauma related to unwanted or uncomfortable sexual experience by a male resident boyfriend (R76) initiated 2/17/23. The interventions include the residents to visit in a common area. On 2/28/23 at 1:07 PM Surveyor spoke with R76 who walked into the Social Worker's office. R76 was smiling and pleasant. R76 did not recall a boyfriend (R23), nor any dating in the facility. R76 indicated all their friends are special. R23's medical record was reviewed by Surveyor. R23 has diagnoses of multiple sclerosis, paraplegia, developmental disorder of scholastic skills. R23 has a Power of Attorney (POA) and POA is activated since 12/5/2019. R23's plan of care indicates Resident displays socially inappropriate behaviors related to intellectual disability dated 6/1/2022 includes: * 6/1/22- residents separated, no adverse outcomes or change in behavior noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social services to follow up as needed. Resident was educated that this behavior is inappropriate due to the other resident being unable to say she wants to be kissed. Resident verbalized understanding. * 2/15/23 inappropriate touching of another resident within a dating relationship. INTERVENTIONS: -6/01/22 Resident was educated not to kiss other residents due to some residents can't say if they want to be kissed. -2/16/23 Resident was educated on intimate expressions allowed by girlfriend's responsible party due to severe cognitive impairment unable to consent to intimacy. Residents to visit in common areas secondary to cognitive defect with inability to give consent. On 2/20/23 R23 had a Recommendation for Addressing Resident Relationships Intimacy and Sexual History assessment conducted. Surveyor noted this was after the incident with R76. This assessment indicates R23 is in a relationship with R76. There is not a defining explanation of what this relationship involves. On 2/22/23 R23 had a Resident Interviewing Assessment completed. The assessment indicates R23 understands what sexual contact means. The assessment does not indicate R23 is in a sexual relationship in the facility or wants to have sex. On 2/27/23 at 2:16 PM Surveyor spoke with R23 about any relationships in the facility. R23 indicates R76 and R23 are good friends. They like R76 and they just hold hands in the common area. They just love each other and like companionship. On 2/28/23 at 12:52 PM Surveyor spoke with SW (Social Worker)-E who assisted with the sexual abuse investigation on 2/15/23. SW-E just had interviewed R23 and R76 separately to complete the relationship assessments. SW-E felt R76 could give consent to a relationship with R23 regardless of mental capacity. SW-E did not involve any of R23 or R76's family or friends at the time of the relationship assessments. On 2/28/23 at 3:19 PM Surveyor spoke with RNC (Regional Nurse Consultant)-G, DON (Director of Nurses)-B and Administrator-A at the Exit Meeting. Surveyor shared concerns with R23 and R76's ability to fully comprehend and consent to an intimate relationship. Surveyor requested the sexual history and trauma assessment policy and procedure (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/02/23 8:01 AM DON-B and RNC-G spoke with Surveyor. RNC-G indicated they monitor R23's interactions with any residents. RNC-G felt the kiss on the check from 6/1/22 was not sexual. They indicated they will revise the plan of care to be more detailed for actual relationships. They have not seen anything besides hand holding from R23 and the kiss was a peck on the cheek on 6/1/22. They felt the sexual contact on 2/15/23 by R23 and R76 did not really happen. R23 would not be physically able to touch R76 and R76 would say no if someone tried to touch them. RNC-G indicated SW-E supplied their own assessment forms. Surveyor noted here there is not a specific policy and procedure. Surveyor noted the facility self report indicates R76 is inconsistent in her comprehension and the self report puts the responsibility on R23 to be aware of R76's inconsistency regarding their relationship status rather than a facility responsibility. On 3/20/23 at 3:30 PM Administrator-A and DON-B were given the above findings at the daily exit conference. Additional information was requested if available. None was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interviews/ and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 3 Residents (R162, R94 & R462) of 5 residents reviewed who potentially had a crime committed against them. R94 had a resident-to-resident verbal altercation in which R162 expressed being very afraid of R94. The facility did not notify the police of R94's threat to R162. Agency Certified Nursing Assistant (CNA) Z was verbally and physically abusive towards R94 and Agency CNA Z was asked to leave the facility. The facility did not call the police. Additionally, the facility did not investigate threats made to another resident by CNA Z that staff referenced in their statements. R45 had an allegation of misappropriation of R462's funds and the facility did not call the police and the investigation was not completed and submitted to the state agency. Findings include: The facility abuse policy dated 10/24/22 indicate: . VII. Reporting/response All alleged violations will be reported to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. 1.) R94 was admitted to the facility on [DATE] with diagnoses of alcohol induced mood disorder, amputation of left lower leg and anxiety disorder. The quarterly MDS (minimum data set) dated 12/7/22 indicate R94 is cognitively intact and is independent with ADLs (activity of daily living) and transfers. The facility self report dated 12/18/22 indicate R94 and R164 were roommates. R164 was watching a show on his phone when R94 got mad at R164 because R164 did not turn the volume down. R94 because verbally aggressive and threatened to break R164 or R164's phone. R94 left the room. R164 told the nurse he was in fear for his life because of R94's threat. R164 was moved immediately to a different room. The self report indicate Nursing Home Administrator (NHA) A and Director of Nursing (DON) B were made aware. There is no evidence in the self report the police were called because R164 stated he was in fear for his life because R94 threatened R164. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/1/23 at 9:30 a.m. Surveyor interviewed NHA A and Assistant Administrator D. Surveyor asked if the police were called when R164 indicated he was fearful of what R94 threatened he would do to R164. Assistant Administrator D stated R164 was scheduled to be discharged the next day. Assistant Administrator D stated they did not call the police. 2) Surveyor reviewed a self report dated 2/12/23 involving R94 and Agency Certified Nursing Assistant (CNA) Z. The investigation indicates on 2/12/23, Agency CNA Z became verbally abusive toward R94 and pushed R94's arm off the door jam. R94 became very upset and staff escorted R94 away from Agency CNA Z and into the dining room. Agency CNA Z was told to leave the building immediately and NHA A and DON B were notified. The facility allegation investigation statement included details the allegation was R94 was in another resident's room. CNA-Z came in to the room and R94 attempted to engage in a conversation with CNA Z. CNA Z allegedly came back with threatening remarks calling R94 a cripple and a little man and allegedly threatened to fight R94 outside. R94 allegedly stood up and CNA Z pushed R94 at the arm almost knocking him off balance. Staff statements clearly indicated that CNA Z was the aggressor in this situation and that an altercation occurred between CNA Z and R94. Additionally, staff statements indicate even stronger language was used by CNA Z than what the facility indicates in their investigation details. Additionally, facility staff indicated in statements that CNA Z threatened other residents indicating he would beat their a**. There is no indication the facility further investigated or reported the threats CNA Z made to other residents as indicated in the staff statements. There is no evidence in the self report the police were called regarding Agency CNA Z being verbally abusive and physically pushing R94's arm off the door jam. On 3/1/23 at 9:30 a.m. Surveyor interview Nursing Home Administrator (NHA) A and Assistant Administrator D. Surveyor asked if the police were called regarding the 2/12/23 incident. Assistant Administrator D stated they did not call the police. Assistant Administrator D stated it was difficult to get Agency CNA Z's statement after they left the building. Agency CNA Z would not return the facility's or the Agency's phone calls and messages. 46517 3.) R462 was admitted to the facility on [DATE] with diagnosis including Metabolic Encephalopathy, Alcohol Dependence and Non-traumatic Brain Dysfunction. R462's quarterly Minimum Data Assessment (MDS), dated [DATE], documented R462 had a BIMS (Brief Interview for Mental Status) of 8, which indicated R462 had cognitive deficits. R462's Healthcare Power of Attorney (HCPOA) was activated on 04/21/22. R462 had a Representative Payee, appointed on 01/03/2023, to manage finances. R45 was admitted to the facility on [DATE] with diagnoses including Multiple Fractures, Paraplegia, Other Psychoactive Substance Use, Anxiety and Depression. R45's most recent quarterly MDS on 01/09/23 documented R45 had a BIMS of 15 indicating R45 is cognitively intact. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed a Facility Self Report which alleged potential financial misappropriation between R45 and R462. The incident was discovered on 01/09/2023, but the full report was not submitted until 02/13/2023. Per the self-report, R462 was packing belongings to discharge from the facility when nursing staff noted multiple carbon copies of checks made out to R45 and made out to cash. The facility's Social Worker filled out and filed the report with the State. On 03/01/23, at 8:15 AM, Surveyor interviewed SW (Social Worker) E. (SW E filed the self-report). SW E informed Surveyor she was made aware of the incident on 01/09/23 when nursing staff informed her they found carbon copies of checks on R462's person made out to R45 and some made out to cash. Per SW E, R462 was discharging from the facility that day and nursing staff were assisting R462 with packing when the carbon copies were noted. SW E informed Surveyor she filed the incident report the same day, however, SW E was unaware the follow up investigation was due within five days and that is why the completed report was late. SW E stated she spoke with a Social Worker Consultant who informed her the police need to be notified, however, per SW E the police were not notified because she and the nursing staff had asked R462 if they wanted the police called and R462 stated no. SW E stated she notified R462's healthcare power of attorney and representative payee. SW E stated she also informed Adult Protective Services. SW E informed Surveyor she felt R462 had some cognitive deficits, however, SW E stated R462 seemed intoxicated most days and spent time going back and forth to R45's room. Per SW E, there was a previous allegation of financial exploitation of R462 by R45. SW E stated she was not employed at the facility at the time of that incident and the other Social Worker would have additional information. Per SW E, R45 denied any wrongdoing and informed SW E, R462 gave R45 permission to write checks and buy things for R462. Surveyor's attempts to interview R45 were unsuccessful: On 02/27/23 at 9:53 AM, Surveyor observed R45 lying in bed with eyes closed. Surveyor knocked on the open door, but R45 did not answer. On 02/28/23 at 11:00 AM, Surveyor noted R45 was not in room. Surveyor was unable to locate R45 at that time. On 03/01/23 at 8:00 AM, Surveyor observed R45's door shut. Surveyor knocked on the door, however no one answered. On 03/01/23 at 9:50 AM, Surveyor observed R45's room was empty. Surveyor was unable to locate R45 at that time. On 03/02/23 at 8:15 AM, Surveyor observed R45's door shut. Surveyor knocked on the door; no one answered. On 03/01/23 at 12:35 PM, Surveyor interviewed NHA (Nursing Home Administrator) A. NHA A informed Surveyor SW E notified NHA A about the incident on 01/09/23 and contacted Adult Protective Services. Per NHA A, SW E did not get statements from staff/residents, nor did SW E contact the police. NHA A stated R462 did not want the police contacted and told staff they gave permission for R45 to use the bank account. NHA A did acknowledge the police should have been contacted. NHA A stated there has been education for staff regarding reporting incidents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/01/23 at 2:30 PM, during the end of the day meeting with NHA A, DON (Director of Nursing) B, and Corporate Nurse Consultant G surveyor relayed the concern of not submitting the Facility Self Report timely, non-notification of the police and not completing a thorough investigation. No additional information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based upon record review and interview, the facility did not ensure investigations of allegations of neglect involving 2 Residents (R61 & R42) of 2 allegations of neglect were reported timely to the state agency. The facility did not ensure investigated allegations of neglects involving R61 and R62 were submitted timely to the state agency as facility administration forgot to submit the investigations to the state agency. Findings include: 1.) R61 was admitted to the facility on [DATE] with diagnoses of epilepsy, depression, bipolar disorder, anxiety, and obesity. R61's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R61 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 00 and needed extensive assistance with bed mobility and cares. On 1/4/2023 at 8:22 PM in the progress notes, nursing charted R61 fell out of bed while receiving care by a Certified Nursing Assistant (CNA). The progress note at 9:25 PM stated the CNA was providing cares to R61 and while repositioning R61, the left lower extremity slid off the bed and R61 started sliding off the air mattress. The CNA attempted to assist R61 into the bed but was unable and assisted R1 to the floor. R61 did not hit their head. X-rays were ordered for left knee pain. A facility self-report for the incident on 1/4/2023 was initiated. The report stated the incident was discovered on 1/5/2023 and was signed by Assistant Administrator (AA)-D on 1/12/2023. The report was submitted to the State Agency on 1/19/2023. In an interview on 3/1/2023 at 3:19 PM, Surveyor asked AA-D why the facility reported incident stated the incident was discovered on 1/5/2023 when staff were present at the time of the incident on 1/4/2023. AA-D stated AA-d did not have access to the reporting system until 1/5/2023 so that was when AA-D could report the incident so AA-D used that date. AA-D stated AA-D should have put down 1/4/2023 instead of 1/5/2023. Surveyor asked AA-D why the report was not filed with the State Agency until 1/19/2023. AA-D stated AA-D does the investigation into any incident reports, but it did not take two weeks to investigate a fall. AA-D stated when AA-D made out the report, AA-D printed out the report but did not hit the submit button. AA-D stated AA-D signed the report on 1/12/2023 but on 1/19/2023 discovered the report had not been submitted. Surveyor asked AA-D how AA-D became aware of the late submission for the report. AA-D stated the State system sends an email saying the final report had not been received so that is what alerted AA-D to the report not being submitted. On 3/2/2023 at 8:16 AM, Surveyor met with Director of Nursing-B and Regional Nurse Consultant-G and shared the conversation with AA-D regarding the late reporting of the Facility Self Report. No further information was provided at that time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R42 was admitted to the facility on [DATE] with Diagnoses of Dementia, mild protein-calorie malnutrition, and Major depressive disorder. R42 was admitted into Hospice on 11/1/2022. R42's significant change Minimum Data Set (MDS) assessment dated [DATE] indicated R42 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 00 and needed extensive assistance with bed mobility and cares. On 11/23/2022 at 3:30 PM the Hospice Certified Nursing Assistant (CNA) nursing alleged that R42 had a strong smell of urine. Nursing went to assess R42 and found R42's brief saturated with urine. R42's buttocks was reddened caused by fecal matter. A facility self- report for the incident on 11/23/2022 was initiated. The report stated the incident was discovered on 11/23/2022 and was signed by the Assistant Administrator (AA)-D on 11/30/2022. The report was submitted to the State Agency on 12/12/2022. In an interview on 3/1/2023 at 3:19 PM. Surveyor asked AA-D why the report was not filed with the State Agency until 12/12/2022. AA-D stated when AA-D made out the report, AA-D printed out the report but did not hit the submit button. AA-D stated AA-D signed the report on 11/30/2022 but on 12/12/2022 discovered the report had not been submitted. Surveyor asked AA-D how AA-D became aware of the late submission for the report. AA-D stated the State system sends an email saying the final report had not been received so that is what alerted AA-D to the report not being submitted. On 3/2/2023 at 8:16 AM, Surveyor met with Director of Nursing-B and Regional Nurse Consultant-G and shared the conversation with AA-D regarding the late reporting of the Facility Self Report. No further information was provided at that time.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, record review, and interview, the facility did not ensure residents received treatment and care in accordance with professional standards for 1 (R262) of 22 sampled residents. * R262 had an order on admission to have a shower daily. The order was not transcribed and R262 only received a weekly shower while in the facility. Findings include: R262 was admitted to the facility on [DATE] status post a cerebral shunt replacement and had a surgical wound to her head. On 3/1/23 R262's hospital discharge instruction dated 12/27/23 were reviewed and read: Post operative VP (Venticulooeritoneal) shunt instructions. Showering: please shower daily. Gentle cleaning and rinsing of the incision is ok. On 3/1/23 R262's treatment and daily care records were reviewed. Showering daily was not included in the records. Shower weekly on Tuesday was on the care record and documented as completed while R262 was at the facility. On 3/2/23 at 10:30 AM Regional Nurse Consultant-G was interviewed and indicated the facility was unaware of R262's daily instructions for showering but the facility would not have had staff to complete daily showering. Regional Nurse Consultant-G indicated the facility should have called R262's physician with any concerns with the hospital orders and they did not. On 3/1/23 R262's medical record was reviewed and no adverse outcome related to not being showered daily was found, The above findings were shared with the Administrator and Director of Nurses at the daily exit meeting on 3/1/23 at 2:30 PM. Additional information was requested if available. None was provided.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents received care, consistent with professional standards of practice, to prevent pressure injuries for 2 (R7, R29) of 6 residents reviewed for pressure injuries. * R7 developed a facility acquired, Stage 4 pressure injury with an exposed tendon under a splint that had been applied to R7's hand. There was not a doctor order for R7's splint. The splint did not appear to have been removed for cares to check R7's skin impairment, the splint was not on the care plan or care delivery guide. Facility failure to obtain a doctor's order, care plan, and provide care for R7's splint caused R7 to develop a Stage 4 pressure injury with exposed tendon created a finding of immediate jeopardy that began on 1/6/2023. Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the immediate jeopardy on 3/2/2023 at 3:28 PM. The immediate jeopardy was removed on 1/8/2023. However the deficient practice continues at a scope/severity of D as evidenced by the following example. * R29 was readmitted to the facility with a deep tissue injury (DTI). The facility did not comprehensively assess the area upon admission or establish a care plan until later. Findings include: The facility policy entitled Pressure Injury Prevention and Management' implemented on 1/6/2023 states: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Policy Explanation and Compliance Guidelines: . 2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk . e. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. 4. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/ evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. e. the goals and preferences of the resident and or/authorized representative will be included in the plan of care. 6. Modifications of Interventions b. Interventions on a resident's plan of care will be modified as needed. 1.) R7 was admitted to the facility on [DATE] and has diagnoses that include: encephalopathy, anxiety, major depressive disorder, dementia, muscle wasting and atrophy. (continued on next page)

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	525482	A. Building B. Wing	03/21/2023

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7's annual Minimum Data Set (MDS) dated [DATE] indicated R7 had severely impaired cognition with Brief Interview for Mental Status (BIMS) score of 00 and assessed R7 as needing extensive assist with bed mobility, dressing, eating, toileting, and hygiene, and total dependence with transferring and bathing. R7 was non ambulatory, used a Hoyer lift for transferring and had a Broda wheelchair. R7 was incontinent of bowel and bladder and wore a brief. R7's Braden score on 1/10/2023 was 13 indicating R7 was high risk for developing pressure injuries. R7's Potential for Impaired Skin Integrity was initiated on 2/19/2021 with the following interventions: - pressure redistribution mattress - apply cushion to wheelchair - Complete Braden scale upon admission, weekly X4, quarterly, with significant change of condition and as needed - lotion with skin cares - Weekly skin assessment - Monitor skin with all cares. Report any changes to Nurse - Update Physician as needed, refer to Registered Dietician and therapy as needed. - Tubi grips to bilateral upper arms, put on in AM and take of at bedtime. Offer long sleeve shirts to resident if available- initiated 8/5/2022 - Encourage to Free float heels in bed- initiated 11/15/2021 - Barrier cream after each incontinent episode and as needed- initiated 11/15/2021 - Encourage to reposition approximately every 2-3 hours and as needed-initiated 11/15/2021 On 8/18/2022 the Nurse Practitioner (NP) wrote an order for Occupational Therapy (OT) to evaluate and treat R7 due to R7 having stiff, swollen fingers and knuckles of the left hand. On 8/24/2022 OT started to see R7 per NP order. On 8/30/2022 OT implemented R7 to start wearing a palm guard with finger separators. OT noted deficits with positioning of R7's left upper extremity (LUE) impacting the risk of skin breakdown and functional use of LUE. OT applied a long skinny pillow under R7's elbow to support the elbow and the LUE to improve positioning while R7 was up in R7's Broda wheelchair. OT wrote up education for nursing to educate staff on R7's [NAME] guard schedule and how to position the LUE while R7 was in Broda wheelchair. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/21/2022 R7 was discharged from therapy with the following discharge recommendations: staff were educated on the use of the palm guard and Isotoner glove for the left hand. Surveyor noted that R7 did not have a care plan initiated regarding R7's [NAME] guard with finger separators for R7's left hand or to have R7's left hand brace removed for cares or to check skin impairment. On 1/6/2023 at 12:39 PM in the progress notes, nursing charted R7 was noted to have a new open area to the base on R7's left thumb. R7 had been wearing a splint and the splint was removed. Nursing assessed the Skin. Nursing contacted R7's Power of Attorney (POA) and the NP. Nursing obtained a new order to have R7 seen in house by the wound doctor. The wound doctor was made aware and will see R7 on their next visit. Nursing obtained treatment orders and applied the treatment to R7. On 1/6/2023 on the Initial Wound Assessment, nursing documented the base of the left thumb had a Stage 4 pressure injury measuring 1.1 cm x 1.5 cm x 0.2 cm with 100% non-granulating tissue with exposed tendon. R7's Impaired Skin Integrity Care Plan was initiated on 1/6/2023 with the following interventions: - Complete Braden scale upon admission, weekly X4, quarterly, with significant change of condition and as needed - Consult in-house wound physician - Measure area weekly - Monitor of signs/ symptoms of infection - Monitor of signs/ symptoms of worsening skin tissue - Monitor pain and offer as needed analgesic as ordered - Monitor skin with all cares. Report any changes to Nurse/ physician. - Wound team to follow - Treatment as ordered - Update physician with changes in wound status and PRN (as needed). On 1/10/2023, the wound physician assessed R7's pressure injury to the base of the left thumb. The wound physician documented the Unstageable pressure injury measured 0.4 cm x 0.95 cm x 0.1 cm with early granulation tissue. The wound physician ordered the following treatment: cleanse the wound with normal saline, pat dry, apply skin prep to area around the wound, apply Xeroform dressing and bandage the wound daily and as needed. The wound physician documented the wound was crusted over with no tendon exposed at that time with no signs or symptoms of infection. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/17/2023 R7's measurements were: 1.39 cm X 0.59 cm X 0.1 cm, stage 4, 75-99% granulation tissue. The treatment was changed from Xerofoam dressing to bordered foam dressing. R7's Stage 4 pressure injury to the left thumb was assessed weekly and had the following measurements: -1/24/2023: 1.2 cm X 0.3 cm X 0.1 cm with early granulation tissue. -1/31/2023: 0.7 cm X 0.2 cm X 0.1 cm with early granulation tissue. -2/7/2023: 0.4 cm X 0.2 cm X 0.1 cm with early granulation tissue. -2/14/2023: 0.2 cm X 0.2 cm X 0.1 cm with early granulation tissue. -2/21/2023: 0.1 cm X 0.1 cm X 0.1 cm with early granulation tissue. On 2/28/2023, R7's measurements were: 0.93 cm X 0.68 cm X 0.1 cm, stage 4, 76% granulation with no other percentage type. (The wound base description should have 100% tissue type documented.) New treatment orders were received to cleanse R7's pressure injury with normal saline, protect around the wound with skin prep, cover with foam dressing every Tuesday, Thursday, Saturday, and as needed and to apply a washcloth under the left hand contractures to prevent further skin breakdown. An order was received to check skin integrity under washcloth every shift. On 3/2/2023 at 12:27 PM, Surveyor observed Licensed Practical Nurse (LPN)-O change R7's dressing to R7's left thumb per the wound physician's orders. Surveyor observed light brown drainage on the dressing. Surveyor observed R7's pressure injury at the base of R7's left thumb, measuring approximately 0.5 cm X 0. 5 cm, with no depth noted, and pink tissue at wound base. Surveyor asked LPN-O how R7 developed the pressure injury. LPN-O stated R7 had a [NAME] soft brace for R7's contractures and the corner of R7's brace by the thumb area was doubled over and R7 would squeeze it tightly because of R7's contractures. Surveyor asked LPN-O if LPN-O ever took off R7's brace. LPN-O stated third shift staff would take R7's brace off and morning staff would put R7's brace on. LPN-O stated LPN-O never took off R7's brace. Surveyor asked LPN-O if LPN-O could show Surveyor R7's brace. LPN-O stated R7's brace was thrown out, but the brace was a palm guard, and the brace would go over the thumb and Velcro together. LPN-O stated that R7's brace had sheepskin under the fingers so R7 could not bend R7's fingers into R7's palm of the hand due to the contractures. On 3/2/2023 at 12:55 PM Surveyor asked the Director of Rehab (DoR)-P if therapy was consulted for R7 to be seen for a brace. DoR-P stated therapy had an order for R7 for OT to evaluate and treat R7 for stiff, swollen fingers and knuckles of the left hand. DoR-P stated R7 was seen from 8/24/2022 - 10/21/2022. On 3/2/2023 at 12:55 PM Surveyor asked OT-Q if OT-Q recommended a brace for R7. OT-Q stated OT-Q recommended a palm guard with finger separators for R7's left hand because of R7's contractures. OT-Q stated R7 could not tolerate the finger separators and recommended staff to take off or not wear the palm guard if R7 developed skin issues. Surveyor asked if OT-Q saw R7 to assess R7's brace. OT-Q stated OT-Q had not seen R7 since discharging from therapy in October 2022. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/2/2023 at 1:25 PM Surveyor asked the Regional Nurse Consultant (RNC)-G what orders R7 had for the palm guard with finger separator brace. RNC-G stated to Surveyor that the Nursing Home Administrator (NHA)-A had the past noncompliance binder and Surveyor would need to talk with NHA-A. Surveyor asked RNC-G to clarify about the binder for R7. RNC-G stated when R7's pressure injury was found RNC-G realized that R7 did not have orders for a brace and R7 was not supposed to have a brace. On 3/2/2023 at 1:30 PM Surveyor asked the NHA-A for information regarding R7's pressure injury that was found on 1/6/2023. NHA-A stated that when staff found R7's pressure injury on R7's left thumb, staff noted that there was not an order for R7 to have a brace and R7 did not have a care plan to do checks on R7's skin under the brace or to remove R7's brace. The facility's failure to obtain a doctor's order, care plan, and provide cares for R7's splint caused R7 to develop a Stage 4 pressure injury with exposed tendon created a finding of immediate jeopardy. The facility removed the jeopardy on 1/8/2023 when it had completed the following: - Audited all residents with splints/ medical devices. - Talked with staff regarding what residents were wearing splints. - Had therapy provide a list of all residents with splints. - Education was given to Nursing and CNAs regarding orders for splints, checking for skin impairment, and who to inform if a resident has a device and is not on the resident's care card. - facility to perform random audits of residents with/ without splints X4 weeks. - Audit of communication between therapy and nursing for use of devices. The deficient practice continues as a scope/severity of D based on the following examples: 46517 2.) R29 is a long-term resident at the facility with diagnosis including, unspecified severe protein calorie malnutrition, Chronic Kidney Disease stage 4, and Chronic Obstructive Pulmonary Disease. R29's quarterly MDS (Minimum Data Set) Assessment documents R29 has a BIMS (Brief Interview for Mental Status) of 14, indicating R29 is cognitively intact; R29 is at risk for pressure injuries and has one stage three pressure injury. R29's skin integrity care plan, initiated on 07/18/2019, documents: Resident has Potential for impaired skin integrity r/t (related to): decreased mobility, unspecified severe protein calorie malnutrition, dermatitis, left hip brace and has interventions that include: 10/11/22 skin prep to left heel . 10/28/22- soft boots on at all times (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in-house wound MD to follow . 11/22/22-Tx as ordered . 2/14/23-new treatment to left lateral heel . 2/21/23-new treatment to left lateral heel . pressure redistribution mattress; initiated on 09/16/2019 Assist with reposition PRN (As needed) Surveyor reviewed R29's medical record and noted the following nurses progress note dated 10/11/2022 at 3:53 PM: Resident returned from the hospital, writer looked at residents' heels, noted faint discoloration to L heel measuring 2cm x 2cm. Denies pain to area. [Name of Nurse Practitioner] NP (Nurse Practitioner) from [name of group] notified. New orders received to apply Skin Prep to area . Surveyor noted R29 had been hospitalized from 10/4/22 to 10/11/22. R29's medical record contained no documentation of a DTI prior to 10/4/22. Surveyor noted R29 had the following physician's order dated 10/11/22 and discontinued on 10/28/23: L (Left) HEEL: Cleanse area with saline, apply skin prep daily and PRN (As needed). On 03/01/23 at 10:12 AM, Surveyor interviewed Unit Manager LPN (Licensed Practical Nurse) J. LPN J informed Surveyor she noticed the DTI to R29's left heel upon admission and received an order for skin prep and soft boots. Surveyor reviewed R29's medical record and noted R29's care plan was not updated until 10/28/22 to include the intervention of soft boots on at all times. Surveyor could not locate pressure off-loading interventions added on 10/11/22 when the DTI was first discovered. On 03/02/23 at 9:39 AM, Surveyor interviewed DON (Director of Nursing) B and Corporate Nurse Consultant G. Surveyor asked if there were off-loading interventions added to R29's care plan after the discovery of the DTI on 10/11/22. DON B stated she would check R29's medical record and get back to Surveyor. On 03/02/23 at 1:50 PM, DON B informed Surveyor there were no pressure off-loading interventions added at the time of the DTI discovery on 10/11/22. No additional information was provided.

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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 38253 Based on observation, record review, and interview, the facility did not ensure adequate supervision and assistive devised were used to prevent accidents for 3 (R61, R37, and R463) of 6 residents reviewed for falls. R61 fell out of bed on 1/4/2023 while receiving cares with the assist of one Certified Nursing Assistant (CNA). The facility staff were not following F61's plan of care: R61 required the assist of two CNAs when receiving cares per the Care Plan. R37 had three falls out of bed, 11/5/2022, 11/23/2022, and 12/15/2022, without having a body pillow in place. R37 was to have a body pillow in place per plan of care. Multiple observations were made during the survey of no body pillow in place when R37 was in bed. R463 fell on [DATE] when being transferred with no gait belt in place. R463 was to have a gait belt used when transferring per plan of care. Findings include: The facility policy and procedure entitled Falls and Fall Risk, Managing from MED-PASS (C)2001 revised on 3/2018 states: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 1.) R61 was admitted to the facility on [DATE] with diagnoses of epilepsy, depression, bipolar disorder, anxiety, and obesity. R61's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R61 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 00 and needed extensive assistance with bed mobility and cares. R61's Potential for Falls Care Plan had the following interventions initiated on 12/28/2020: two-person assist with cares/repositioning On 1/4/2023 at 8:22 PM in the progress notes, nursing charted R61 had a fall when a CNA was providing care. The nurse practitioner and Director of Nursing (DON) were updated. On 1/4/2023 at 9:25 PM in the progress notes, Licensed Practical Nurse (LPN)-N charted a CNA was providing cares to R61 and while repositioning R61, the left lower extremity slid off the bed and R61 started sliding off the air mattress. The CNA attempted to assist R61 into bed but was unable and assisted R61 to the floor. The nurse practitioner ordered an x-ray for left knee pain and swelling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility incident report stated the fall occurred on 1/4/2023 at 7:30 PM. The immediate intervention was to have 2 CNAs provide cares due to R61's size and weight. The interdisciplinary team met on 1/5/2023 and determined the CNA was not following the care card to have two staff assist with cares and repositioning. The immediate intervention was to re-educate staff for not following the care card and requesting an alternating pressure mattress with bolsters when available. A self-report was filed with the State Agency. R61's Potential for Falls Care Plan was revised on 1/4/2023 with the following intervention: re-education to staff for not following the care card - CNA is not returning to the facility; will request alternating pressure mattress with bolsters when available. On 1/10/2023 the intervention was revised to read: x-rays ordered to left knee and lower back; negative for fracture. In an interview on 3/1/2023 at 9:13 AM, Surveyor reviewed with DON-B and Regional Nurse Consultant-G R61's fall on 1/4/2023. Surveyor shared with DON-B and Regional Nurse Consultant-G the incident investigation stated there was a self-report for the incident. Surveyor asked to review the self-report. Regional Nurse Consultant-G stated Nursing Home Administrator (NHA)-A was looking for the report. On 3/10/2023 at 1:23 PM, Surveyor received the facility self-report of R61's fall on 1/4/2023. The self-report stated who the CNA was that was involved in R61's fall and the report named the nurse that assessed R61 prior to moving R61 back into bed with a Hoyer lift. Surveyor noted the nurse that did the assessment was an LPN, not a Registered Nurse (RN). In an interview on 3/1/2023 at 3:01 PM, LPN-N stated R61 fell out of bed when a CNA was repositioning R61. LPN-N stated R61 was not centered in the bed and the foot slipped off the air mattress. LPN-N stated the CNA tried to keep R61 from falling, but R61 was too big to stop. Surveyor asked LPN-N who assessed R61 prior to moving R61. LPN-N stated the RN in the building at the time came over to the unit and assessed R61. Surveyor noted the RN made a note in R61's medical record of the fall at that time. LPN-N stated R61 was supposed to be a two-person assist and the CNA was not following the care plan. In an interview on 3/2/2023 at 8:16 AM, Surveyor shared with DON-B and Regional Nurse Consultant-G the concern R61 fell out of bed on 1/4/2023 due to the CNA not following the care plan and having someone assist the CNA with R61's cares and repositioning. Regional Nurse Consultant-G stated some of the staff were educated on following care plans, but not all the staff were educated. No further information was provided at that time. 2.) R37 was admitted to the facility on [DATE] and has diagnoses that include diffuse traumatic brain injury, Large B-cell lymphoma, malignant neoplasm of the brain treated with radiation, retroperitoneal mass, history (HX) if intracranial mass, and HX chemotherapy. R37's quarterly Minimum Data Set (MDS) dated [DATE] indicated R37 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 00 and coded R37 needing extensive assist with bed mobility, transferring, and dressing and total assist with toilet use, hygiene, and bathing, R37 self-propels in a wheelchair and requires an EZ stand transfer with assist X2 for transferring. R37 in incontinent of bowel and bladder and wore a brief. R37's Risk for falls Care Plan was initiated on 2/23/2018 with the following interventions: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Follow therapy recommendations for transfers/ mobility. - Anticipate and meet residents needs. Encourage resident to call for assistance. - Body pillows when resident in bed- initiated 5/30/2018 - Ensure resident to stay in high traffic areas- initiated 8/15/2018 - Assist to toilet resident upon rising, before and after meals, at bedtime and with rounds during the night- initiated 3/1/2019 - Not to leave resident in bed fully dressed in the morning. Get the resident up when he wakes in the morning and bring him to common area- initiated 12/27/2019 - have all necessary persons/ equipment ready before bringing resident to his room for cares- initiated 3/9/2020 - Staff not to bring resident to the dining room until staff are present- initiated 4/10/2022 - Taken off the night shift get up list- initiated on 7/23/2022 - bed in lowest position, mat on floor, bowel and bladder patterning- initiated 7/31/2019 - Resident to have footrests up when in wheelchair- initiated 9/9/2019. - Ensure foot pedals are in place before pushing wheelchair- initiated 9/9/2019 - Staff to ensure lid is placed on water cup- initiated 9/30/2021 - Lid to be placed on coffee cup- initiated on 8/9/2022 - Dycem under wheelchair cushion- initiated 12/8/2022 - Immediate intervention: placed Dycem to top of wheelchair cushion and offer resident to lay down after meals- initiated 12/10/2022 R37's care card has the following interventions listed for R37's needs: - Body pillows when in bed. - Bed in low position. - Dycem to top of wheelchair cushion and under the cushion. - Make sure all equipment is in the room prior to starting. - Don't bring the resident to dining room until staff are present. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Encourage to stay in high traffic areas. - Air pressure mattress (settings marked on box). - Make sure floor mat in down. Resident to lay down after meals. - Encourage to be up for meals only. On 11/5/2022 at 9:00 PM in the progress notes, nursing charted nursing was called to R37's room by R37's roommate. Found R37 lying on R37's left side on floor mat. R37's bed was in low position, call light was within reach but not on. R37 was in gown in bed and barefoot. R37 was not incontinent at time of incident. On 11/6/2022 the Interdisciplinary Team (IDT) reviewed R37's fall from 11/5/2022 and documented the root cause of R37's fall was related to R37 rolling out off the mattress. R37 is care planned to have body pillow when in bed. R37's Risk for Falls Care Plan was revised on 11/5/2022 with the following intervention: Staff educated to follow care card for safety interventions. Let the nurse know if something is unavailable or not in place. On 11/23/2022 at 8:30 PM in the progress notes, nursing charted R37 was found on R37's floor mat. R37 had no injuries, bruising, cuts, or abrasions. R37 denies pain or hitting R37's head. Neurological checks within normal ranges. Vital signs stable (110/76, 96, 16, Temperature 98.1, pulse oximetry 95% at room air). R37 did not have incontinence and had gripper socks on R37's feet. On 11/24/2022 the IDT reviewed R37's fall from 11/23/2022 and documented the root cause of R37's fall was to be determined from R37's body pillow not being in place. R37's Risk for Falls Care Plan was revised on 11/23/2022 with the following intervention: Staff was re-educated regarding following the care cards to have body pillow in place. On 12/15/2022 at 6:15 PM in the progress notes, nursing charted R37 experienced an un-witnessed fall without injury. R37 was in bed which was in the lowest position. R37 was found lying on the fall mat beside R37's bed. R37 was tangled in R37's bed covers and laying beside the bed. R37's bedside table was by R37's bed. R37 had no noted injuries at time of fall. Vital signs taken (127/84, 76, 18, temperature 97.7, pulse oximetry 97% on room air. R37 denied pain. R37's neurological checks within normal ranges. R37 unable to tell nursing what R37 was attempting to do. R37 was placed in bed minutes before R37 was found lying on floor mat. R37 did not use call light that was next to R37 and was not incontinent at time of fall. Nursing charted that R37 presented with anxiety prior to fall when R37 was asked to take a bath. On 12/16/2022 the IDT reviewed R37's fall from 12/15/2022 and documented that R37 was supposed to have a body pillow when in bed. There was not a body pillow in R37's room. R37's Risk for Falls Care Plan was revised on 11/15/2022 with the following interventions: Staff educated to place body pillow when resident in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/1/2023 at 12:42 PM Surveyor observed a floor mat on the floor next to R37's bed. There was not a body pillow on R37's bed or in R37's bedroom that Surveyor was able to tell. On 3/1/2023 at 3:07 PM Surveyor observed R37 lying in R37's bed. R37 was covered with sheets. R37 was positioned on the very edge of R37's mattress tilted on R37's left side. R37's floor mat was on the floor next to R37's bed and R37's bed was in lowest position. Surveyor did not observe a body pillow on R37's bed. On 3/1/2023 at 3:10 PM Surveyor asked Certified Nursing Assistant (CNA)-R what interventions R37 should have in place when lying in bed. CNA-R stated that R37's bed needs to be low to the ground and R37's fall matt next to bed. CNA-R also stated that R37 should be positioned close to the wall. Surveyor asked CNA-R if R37 should have any body pillows placed in bed with R37 when lying down. CNA- R stated CNA-R was not aware of R37 needing a body pillow. Surveyor showed CNA-R how R37 was lying in bed. CNA-R assisted R37 move away from the edge of the mattress. CNA-R did not put a body pillow on R37's bed per R37's care plan and care card interventions state. On 3/2/2023 at 7:52 AM Surveyor observed R37's bed was made and fall mat on the floor. There was not a body pillow in R37's bed or in R37's room. On 3/2/2023 at 7:59 AM Surveyor asked CNA-S what interventions R37 had in place for when R37 laid down in bed. CNA-S stated R37 needed to have R37's bed low to the ground with a fall matt on the floor. Surveyor asked CNA-S if R37 needed a body pillow to prevent R37 from falling out of bed. CNA-S stated CNA-S was not sure, CNA-S did not have a chance to look over R37 yet. On 3/2/2023 at 8/19/2023 Surveyor informed the Director of Nursing (DON)-B and the Regional Nurse Consultant (RNC)-G of Surveyors concern of R37 not having interventions in place for 3 of R37's falls and observations of body pillow not being in room and CNA's not know of R37's intervention of needing a body pillow when R37 was in bed. 46517 3.) R463 was admitted to the facility on [DATE] and had diagnoses that included CVA (Cerebral Vascular Accident) with left sided hemiparesis. R463 was discharged from the facility in December 2022. R463's admission MDS (Minimum Data Set) Assessment documented R463 had a BIMS (Brief Interview for Mental Status) of 12 which indicated R463 was cognitively intact. R463's fall care plan initiated on 11/29/2022 documented, Resident has the potential for falls, accidents and incidents related to CVA, history of falls, unaware of safety needs, left eye visual defect, 2nd toes of both feet amputated, and had interventions which included, Resident re-educated by staff RN to use call light for transfers and not to attempt to get up unassisted .given non-skid socks; Bed in low position with mat on floor; Mattress changed to a scoop mattress; and staff re-educated to use gait belt with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed fall documentation from 12/21/2022 which stated, CNA (certified nursing assistant) called writer into room, resident kneeled down to the floor during a transfer with the assist of the CNA. Resident was being transferred from the wheelchair to his bed at the time of the fall .CNA was educated to use a gait belt to help [resident's name] transfer .No injuries were obtained .Staff did not use a gait belt. Staff was re-educated that a gait belt should be used for safe transfers. On 03/01/23 at 10:15 AM, Surveyor interviewed Unit Manager, LPN (Licensed Practical Nurse) J. LPN J informed Surveyor R463 was very impulsive and the facility implemented numerous fall interventions. Surveyor asked if staff should use a gait belt when transferring a resident who requires an assist of one. LPN J stated yes, staff should always use a gait belt. On 03/02/23 at 9:39 AM, Surveyor interviewed DON (Director of Nursing) B and Corporate Nurse Consultant (CNC) G. Surveyor relayed the concern of R463 suffering a fall while being transferred by a CNA who was not using a gait belt. CNC G informed Surveyor the facility did education with the staff regarding using a gait belt for transfers. Surveyor asked to view the education and any other additional information the facility may have on the concern. No additional information was provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46214 Based on interview and record review, the facility did not ensure 2 (R17 and R262) of 7 residents reviewed for weight loss had their nutritional care needs recognized, evaluated, and addressed to provide adequate parameters of nutritional status. * A review of R17's admission weight on 8/10/22 was documented at 198 pounds in the medical record and the admission nutritional assessment documented an admission weight of 220 pounds. The Dietician disputed the admission weight value with no further follow up or reweigh. R17's documented weight on 8/30/22 was 177.6 pounds which was a 10.30% weight loss from 198 pounds. The facility did not implement an intervention until 10/25/22. * R262 was not assessed for fluid needs on admission. R262 was not screened for beverage preferences and there was no care plan for dehydration. Findings include: The facility policy, entitled Nutrition and Hydration Guideline, dated 10/3/22, states: Purpose: The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters for nutritional and hydration status through: Providing nutritional and hydration care and services consistent with the nutritional comprehensive assessment Recognizing, evaluating, and addressing the needs of every resident, including but limited to, those at risk or already impaired nutrition and hydration Providing a therapeutic diet that considers the clinical condition, and preferences, when there is a nutritional indication. Assessment A comprehensive nutritional assessment should be completed on any resident identified as being at risk for unplanned weight loss/gain and/or compromised nutritional status. The interdisciplinary team a comprehensive nutritional assessment, the interdisciplinary team clarifies: Nutritional issues, needs and goals. The nutritional assessment may utilize existing information from sources: RAI (Resident Assessment Instrument) Assessments from other disciplines The existing medical record Observations Direct care staff interviews (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident and family interviews The assessment should identify those factors that place the resident at risk for inadequate nutrition/hydration. The nutritional assessment may include the following information: Weight Weight can be a useful indicator of nutritional status, when evaluated within the context of the individual's personal history and overall condition. Weight goals should be based on a resident's usual body weight or desired body weight. Upon Admission: Obtain a weight Consider a weight for the first 3 days Weigh weekly x 4 weeks Monthly and as directed by the physician As needed i.e.: diuretic changes, observed edema, significant changes in condition, food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance Suggested Parameters for Evaluating Unplanned or Undesired Weight Loss Interval Significant Loss Severe Loss 1 month 5% >5% 3 months 7.5% >7.5% 6 months 10% >10% Food and fluid intake The nutritional assessment includes an estimate of calorie, nutrient and fluid needs, and whether intake is adequate to meet those needs. It also includes information such as the route (oral, enteral, or parenteral) of intake, any special food formulation, meal, and snack patterns (including the time of supplement or medication consumption in relation to the meals), dislikes, and preferences (including ethnic foods and form of foods such as finger foods); meal/snack patterns, and preferred portion sizes. While there is no reliable calculation to determine an individual's fluid needs, an assessment should consider those characteristics pertinent to the resident, such as age, medical diagnoses, activity level, etc. Care Planning (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan, to the extent possible should: Identify causes of impaired nutritional status Reflect the personal goals and preferences Identify resident-specific interventions and a time frame and parameters for monitoring The care plan should be: Updated as needed, such as when the resident's condition changes, goals are met, interventions are determined to be ineffective, or as new causes of nutrition-related problems are identified Include the resident, resident representative Physician as needed Interventions Interventions related to a resident's nutritional status must be individualized to address the specific needs of the resident. Examples of care plan development considerations can include, but are not limited to: Diet Liberalization Talk with the resident, their family and representative (whenever possible) and provide information pertaining to the risks and benefits of a liberalized diet Work with the physician and other nursing home professionals (dietary manager, nurses, speech therapists, etc.), using the care planning process, to determine the best plan for the resident; and Accommodate needs, preferences, and goals Weight-Related Interventions For at risk residents, the care plan should include nutritional interventions to address underlying risks and causes of unplanned weight loss or unplanned weight gain, based on the comprehensive or any subsequent nutritional assessment. The development of these interventions should involve the resident and/or the resident representative to ensure the resident's needs, preferences and goals are accommodated. Food Intake (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Improving intake with wholesome foods is preferable to adding nutritional supplements. However, if the resident is not able to eat recommended portions at meal times, to consume between-meal snacks/nourishments, or if he/she prefers the nutritional supplement, supplements may be tried to increase calorie and nutrient intake. Examples of other interventions to improve food intake include: Fortification of foods (e.g., adding protein, fat, and/or carbohydrate to foods such as hot cereal, mashed potatoes, casseroles, and desserts) Offering smaller, more frequent meals Providing between-meal snacks or nourishments Increasing the portion sizes of a resident's favorite foods and meals Providing nutritional supplements 1.) R17 was admitted to the facility on [DATE]. R17's diagnoses include Parkinson's disease, type 2 diabetes mellitus without complications, polyneuropathy, vascular dementia, muscle weakness and depression. A review of the admission MDS (Minimum Data Set), dated 8/17/22 documents a BIMS (Brief Interview for Mental Status) score of 3 indicating R17 is severely cognitively impaired. R17 needs extensive assistance with bed mobility and personal hygiene and total dependence for transfers and toileting. R17 eats independently and requires set up help only. R17's height is 72 inches and weight is documented at 198 pounds. Section M of the MDS also documents that R17 is at risk for the development of pressure injuries. A review of the Quarterly MDS, dated [DATE] documents R17's height as 72 inches and weight 175 pounds. It also documents that R17 has had a weight loss of 5% or more in the last month or 10% or more in the last 6 months and that R17 is not on a prescribed weight loss regimen. Section M of the Quarterly MDS also documents that R17 has 1 stage 3 pressure injury. Surveyor reviewed R17's Individual Care Plan which documents that R17 has increased nutrient needs (protein/calories) due to skin integrity AEB (as evidenced by) need for nutritional interventions and regular nutritional intake monitoring, date initiated 8/12/22 with the following interventions: weigh resident per facility protocol/MD order and monitor weights, record and monitor nutritional intake daily, and provide diet as ordered date initiated 8/12/22. Interventions initiated on 9/15/22 include provide nutritional supplements as ordered and monitor intake: Mighty Shake TID (three times daily) (for weight loss/wound healing) and ProSource 30 ml TID (for wound healing) and provide MVI (multivitamin injection) as ordered. Intervention initiated 10/6/22 include encourage resident to be up for meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R17's Physician Orders which documents the following: Mighty Shake two times a day for weight loss/wound healing, date initiated 10/25/22 and discontinued 11/15/22. Mighty Shake three times a day for weight loss/wound healing, date initiated 11/16/22. Pressure injury risk: weekly weights for 4 weeks every evening shift, every Wednesday for 4 weeks, date initiated 11/8/22 and discontinued 12/6/22. Weekly weights for 3 weeks every day shift every Wednesday until 8/31/22, date initiated 8/17/22 and discontinued 8/31/22. ProSource Liquid (Nutritional Supplements) Give 30 ml by mouth two times a day for wound healing, date initiated 8/23/22 and discontinued 10/25/22. ProSource Liquid (Nutritional Supplements) Give 30 ml by mouth three times a day for wound healing, date initiated 10/25/22. Surveyor reviewed R17's weights documented in the Weights and Vitals Summary which were documents as the following: 08/10/22 198 lbs. 08/16/22 198 lbs. 08/30/22 177.6 lbs. 09/20/22 178.2 lbs. 10/18/22 179.2 lbs. 11/01/22 172.8 lbs. 11/08/22 171.0 lbs. 11/15/22 159.6 lbs. 11/22/22 158.2 lbs. 11/29/22 163 lbs. 12/06/22 158.2 lbs. 12/13/22 159 lbs. 12/20/22 158.2 lbs. 12/27/22 175.6 lbs. 1/10/23 175.2 lbs. 01/21/23 179.6 lbs. 01/31/23 178 lbs. 02/02/23 171.2 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/07/23 174 lbs. 02/14/23 174 lbs. 02/21/23 175 lbs. 03/01/23 176 lbs. Surveyor notes that on 08/16/2022, the resident weighed 198 lbs. On 08/30/2022, the resident weighed 177. 6 pounds which is a 10.30 % loss. Surveyor notes that on 11/08/2022, the resident weighed 171 lbs. On 11/15/2022, the resident weighed 159. 6 pounds which is a 6.67 % loss in one week. Surveyor notes the admission weight was obtained on 8/10/22 of 198 pounds. A second weight was documented on 8/16/22 of 198 pounds. A third weight was documented on 8/30/22 of 177.6 pounds. The next weight was documented on 9/20/22 of 178.2 pounds. Per facility policy and procedure, the facility should have weighed R17 again in the weeks between 8/16/22 and 8/30/22 and the week after 8/30/22. The policy states to weigh weekly times 4 weeks post admission. There is no documentation that R17 refused to have weights obtained. Surveyor reviewed R17's Nutritional Assessment with an assessment date of 8/12/22. Documented was: Most recent weight 220.4 pounds, status: overweight. Nutritional Assessment/Recommendations documents: Resident receiving HCC diet (diet rich in polyunsaturated fatty acids .) due to diagnosis of diabetes. Tolerating well and denies and c/s difficulties, GI upset. He reports good appetite, denying any recent changes. Encourage fluids throughout day - may be at risk for dehydration due to sepsis, dementia diagnosis. No food preferences to obtain at this time. Current body weight 220.4 pounds, resident report usual body weight 210 pounds. Noted weight history from last admission 2017-2018 was in 250s. Goal is weight maintenance at current body weight AEB no significant changes. Goal: resident to consume at least 75% of meals with no difficulties. Plan/Recommendations: diet per MD order, monitor food and fluid intake, weights per facility protocol. Surveyor notes this Nutritional Assessment is using 220.4 lbs. as an admission weight which is not the admission weight of 198 lbs. which is used in the MDS and the Weights and Vital Summary in the medical record. There is a noted discrepancy of what the accurate admission weight is for R17 and no recommendation for a reweigh. Surveyor reviewed a Quarterly Nutritional Assessment with a date of 11/14/22 which documents most recent weight as 171 pounds. Significant weight changes is marked yes. Nutritional Assessment/Recommendations documents: current weight is 171 pounds, triggering significant weight loss of 13.6% x 90 days from 8/16/22 weight of 198 pounds. Question accuracy of 8/16 weight, but weight in past has been much higher. Resident previously reported usual body weight was 210 pounds. Intake is 75-100%, take Mighty Shakes BID and 30ml ProSource TID for weight and wound healing. No new recommendations at this time. Continue to monitor weights. Care plan reviewed. Goals: Resident to consume at least 75% of meals with no difficulties, no significant weight changes through next assessment. Plan/Recommendations: Continue plan of care, monitor weights, supplement changes PRN. Surveyor notes there are no additional Nutritional Assessments in the medical record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documented in R17's Progress Note for Nutrition on 9/15/22 at 13:17 was, Follow-up on weights/skin. Weight 178# (pounds) (8/30) and 198# (8/16). Question accuracy of weights; will request reweigh/current monthly weight to further eval. BMI 24.1-WNL (within normal limits). Per weekly wound assessment, unstageable sacrum. Diet downgraded per ST (Speech) to mech soft with NTL (nectar thick liquids). Good appetite, PO (by mouth) intakes 76-100%. Assisted at meals. Accepts fluids. ProSource 30ml BID (twice daily) in place to aid in skin healing (200kcal, 20g pro). BS (blood sugars) 100s; controlled. Meds reviewed. Increased nutrition needs due to wound healing. Rec 1. Increase ProSource to 30ml TID 2. Add Mighty shake 4oz BID 3. MVI QD 4. Reweigh. Continue to monitor. Surveyor cannot locate a physician order for Mighty Shake 4 oz two times per day after this recommendation was documented. A physician order for Mighty Shakes two times per day was started on 10/25/22. This is over 30 days from when it was originally recommended. Surveyor cannot locate a physician order for increase ProSource to 30ml three times per day. A physician order for ProSource 30 ml three times per day was started on 10/25/22. This is over 30 days from when it was originally recommended. Documented in R17's Progress Note for Nutrition on 10/21/22 at 9:56 AM was, Follow-up on weights/skin. Wt 179# (10/18), 178# (9/20), 198# (8/16). Anticipate error in admit weight but noted resident weight much higher in the past. Weight stabilizing in 170s now x 2 months. Continue to monitor weights. BMI 24.3-WNL. Mech soft diet with NTL. Tolerating diet. PO intakes 50-100%. Feeds self after set-up. Accepts fluids. BS 90-100s. Per weekly wound assessment 10/18, Unstageable - sacrum and trauma - right great toe. ProSource 30ml BID (200kcal, 20g pro) in place to aid in skin healing. Inc needs due to skin healing and weight loss. Will rec again to help meet nutrition needs 1. Increase ProSource to 30ml TID (300kcal, 30g pro) 2. Add Mighty shake 4oz BID 3. Add MVI QD 4. Encourage intake. Monitor. Surveyor notes the request again by the Dietician to increase ProSource 30ml to three times per day and add Mighty Shake 4oz two times per day. Both these recommendations were added to physician orders on 10/25/22. On 3/01/23, at 10:50 AM, Surveyor interviewed Dietician-W regarding R17's admission weight discrepancy. Dietician-W stated that admission weight of 198 came from hospital documentation. Dietician-W stated that he was aware of the 20 pound weight loss in the first month, however he didn't think that there really was an actual 20 pound weight loss and questioned the admission weight. Dietician-W stated he did not remember requesting a reweigh of the resident, but that would have been practice. Dietician-W stated since he questioned the weight loss, he and did not recommend any interventions at that time. He further explained that he added Mighty Shakes and ProSource in October and then increase them in November. Surveyor asked why there was a delay in getting the Mighty Shakes started in September when he originally recommended them, and Dietician-W stated it must have been missed. Dietician-W informed Surveyor that R17 was eating well and was not refusing meals. He further stated that R17's BMI was within normal range and therefore did not see a reason to recommend more frequent weights either. On 3/01/23, at 3:11 PM, at the end of day meeting with Nursing Home Administrator-A (NHA) and Director of Nursing-B (DON), Surveyor requested the facility policy and procedures on nutrition and weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/02/23, at 8:39 AM, Surveyor interviewed DON-B with NHA-A present in the room, about expectations if a resident has a significant weight loss. DON-B informed Surveyor that if a significant weight loss is found they would document it, call family and medical doctor (MD), notify the dietician, see what recommendations the dietician or MD have and get a reweigh. Surveyor asked DON-B if she was aware of a significant weight loss for R17 within his first month of admission. DON-B stated she was not sure and would have to look into it. Surveyor asked DON-B to clarify what the statement Weigh Resident per facility protocol/MD order and monitor weights in a care plan. DON-B stated that if the doctor orders weekly weights versus us just getting a resident monthly weight. Surveyor asked DON-B to explain the process after a weight loss is documented. DON-B explained that the dietician sends over recommendations in an email after nutritional assessments are completed. If any recommendations are requested, then herself or a unit manager would put the order in. DON-B did not remember adding any interventions in after the weight loss for R17 in August or September. Surveyor explained concerns that the nutrition assessments on 8/12/22 and 11/14/22 both reference that the dietician did not believe the admission weight and therefore did not believe a significant weight loss within the first month. DON-B stated that if the dietician didn't believe the admission weight, then he should have done a reweigh. Surveyor also explained the concern that a significant weight loss was documented on 8/30/22 for R17 and a recommendation was requested on 9/15/22 to add Mighty Shakes two times per day however this order was not started until 10/26/22. DON-B stated that she would look more into this. On 3/2/23, at 1:52 PM, Surveyor asked DON-B if they had found any documentation of a Mighty Shake being started in September, and she stated no. No additional information was provided at this time. 22692 2.) R262 was admitted to the facility on [DATE] with diagnosis that included Clostridium difficile (C-Diff), Urinary tract infection (UTI). R262 was also admitted to the facility with an order for nectar thickened liquids. On 2/28/23 R262's Initial Minimum Data Set (MDS) dated [DATE] was reviewed and indicated R262 had a Brief interview for Mental Status score of 13 (no memory impairment). On 3/1/23 R262's physicians orders were reviewed and included: Provide a large cup of water several times a day with a start date of 1/15/23 and continued to discharge on 1/22/23. Another order read: Push fluids. Resident very dehydrated. She does not like water with a start date of 1/20/23 and continued to discharge on 1/22/23. R262 required Intravenous hydration starting 1/20/23 and continued until she was discharged to the hospital on 1/22/23. On 3/1/23 at 10:50 AM Dietician-W was interviewed and indicated he did not calculate R262's estimated daily fluid needs, protein needs or calorie needs on her initial nutritional assessment. Dietician-W indicated this was not done until 1/19/23 when the regional dietician completed this, Dietician-W indicated he would have considered R262 at high risk of dehydration due to her C-Diff diagnosis, need for thickened liquids and history of dehydration. Dietician-W indicated he never asked R262 of her fluid preferences and did not know she disliked water. (continued on next page)

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	03/21/2023

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/1/23 R262's fluid intake records were reviewed and indicated she was drinking at least 1,000 milliliters (ml) a day until 1/16/23 when she only consumed 640 (ml). She was reassessed on 1/19/23 and her estimated fluid needs calculated at 1,335 ml a day. Over the next 3 days she was carefully monitored and assessed to be dehydrated and IV hydration was started on 1/20/23 until her discharge to the hospital on 1/22/23. On 3/1/23 the facility's policy titled Hydration dated 10/22 which read: The dietician will assess hydration as part of the comprehensive nutritional assessment within 72 hours of admission, annually, and upon significant change in condition. The dietary manager or designee shall obtain the resident's beverage preferences upon admission. The above findings were shared with Administrator-A and Director of Nurses-B at the daily exit meeting on 3/1/23 at 2:30 PM. Additional information was requested if available. None was provided.