STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the Facility did not ensure 4 (R3, R6, R16, and R18) of 18 Residents reviewed for notification, that the Physician and Resident's representatives were notified of changes. * R3 sustained a fall on 3/12/22, time unknown, resulting in injury. Per incident report, R3's physician was notified of the fall on 3/13/22 and R3's activated Health Care Power of Attorney(HCPOA) was notified on 3/14/22. On 3/14/22, R3 went to the emergency room for a CT scan of the head, and R3's activated HCPOA was not notified of the transfer. * On 3/21/22 R6 had 10 minutes of unresponsiveness. R6's electronic medical record (EMR) does not contain documentation that R6's physician and family were notified. * On 3/20/22, R16's EMR (Electronic Medical Record) indicates R16 had a 7.9% unplanned weight loss in 30 days. R16's EMR does not contain documentation that R16's physician and legal guardian were notified. * R16's EMR did not contain documentation that R16's physician and guardian were always notified of a fall resulting in injury. * R18 placed a call to 911 on 3/30/22 and was transported to the hospital. R18's Activated Power of Attorney for Healthcare (HCPOA) was not updated of this hospital transfer. Findings Include: Surveyor reviewed the facility's Change in a Resident's Condition or Status policy and procedure revised May 2017 and noted the following applicable: Policy Statement Our facility shall promptly notify the Resident, his/her Attending Physician, and representative(sponsor) of changes in the Resident's medical/mental condition and/or status. Policy Interpretation and Implementation (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The nurse will notify the Resident's Attending Physician or physician on call when there has been a (an): a. Accident or incident involving the Resident b. Discovery of injuries of an unknown source c. Adverse reaction to medication d. Significant change in Resident's physical/emotional/mental condition e. Need to alter the Resident's medical treatment significantly f. Refusal of treatment or medications 2 or more times g. Need to transfer the Resident to a hospital h. Discharge without proper medical authority i. Specific instruction to notify the Physician of changes in the Resident's condition 2. A significant change of condition is a major decline or improvement in the Resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions b. Impacts more than one area of the Resident's health status c. Requires interdisciplinary review/revision to the care plan 3. Prior to notifying the Attending Physician, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact SBAR (Situation, Background, Assessment, Recommendation) Communication Form. 4. Unless otherwise instructed by the Resident, a nurse will notify the Resident's representative when: a. The Resident is involved in any accident or incident that results in injury including injuries of an unknown source b. There is a significant change in the Resident's physical, mental, or psychosocial status c. There is a need to change the Resident's room assignment d. A decision has been made to discharge the Resident from the facility e. It is necessary to transfer the Resident to a hospital (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the Resident's medical/mental condition or status. 8. The nurse will record in the Resident's medical record information relative to changes in the Resident's medical/mental condition or status. Surveyor reviewed the facility's Acute Condition Changes-Clinical Protocol policy and procedure revised March 2018 and noted the following applicable: Assessment and Recognition 8. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). Treatment/Management 1. The physician will help identify and authorize appropriate treatments Monitoring and Follow-up 3. At the next visit, the physician will review the status of the condition change and document his/her evaluation, including the anticipated impact on the individual's function, prognosis, and quality of life. 1. R3 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Encephalopathy, Bipolar, Cognitive Communication Deficit, Unspecified Dementia, Major Depressive Disorder, and Transient Cerebral Ischemic Attack. R3 has an activated Health Care Power of Attorney (HCPOA). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview for Mental Status (BIMS) score to be 5, indicating R3 demonstrates severely impaired skills for daily decision making. R3's Patient Health Questionnaire (PHQ-9) score is 8, indicating R3 has mild depression. R3 requires extensive assistance with bed mobility, locomotion on/off the unit, and transfers. R3 is not steady with balance during transitions and walking. Per incident report, R3's physician was notified of the fall on 3/13/22 and R3's activated Health Care Power of Attorney (HCPOA) was notified on 3/14/22. On 3/14/22, R3 went to the emergency room for a CT scan of the head due to chin being severely bruised and edematous to rule out any fractures. Surveyor reviewed R3's EMR and notes there is no documentation that R3's activated HCPOA was notified of R3 being transferred to the ER. On 3/30/22 at 10:45 AM, Surveyor spoke to Director of Nursing (DON-B) in regards to R3. DON-B stated that R3's activated HCPOA was probably not notified of the transfer for the CT scan and that is something the activated HCPOA should have been notified for. 2. R6 was admitted to the facility on [DATE] with diagnoses of Tracheostomy status, Autonomic Neuropathy, and Essential Hypertension. R6 is her own person. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor notes there is no MDS (Minimum Data Set) completed for R6. Surveyor reviewed R6's EMR (Electronic Medical Record) and notes that on 3/21/22, R6 was found in room unresponsive and foaming at the mouth. Ambulance was called but R6 did not go to the hospital due to R6 becoming responsive after 10 minutes of bagging. R6 was placed on vent AC mode and tolerating well. Surveyor notes there is no documentation that R6's physician and contact designee were updated. On 3/30/22 at 11:03 AM, Surveyor spoke to DON-B who stated that R6's unresponsiveness would be something that R6's contact designee should have been notified of. DON-B stated that is the expectation per policy. 3. R16 was admitted on [DATE] with diagnoses of Huntington's Disease, Unspecified Dementia, Schizophrenia, Bipolar, Psychotic Disorder with Delusions, Unspecified Intellectual Disabilities, and Dysphagia. R16 has a legal guardian. R16's Admission MDS (Minimum Data Set) dated 2/25/22 documents R16's short and long term memory is impaired and R16 demonstrates severely impaired skills for daily decision making. R16's PHQ-9 score done by staff is a 8, indicating mild depression. There are no behaviors documented on R16's MDS. R16 is extensive assistance for bed mobility. R16 requires total dependence of 2 staff for transfers. R16 is total dependence for dressing, toileting, and bathing. R16 has both upper and lower bilateral range of motion impairment. R16 is always incontinent and requires tube feeding. Surveyor reviewed R16's EMR (Electronic Medical Record) and noted that on 3/20/22 it is documented that R16 had a 7.9% unplanned weight loss in 30 days. R16's EMR does not contain documentation that R16's physician and legal guardian were notified of the weight loss. Surveyor further reviewed R16's EMR and noted there is no documentation of R16's physician and/or legal guardian being updated on the following falls: Per facility policy and procedure, all accidents or incidents regardless of injury that require a Resident's comprehensive care plan to be revised require both a physician and representive notification. 1. 3/21/22-R16 had a fall resulting in R16's G-tube coming out and was transferred to the emergency room (ER). Surveyor notes no notification of both physician and guardian is documented. 2. 3/27/22-R16 had 3 falls, 1 resulting in an injury which required a transfer to the ER in which R16 received stitches. Surveyor notes no notification of both physician and guardian is documented. On 3/31/22 at 3:05 PM, Surveyor shared the concern with Administrator (NHA-A) that required notification of R3, R6, and R16's physician and/or representative had not been done for each of their significant changes per facility policy and procedure. No further information was provided at this time. On 4/5/22 at 12:04 PM, Surveyor received a call from R16's DR-H. DR-H stated that DR-H was not notified of R16's significant weight loss. DR-H also confirmed that DR-H does not believe DR-H was notified of all of R16's falls. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16584 4. R18 was originally admitted to the facility on [DATE] with diagnosis that included end- stage renal disease, chronic pain syndrome, Type 2 diabetes, alcoholic cirrhosis of liver and end stage renal disease. Surveyor conducted a review of R18's medical record and noted that on 2/15/22, R18's Power of Attorney for Healthcare was activated while being treated at the hospital. On 3/31/22 at 8:40 a.m., Surveyor went to made observations of R18. It was noted that R18 was not in her room, the evening meal tray, with food still present, was on the overbed table as well as 2 pills in a medicine cup. On 3/31/22 at 8:44 a.m., Surveyor interviewed Licensed Practical Nurse (LPN)- F in regard to R18's whereabouts. LPN- F stated that she wasn't exactly sure where R18 was but got a written report that R18 had called 911 emergency services herself the night before on 3/30/22 at approximately 8:20 p.m. Surveyor asked LPN- F if she knew why R18 went to the hospital and LPN- F reviewed the electronic medical record and verified there was no nursing notes regarding the incident. LPN- F stated she was not provided any details, just that R18 had sent herself out. On 3/31/22 at 9:26 a.m., Surveyor interviewed Administrator- A in regard to R18 sending herself out to the hospital by calling 911 Administrator- A stated that she was not aware of this incident and would look into it. Surveyor told Administrator- A that the nurse on the unit did not know any details of the incident and that there was nothing written for communication within the nursing notes. Administrator- A verified that an agency nurse was working on 3/30/22 when R18 called 911 and she would need to contact the nurse for details. On 3/31/22 at 10:40 a.m., Administrator- A stated that she had heard R18 sent herself out to the emergency room after a family visit had concluded. Administrator- A stated she is still unaware what hospital R18 went to or any other details. Surveyor contacted R18's Healthcare Power of Attorney on 3/31/22 at 1:48 p.m. R18's AHCPOA stated that she was made aware that R18 wanted to go to the hospital because she was in an extreme amount of pain and could not get any assistance. R18 had reported to a family member she was just going to call 911 herself. AHCPOA (Activated Health Care Power of Attorney) for R18 stated that they had no idea what hospital R18 had went to and they had to call around to all of the local hospitals to find where R18 had been admitted to. AHCPOA for R18 stated that the facility never called her on 3/30/22 when R18 was being transported to the hospital after calling 911. Further review of the medical record did not show evidence that the facility notified R18's primary physician that R18 was being transported to the emergency room for further evaluation and treatment.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on observations, interviews and record review, the facility failed to ensure that 70 out of 70 residents were free from neglect. The facility was aware of the needs of each of the 70 residents living in the facility. The facility did not provide sufficient staffing to provide cares to all residents. Due to inadequate staffing levels, residents did not receive personal cares such as showers/ baths, adequate supervision to prevent falls, and care and treatment of pressure ulcers. Medication were not administered timely, some of which are significant to residents' health. One resident admitted herself into a hospital as was in an extreme amount of pain and was not getting assistance. Dietitian and Physician recommendations for residents' weight loss were not followed through on. As a result, there were residents who experienced falls, some of them with injury, worsening pressure injuries, development of new pressure injuries, medication errors, resident weight loss, and residents expressing feelings of being neglected because there is not enough staff to take care of their needs. The facility failure to ensure residents were free from neglect, created a finding of immediate jeopardy that began on 2/28/22. Administrator- A and VP of Operations- L were notified of the immediate jeopardy on 4/4/22 at 4:45 p.m. As of the exit of the partial extended survey on 4/14/22, the Immediate Jeopardy was not removed. This is evidenced by: Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. 1. Insufficient Staffing Levels to meet the needs of the residents: According to the Facility Assessment Tool, last updated on 1/24/2022, the facility is licensed to provide care for 87 residents. The average daily census is 71 residents. The Facility's Assessment Tool indicates: 3.2) Staffing plan: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[NAME] of [NAME] provides adequate staffing to meet its residents' daily needs, preferences, and routines in order to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well -being. This includes services of a registered nurse for at least eight (8) consecutive hours a day, 7 days a week, a designated licensed nurse to serve as a charge nurse on each tour of duty and adequate staffing on each shift to ensure that our residents' needs are met by registered and licensed nursing staff, certified/ state tested nursing assistants, and other support services that include, but are not limited to, dietary, activities/ recreational, social, therapy and environmental services. Respiratory Therapists will be on staff for the ventilator unit 24 hours a day. During extreme events such as a pandemic if the facility is not able to maintain the minimum number of qualified staff to meet the needs of the residents, all staff will assist with ensuring basic cares are met as the facility is in crisis staffing modes. The non- qualified staff will assist with answering call [NAME], serving meals, making beds, duties which you do not need to be certified to perform. [NAME] of [NAME] consistently reviews adequate staffing based on census, acuity, and diagnoses of our resident population to ensure staffing is sufficient with the appropriate skills and competencies to carry out the needs, care and services of our residents at any given time. The survey team entered the facility on 3/28/22 at 8:00 a.m. Staff interview was conducted, and it was confirmed that there was only 1 Registered Nurse and 5 Certified Nursing Assistants to care for 70 residents. Facility staff stated that the morning medication pass on 3/28/22 would not be completed and the only Registered Nurse had to stay on the Vent unit, leaving the other 4 units without a licensed nurse. The facility is composed of five units (East, West, North, Rehab and the Vent unit). A review of the facility staff schedules for the month of March 2022 showed that the facility was often understaffed causing staff to work on more than one unit and at times working without the assistance of another staff member on their assigned unit. On 3/29/22, at 5:00 AM, Surveyor interviewed LPN-P (Licensed Practical Nurse) who stated she was working overnight on 3 units (North, East, Vent) with 3 CNAs one each on the Vent, Rehab, and [NAME] units. LPN-P stated all the care was not provided as they were supposed to split the units, rounds were not done as it is too hard to do it when staffing is horrible. LPN-P stated no rounds done since residents went to bed last night and she planned to look for one of the CNAs to she can help him start. LPN-P stated there are no care plans so the CNAs do not know what care to provide and how to transfer residents. LPN-P stated no charting by CNAs in the electronic medical record so the nurses are unable to check if care was provided or not. LPN-P stated the example of no charting on eating so she is unable to tell families about the residents. LPN-P stated no showers are given by CNAs as there is no staff. Surveyor noted R2's call light was on at 5:00 AM when Surveyor began interviewing LPN-P. When Surveyor called attention to the long period of time that R2's call light was on, LPN-P stated See, I don't even know where to start because there is so much to do. R2's call light remained unanswered as LPN-P distributed paper bags of pharmacy medications to each nursing cart. LPN-P stated she needed to go to the rehab unit and login the agency nurse into the electronic medical record under LPN-P's name. LPN-P stated the agency nurse does not have a login to chart so it has to be done under her name. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/29/22, at 5:15 AM, Surveyor interviewed CNA-U working on R2, R4, and R14's unit who stated she has worked here since 2/22 and regrets it as there is terrible care provided in this facility. CNA-U stated she could go on and on about the residents' needs. CNA-U stated one resident needed to be changed when she came in at 10 PM but she had to wait as until 12:30 AM for help to turn and reposition. CNA-U stated the facility does not provide the proper linen to clean and change people. CNA-U stated she is unable to get any assistance to turn residents so no repositioning for some residents and rounds are hard to do, to change residents without help. CNA-U stated she tries her best but there is no staff and sometimes night staff leave and come back at 5:30 AM or just sleep during the night On 3/30/22, at 7:00 AM, Surveyor interviewed LPN-P who stated she was the only nurse in the facility when the PM nurse who stayed to help night shift left around 4:00-5:00 AM. LPN-P stated there were only 2 CNAs overnight in the facility so not all care was possible because repositioning requires 2 people. LPN-P stated there was a fall but she did not have time to document, computer not working, and she was returning to the facility at 3:00 PM. LPN-P stated the PM nurse completed the blood sugars prior to leaving in the early AM. LPN-P indicated concerns about minimum standards for staffing. Interviews with staff provided additional evidence that many staff were feeling frustrated with long hours and were very aware that not all of the care was being provided to residents. Administration was aware of these staffing concerns and continued to admit residents. 47 residents had been admitted to the facility from 2/1/22-3/31/22. With each new admission, comprehensive assessments needed to be completed to assure that all of their care needs were being met. Often times, due to lack of staff, comprehensive assessments were not conducted and care plans were not developed. With each new resident that was being admitted , it would take time for staff to become familiar with resident likes and dislikes and to become familiar with how dependent they were on staff for activities of daily living such as grooming and eating. Often times, the facility used agency staff who were not familiar with the electronic medical record system (access to care plans and nursing notes) and were not familiar with the residents on their assignment because they had not worked at the facility on a consistent basis. (Cross Reference F725) 2. Lack of prevention and treatment of Pressure Injuries Four residents were reviewed by the survey team (R4, R5, R10, R18) and concerns were that the facility did not ensure they provided comprehensive assessments and care to these residents to prevent pressure injuries from developing and to ensure pressure injuries did not worsen and/or become infected by failure to provide adequate cares and treatments. *Facility has not accessed [NAME] notes since February. This is the weekly skin documentation provided by MD- N (Wound Physican). These notes would indicate the need for new treatments and further interventions that may be needed to assist in the healing of the pressure injuries or prevent the pressure injuries from getting worse. *Facility nurses are not staging or measuring, just describing so the facility is totally reliant on MD-N for staging and measurements. When MD-N is not available, wound care assessments can be delayed with potential for adverse outcomes. Some residents went days without being comprehensively assessed by the wound team. The facility would not have a way to know if the pressure injuries had worsened since they were first observed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	*Facility was not following current treatment orders. *Facility did not address repositioning in the resident's care plan or the CNA care card. Agency CNAs stated they did not know they needed to reposition certain residents. Additionally, the facility did not always have the staff needed to reposition the resident assuming they knew she needed repositioning. Observations were made of residents not getting repositioned, often laying on boney prominences and affected areas where a pressure injury had already developed. *R4: The facility did not have the physician's notes for March 2022 and, thus, did not know the status of the resident's wound or the current treatment orders. The facility did not follow current treatment orders. The facility did not address repositioning in the resident's care plan or the CNA care card. Agency CNAs stated they did not know they needed to reposition R4. Additionally, the facility did not always have the staff needed to reposition the resident assuming they knew she needed repositioning. This resident on 2/14/22 developed three unstageable pressure injuries. These combined into one unstageable wound that is now 56 times larger in area than when first identified (2.02 square cm. vs. 160 square cm.). The resident has not been out of bed and, during observations, remained flat on her back in bed. *R10 acquired an unstageable pressure injury while residing at the facility and was hospitalized , requiring intravenous antibiotic treatment for the infected pressure injury. The facility did not address R10's pressure injury interventions in their plan of care or consistently document treatments or weekly assessments of R10's pressure injury. *R5 acquired a stage 4 pressure injury while residing at the facility and was hospitalized , requiring antibiotic treatment for the infected pressure injury. The facility did not address R5's pressure injury interventions in their plan of care or consistently document treatments or weekly assessments of R5's pressure injury. * R18's pressure ulcer to the coccyx was not compressively assessed upon her original admission on 3/1/22 and then upon readmission on 3/22/22 and 3/23/22. R18 did not have a plan of care addressing the pressure ulcer with interventions put into place to aid in the healing of the pressure ulcer. The facility was unable to determine if the treatment they were applying daily to R18's coccyx was effective because they had no means to know if the area was healing or not. The facility neglected these 4 residents by not providing the necessary care and treatment of their pressure injuries which resulted in these residents experiencing pain, being hospitalized for wound infections and being at risk for further development of pressure injuries by not providing the necessary interventions for prevention and healing. (Cross reference F686) 3. Lack of Supervision to prevent falls: R16 has had 12 falls since admission on 2/18/22. On 3/26/22, R16 received staples to the back of the head. On 3/27/22, R16 received stitches above the right eyebrow. The facility did not complete an initial fall risk assessment on admission, 2/18/22. Given that R16 fell in the hospital prior to admission to the facility and R16's diagnosis of Huntington's Disease would put R16 at risk for falls. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R16's electronic medical record (EMR) does not contain documentation that an incident report and fall assessment including root cause analysis was completed for R16's falls. Per documentation, it is unclear what fall interventions were in place at the time of each fall. R16's fall care plan was not initiated until 2/26/22 when R16 had R16's first fall. R16's care plan was only updated on 5 of the 12 falls that R16 had. The facility was unable to provide documentation that neuro checks and vitals, as well as physician notifications were completed with R16's falls. After review of nursing schedules with each of R16's falls, it is noted that based on census and 15 total Residents residing on the same unit as R16, there was inadequate amount of staff to provide supervision to R16 in order to prevent R16 from frequent falling. For example, there were no certified nursing assistants assigned to R16's unit on 2/28/22, 3/26/22, and 3/27/22. On multiple other shifts, there were 2 or 3 CNAs to work five units. R16 is a high risk for falls and based on inadequate staffing, the facility did not provide adequate supervision and services to prevent R16 from frequent falling. The facility neglected to provide adequate supervision to R16 by completing an initial fall risk assessment and developing a fall risk care plan with revisions for each fall, not completing a root cause analysis of each fall, not completing a thorough assessment including neuro checks after each fall, not updating the physician with all falls, and not providing care and treatment based on a comprehensive assessment. (Cross Reference F-689) On 3/31/22 at 9:05 AM, Surveyor interviewed R17 in regard to R17's fall from bed during the night shift of 3/29/22. Surveyor noted there were only 2 CNAs and 2 nurses in the facility at the time of the fall per facility written schedule. R17 stated R17 had been reaching for R17's phone to call 911 in order to get assistance because R17's call light had been on for a long time. In the process of reaching for the phone, R17 slid out of bed and onto the floor. R17 believes R17 laid on the floor approximately 1 hour before a nurse came. R17 also stated that a CNA watched R17 slide out of bed and walked out of R17's room and did nothing to help stop R17 from sliding, provide any assistance, or go get help. R17 stated R17 has been at the facility 2 other times for rehabilitation and this is the worst experience yet. R17 stated R17 feels more sad and hopeless about everything. R17 is angry at the situation. R17 stated R17 is having more anxiety since the 3rd admission and is scared of not getting the help that R17 needs. R17 feels like R17 cannot talk to anyone about it. R17 stated that R17 is a RN and would and never treat anyone as R17 has been treated while at the facility. R 17 stated I am so fearful I will never get the help when I am laying in bed. During the interview, R17 was crying. 4. Significant medication errors: The Survey team requested the daily schedule for 3/28/22 and was provided with a schedule for the AM Shift that showed the facility had only 1 Registered Nurse working on the Vent unit and no other licensed nursing staff for the other 59 residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/28/22 at 11:40 a.m. Surveyor interviewed Scheduler- M in regard to the staffing for the AM shift for 3/28/22. Scheduler- M stated that there is currently no nurse passing medications to the residents and that the 1 registered nurse on duty is DON- B and she is assigned to work on the Vent Unit which requires its own nurse for each shift. Scheduler- M stated that she is working on getting more staff in and has called all the agencies they have contracts with for staff. Scheduler- M stated she has called every other staff and they either have other jobs or are in school. Scheduler- M stated that there was a Medication Technician that had called in sick, leaving just 1 registered nurse on the shift. Scheduler- M stated that Administrator- A is aware. On 3/28/22, 12 residents (R2, R3, R4, R7, R8, R10, R11, R13, R14, R16, R17 and R18) did not receive their morning and noon medications when the facility only had 1 nurse in the building and could not complete the medication pass. Of the 12 residents, 6 (R2, R4, R10, R11, R13 and R14) residents experienced a significant medication error by not being administered their insulin, tube feeding or IV antibiotic. The facility neglected to provide medications to residents who had physician orders in place to be administered these medications to avoid potential physical harm. (Cross Reference F-755 and F-760) 5. Pain Management R18 was originally admitted to the facility on [DATE] with diagnoses that included end- stage renal disease, chronic pain syndrome, Type 2 diabetes, alcoholic cirrhosis of liver and end stage renal disease. Surveyor conducted a review of R18's medical record and noted that on 2/15/22, R18's Power of Attorney for Healthcare was activated while being treated at the hospital. On 3/31/22 at 8:40 a.m., Surveyor went to made observations of R18. It was noted that R18 was not in her room, the evening meal tray, with food still present, was on the overbed table as well as 2 pills in a medicine cup. On 3/31/22 at 8:44 a.m., Surveyor interviewed Licensed Practical Nurse (LPN)- F in regard to R18's whereabouts. LPN- F stated that she wasn't exactly sure where R18 was but got a written report that R18 had called 911 emergency services herself the night before on 3/30/22 at approximately 8:20 p.m. Surveyor asked LPN- F if she knew why R18 went to the hospital and LPN- F reviewed the electronic medical record and verified there was no nursing notes regarding the incident. LPN- F stated she was not provided any details, just that R18 had sent herself out. On 3/31/22 at 9:26 a.m., Surveyor interviewed Administrator- A in regard to R18 sending herself out to the hospital by calling 911 Administrator- A stated that she was not aware of this incident and would look into it. Surveyor told Administrator- A that the nurse on the unit did not know any details of the incident and that there was nothing written for communication within the nursing notes. Administrator- A verified that an agency nurse was working on 3/30/22 when R18 called 911 and she would need to contact the nurse for details. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/31/22 at 10:40 a.m., Administrator- A stated that she had heard R18 sent herself out to the emergency room after a family visit had concluded. Administrator- A stated she is still unaware what hospital R18 went to or any other details. Surveyor contacted R18's Healthcare Power of Attorney on 3/31/22 at 1:48 p.m. R18's AHCPOA stated that she was made aware that R18 wanted to go to the hospital because she was in an extreme amount of pain and could not get any assistance. R18 had reported to a family member she was just going to call 911 herself. AHCPOA (Activated Health Care Power of Attorney) for R18 stated that they had no idea what hospital R18 had went to and they had to call around to all of the local hospitals to find where R18 had been admitted to. (Cross Reference F580) 6. Activities of Daily Living: The facility did not ensure that 10 (R10, R5, R11, R8, R3, R7, R2, R4, R13, R14) of 10 Residents reviewed who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good hygiene. The facility did not have accurate documentation/information to show R10, R5, R11, R8, R3, R7, R2, R4, R13, R14 received showers consistent with the resident's care plans, in addition skin checks were not always completed as per facility policy for R3, R7, R2, R4, R13, R14. R10 is not receiving weekly showers in accordance with R10's plan of care. R10 appeared very disheveled with dry, flaky skin and excessive facial hair when observed on 3/28/22 at 9:20 AM, 12:20 PM, and 2:45 PM and on 3/29/22 at 7:45 AM R11 was observed in bed on 3/28/22 at 12:39 PM with a sheet draped across his lower body and no clothing to the top half of his body. R11's hair was very disheveled and appeared to be greasy as if not washed in some time. R11 is to have a shower at least weekly however no indication of a set day for the shower. There was no indication that R11 had been refusing a shower or bath. The facility was unable to provide any evidence that R11 had been provided a shower for the months of February and March 2022. R8 has physician orders shows to have a weekly skin check completed every Monday evening when her shower takes place. On 1/31/22, R8 filed a grievance with the facility for not receiving a shower on 1/31/22. R8 was scheduled to have a shower during the day on Friday but it was said the staff person left early and no shower was given. The resolution to the grievance was that R8 was given a shower later that evening by a different staff member. On 3/30/31, Surveyor requested to review any documentation that would provide evidence that R8 was receiving a shower, at least weekly, or a bath. The facility was unable to provide any evidence that R8 had been provided a shower for the months of February and March 2022. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R7 stated on 3/29/22 at 10:06 AM R7 has received 2 showers in 6 weeks. R7 was informed R7's shower day was on Fridays on day shift. R7 informed Surveyor that R7 would prefer a shower 2 times a week. R7 stated that of the 2 showers that R7 received, R7 got R7's hair washed 1 time because R7 asked to get it washed. R7 informed Surveyor that R7's family has come in to give R7 showers. Surveyor also shared that R7 has only received 2 showers since admission. R2 stated on 3/28/22 at 10:06 AM going through hell and supposed to get a shower but since August (2021) have only had a few showers. R2 had only one documented shower on 3/7/22 in the last 30 days. The facility has no completed skin check sheets which are to be done with shower per facility policy for R2. R4 was observed on 3/29/22 at 8:10 AM lying in the bed on her back with lips cracked and no moisture noted on dry mucous membranes and long beard hairs on chin. R4 stated liking to have her chin shaved and telling the nurses if they see anything on the face to take it off. Surveyor noted R4 had only one documented shower on 3/9/22 in the last 30 days. R13 had documented showers on 3/4/22, 3/9/22, 3/10/22 in the last 30 days. Documentation indicated R13 had not had a shower in 20 days. R14 was admitted to the facility on [DATE]. R14 had no documented showers since admission for 12 days. (Cross Reference F677) On 3/22/22, SW-C was informed of an allegation of neglect by R7 being denied assistance of being put on the bedpan and had to wait 2 hours for assistance. R7 is her own person. R7's Admission MDS dated [DATE] documents R7's BIMS score to be 15, indicating R7 is cognitively intact for daily decision making. R7's PHQ-9 score is 1, indicating minimal depression. R7 requires extensive assistance with bed mobility and dressing. R7 requires total assistance for transfers and bathing. On 3/29/22 at 10:06 AM, Surveyor interviewed R7. R7 stated that on 3/17/22, R7 requested the bed pan. The nurse placed the bedpan next to R7's bed on the bedside table and walked out of the room. R7 turned the call light on again and waited 2 hours for assistance. R7 stated R7 had to call family in to assist R7. R7 stated during that time, R7 was cramping, in pain, and crying. R7 stated R7 informed SW-C of the incident. On 3/31/22 at 8:45 AM, Surveyor interviewed R7 in regard to the care that R7 has not been receiving while at the facility. R7 explained that R7 had to call family in several times to come to the facility so R7 could get assistance with cares. R7 explained that R7's call light would be on for a long time and no one would come to assist R7. R7 stated not getting cares is making R7 more sad while at the facility. R7 stated R7 cries when R7 cannot get the help, which is a lot. R7 explained it hurts because R7 has to rely on others for assistance because R7 struggles with the loss of being independent. (Cross Reference F609 & F610) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7. Weight Loss R16 and R9 experienced significant weight loss due to staff neglect. Staff did not alert the physician, did not obtain ordered speech therapy evaluation, and did not follow dietary recommendations based on a comprehensive assessment from the Registered Dietician. This resulted in a finding of immediate jeopardy and substandard quality of care. The dietitian stated R16's weight loss was life-threatening. (Cross Reference F692) The failure to assure that all 70 residents were free from neglect created a finding of Immediate Jeopardy (IJ). As of 4/14/22, the facility continued to have ongoing staffing issues with obtaining and retaining CNAs and licensed nursing staff. The facility owes staffing agencies money which limits their ability to get staff. The facility was not able to retain an MDS nurse. On 4/11/22 from 9:00 PM to 10:00 PM there was only 2 CNAs and 2 nurses for the building. According to Administrator A, on 4/11/22 Scheduler I came in and informed Administrator A, VPO-L and RN-BB expressed concerns with the staffing. Administrator A stated they were piece-[NAME] the evening shift and they couldn't get anyone else. VPO-L and Corporate RN BB were in the building and aware of the staffing shortage. On 4/14/22, Scheduler I provided a written statement to surveryos indicating she shared the 4/11/22 pm staffing concern to both Administrator A and VPO L on 4/11/22. Administrator A stated VPO L and Corporate RN BB are both RNs. Administrator A stated neither VPO L or RN BB went to assist with Resident care. Administrator A stated VPO L and Corporate RN BB left the building at 9:00 PM. According to the facility's removal plan, Corporate RN BB is part of the facility's plan to assist with the stability, training and to ensure clinical systems are reinstituted, monitored and maintained until the facility shows compliance as determined by the Regional Nurse Consultant and Corporate team. Corporate RN BB is also part of the Monitoring, Audit, and QAPI (Quality Assurance Performance Improvement) plan. On 4/14/22 the facility had their QAPI meeting. This was the first meeting conducted after 4/4/22 when the QAPI team met to discuss the IJ citations and plans of abatement. Neither VPO-L or Corporate RN BB were in attendance. On 4/14/22, Administrator A informed Surveyor that earlier this morning on 4/14/22, VPO- L and Corporate Consultant RN BB flew back to North Carolina, and that they informed Administrator A there was an issue with the Management contract. Administrator A stated they VPO-L and Corporate Consultant RN BB indicated they would not be back in the building until the issue with the contract is clarified. As of the exit of the partial extended survey on 4/14/22, the Immediate Jeopardy was not removed.

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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** 38829 Based on record review and staff interviews, the facility did not ensure 3 allegations of abuse and/or neglect involving 3 Residents(R3, R7, and R17) were reported immediately to the State Survey Agency. * On 3/14/22, Social Worker (SW-C) was present with R3 and nurse practitioner when R3 stated a man punched me. The facility did not report this allegation of abuse within 2 hours and did not report the results of their investigation within 5 working days of the incident to the State Agency. * On 3/22/22, SW-C was informed of an allegation of neglect by R7 being denied assistance of being put on the bedpan and had to wait 2 hours for assistance. The facility did not report this allegation of neglect within 24 hours and did not report the results of their investigation within 5 working days of the incident to the State Agency. * On 3/30/22, Surveyor informed Administrator (NHA-A) of R17's allegation of neglect involving a Certified Nursing Assistant(CNA) watching R17 slide out bed to the floor, did not attempt to assist R17, and walked out the room. The facility did not report this allegation of neglect/abuse within 24 hours and did not report the results of their investigation within 5 working days of the incident to the State Agency. Findings Include: Surveyor reviewed the facility's Abuse Investigation and Reporting revised July 2017. Policy Statement All reports of Resident abuse, neglect, exploitation, misappropriation of Resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation Role of the Administrator 1. If an incident or suspected incident of Resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will keep the Resident and his/her representative informed of the progress of the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The Administrator will suspend immediately any employee who has been accused of Resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. 6. The Administrator will inform the Resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the Resident. Role of the Investigator a. Review the completed documentation forms b. Review the Resident's medical record to determine events leading up to the incident c. Interview the person(s) reporting the incident d. Interview any witnesses e. Interview the Resident f. Interview the attending physician g. Interview staff members(on all shifts) who have had contact with the Resident during the period of the alleged incident h. Interview the Resident's roommate, family members, and visitors i. Interview other Residents to whom the accused employee provides cares or services j. Review all events leading up to the alleged incident 3. The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility b. The local/State Ombudsman c. The Resident's representative d. Adult Protective Services(where state law provides jurisdiction in long-term care) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Law enforcement officials f. The Resident's attending physician g. The facility medical director 2. An alleged violation of abuse, neglect, exploitation or mistreatment and misappropriation of Resident property will be reported immediately, but no later than: a. 2 hours if the alleged violation involves abuse OR has resulted in serious bodily injury b. 24 hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury 5. The Administrator, his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within 5 working days of the occurrence of the incident. 11. Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse. 1. R3 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Encephalopathy, Bipolar, Cognitive Communication Deficit, Unspecified Dementia, Major Depressive Disorder, and Transient Cerebral Ischemic Attack. R3 has an activated Health Care Power of Attorney (HCPOA). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview for Mental Status (BIMS) score to be 5, indicating R3 demonstrates severely impaired skills for daily decision making. R3's Patient Health Questionnaire(PHQ-9) score is 8, indicating R3 has mild depression. R3 requires extensive assistance with bed mobility, locomotion on/off the unit, and transfers. R3 is not steady with balance during transitions and walking. Surveyor reviewed R3's comprehensive care plan and noted the following: 1. R3 is at risk for elopement due to cognitive deficits secondary to dementia and exit seeking behavior-initiated 8/25/20 2. R3 displays behavioral symptoms related to paranoia and are manifested by feeling people are talking about her and being afraid to sleep at night, paranoid that R3 won't wake up-initiated 10/28/20 3. R3 is at risk for abuse and neglect due to diagnosis of dementia with behavior disturbance-initiated 8/25/20, revised 9/21/21 Surveyor notes per incident report, R3 had a witnessed fall on 3/12/22 where R3 slipped in the hallway, hitting R3's chin on the floor. Documentation in R3's progress notes located in R3's electronic medical record (EMR) dated 3/14/22 stated the root cause of R3's fall was R3 was combative during redirection and lost balance and fell hitting R3's face. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/22, the nurse practitioner (NP) evaluated R3 with SW-C present. R3 informed NP that a man punched me. R3 repeatedly says this during the evaluation. R3's chin is severely bruised, edematous. NP recommended emergency room (ED) evaluation secondary to concerns for fracture if R3 fell directly on R3's chin. On 3/14/22, R3 went to the hospital for a CT scan of the head. The hospital record dated 3/14/22 documents R3 arrived for an unwitnessed fall that happened yesterday, staff unaware of what time. Swelling and bruising noted to jaw area. Emergency Medical Services (EMS) noted abscess to inner lower lip. Spoke with HCPOA. HCPOA is unsure what was going on at the facility. R3 keeps reporting R3 was struck in the face. HCPOA was told that a door struck R3 in the face. On 3/28/22 at 2:17 PM, Surveyor spoke to NHA-A in regards to R3's incident. NHA-A stated NHA-A did not do a self-report because it was a 'witnessed fall'. Surveyor asked for all staff witness statements from the time of the incident. NHA-A stated NHA-A will have to look for statements. NHA-A stated R3 expressed the day after the incident that someone had hit R3, but NHA-A did not self report to the State Survey Agency because we already knew the story. On 3/28/22 at 2:50 PM, Surveyor shared the concern with NHA-A that R3's allegation of being hit had not been self reported to the State Survey Agency. NHA-A shared that NHA-A has no written statements from the staff member who allegedly witnessed R3's fall or from other staff members. On 3/30/22 at 10:45 AM, Surveyor interviewed Director of Nursing (DON-B) in regards to the incident. DON-B shared DON-B had worked that weekend and noted R3's left side of R3's jaw/chin area was bruised and swollen. DON-B asked questions of staff, but no one had answers. DON-B stated, DON-B was finally informed that R3 had slipped and fell and the staff member probably went to grab her. R3's bible was found outside of the west doorway. DON-B stated, R3 did say a man hit her. DON-B stated DON-B reported the incident to NHA-A. On 3/31/22 at 2:05 PM, Surveyor interviewed SW-C in regards to R3's incident. SW-C confirmed that SW-C heard R3 inform the NP that a man in a uniform had hit R3. SW-C stated SW-C spoke to staff about it, but did not document anything. SW-C stated, it may have happened to R3, but maybe at a different time. SW-C did not report it because it was a witnessed fall. SW-C stated SW-C initiated the NP visit because SW-C had concerns with R3's bruising. On 3/31/22 at 3:05 PM, Surveyor again shared concerns with NHA-A that R3's allegation of abuse had not been reported to the State Survey Agency and in addition, the allegation was not reported to the State Agency within 2 hours of the allegation. Surveyor also noted the facility did not submti a facility investigation into this allegation to the State Agency within 5 working days of the incident. NHA-A understands the concern and no further information was provided at this time. 2. R7 was admitted on [DATE] with diagnoses of Wernickes Encephalopathy, Guillain-Barre Syndrome, Alcohol Abuse with Intoxication, Unspecified Psychosis and Essential Hypertension. R7 is her own person. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Admission MDS dated [DATE] documents R7's BIMS score to be 15, indicating R7 is cognitively intact for daily decision making. R7's PHQ-9 score is 1, indicating minimal depression. R7 requires extensive assistance with bed mobility and dressing. R7 requires total assistance for transfers and bathing. Surveyor reviewed R7's comprehensive care plan and notes R7's care plan is incomplete. On 3/29/22 at 10:06 AM, Surveyor interviewed R7. R7 stated that on 3/17/22, R7 requested the bed pan. The nurse placed the bedpan next to R7's bed on the bedside table and walked out of the room. R7 turned the call light on again and waited 2 hours for assistance. R7 stated R7 had to call family in to assist R7. R7 stated during that time, R7 was cramping, in pain, and crying. R7 stated R7 informed SW-C of the incident. On 3/29/22 at 12:16 PM, Surveyor spoke with SW-C in regards to R7's allegation. SW-C stated SW-C did not write it up because SW-C felt it had been handled right away. SW-C had informed NHA-A of the allegation and the nurse was re-assigned to another unit at the time it was reported. I felt like it had been handled right away. SW-C stated that R7 had stated it took a long time to get the bedpan and that R7 had called R7's niece crying. SW-C stated SW-C did not feel it was abuse/neglect because a CNA eventually came in R7's room. SW-C believes the incident occurred on 3/22/22 but has no documentation of the incident. On 3/29/22 at 3:01 PM, Surveyor shared the concern with NHA-A that R7's allegation of abuse/neglect had not been reported to the State Survey Agency. Additionally, the facility did not submit an investigation into this allegation to the State Agency within 5 working days of the incident. NHA-A understands the concern and provided no further information at this time. 3. R17 was admitted on [DATE] with diagnoses of Major Depressive Disorder, Cerberal Infarction, End Stage Renal Disease, Metabolic Encephalopathy, Coagulation Defect, Bells Palsy, Type 2 Diabetes Mellitus, and Fibromyalgia. R17 is her own person. R17's last documented MDS dated [DATE] documents R17 has a BIMS of 15 indicating R17 is cognitively intact for daily decision making. R17's PHQ-9 score is 3, indicating minimal depression. R17 requires extensive assistance with bed mobility, transfers, dressing, and toileting. R17 is not steady with balance during transitions and walking. R17 has range of motion (ROM) impairment on 1 upper extremity and bilateral lower extremities. Surveyor notes there is no completed admission MDS for this recent admission from 3/7/22. Surveyor reviewed R17's comprehensive care plan and notes R17's care plan is incomplete. On 3/30/22 at 10:20 AM, Surveyor spoke with R17 in regards to an allegation that R17 slid from bed to the floor on 3/29/22 at approximately 10:40 AM. R17 alleges that as R17 was sliding off the bed, a CNA (R17 gave specific description of CNA's hair) watched R17 slide from the bed, did not attempt to assist R17 and walked out R17's room. R17 stated that R17 had been reaching for R17's cell phone to call 911 to get help when R17 slid off the bed. On 3/30/22 at 11:30 AM, Surveyor informed NHA-A of R17's allegation that the CNA walked out on R17 as R17 was slipping out of bed. (continued on next page)

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Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/22 at 3:01 PM, Surveyor shared the concern with NHA-A that the allegation of the CNA walking out on R17 as R17 slid to the floor was not reported to the State Survey Agency. Surveyor notes that NHA-A has not provided any documentation that a self-report was initiated. Additionally, the facility did not submit an investigation into this allegation to the State Agency within 5 working days of the incident No further information was provided at this time.

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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** 38829 Based on record review and staff interviews, the facility did not ensure all allegations of abuse and/or neglect were thoroughly investigated for 3 Residents (R3, R7, and R17). * On 3/14/22, Social Worker (SW-C) was present with R3 and nurse practitioner when R3 stated a man punched me. The facility did not initiate an investigaation regarding this allegation of abuse. * On 3/22/22, SW-C was informed of an allegation of neglect by R7 being denied assistance of being put on the bedpan and had to wait 2 hours for assistance. The facility did not initiate an investigaation regarding this allegation of neglect. * On 3/30/22, Surveyor informed Administrator (NHA-A) of R17's allegation of neglect involving a Certified Nursing Assistant (CNA) watching R17 slide out bed to the floor, did not attempt to assist R17, and walked out the room. The facility did not initiate an investigaation regarding this allegation of abuse/neglect. Findings Include: Surveyor reviewed the facility's Abuse Investigation and Reporting revised July 2017. Policy Statement All reports of Resident abuse, neglect, exploitation, misappropriation of Resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation Role of the Administrator 1. If an incident or suspected incident of Resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will keep the Resident and his/her representative informed of the progress of the investigation. 4. The Administrator will suspend immediately any employee who has been accused of Resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. The Administrator will inform the Resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the Resident. Role of the Investigator a. Review the completed documentation forms b. Review the Resident's medical record to determine events leading up to the incident c. Interview the person(s) reporting the incident d. Interview any witnesses e. Interview the Resident f. Interview the attending physician g. Interview staff members(on all shifts) who have had contact with the Resident during the period of the alleged incident h. Interview the Resident's roommate, family members, and visitors i. Interview other Residents to whom the accused employee provides cares or services j. Review all events leading up to the alleged incident 3. The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility b. The local/State Ombudsman c. The Resident's representative d. Adult Protective Services(where state law provides jurisdiction in long-term care) e. Law enforcement officials f. The Resident's attending physician g. The facility medical director (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) R3 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Encephalopathy, Bipolar, Cognitive Communication Deficit, Unspecified Dementia, Major Depressive Disorder, and Transient Cerebral Ischemic Attack. R3 has an activated Health Care Power of Attorney (HCPOA). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview for Mental Status (BIMS) score to be 5, indicating R3 demonstrates severely impaired skills for daily decision making. R3's Patient Health Questionnaire(PHQ-9) score is 8, indicating R3 has mild depression. R3 requires extensive assistance with bed mobility, locomotion on/off the unit, and transfers. R3 is not steady with balance during transitions and walking. Surveyor reviewed R3's comprehensive care plan and noted the following: 1. R3 is at risk for elopement due to cognitive deficits secondary to dementia and exit seeking behavior-initiated 8/25/20 2. R3 displays behavioral symptoms related to paranoia and are manifested by feeling people are talking about her and being afraid to sleep at night, paranoid that R3 won't wake up-initiated 10/28/20 3. R3 is at risk for abuse and neglect due to diagnosis of dementia with behavior disturbance-initiated 8/25/20, revised 9/21/21 Surveyor notes per incident report, R3 had a witnessed fall on 3/12/22 where R3 slipped in the hallway, hitting R3's chin on the floor. Documentation in R3's progress notes located in R3's electronic medical record (EMR) dated 3/14/22 stated the root cause of R3's fall was R3 was combative during redirection and lost balance and fell hitting R3's face. On 3/14/22, the nurse practitioner (NP) evaluated R3 with SW (Social Worker)-C present. R3 informed NP that a man punched me. R3 repeatedly says this during the evaluation. R3's chin is severely bruised, edematous. NP recommended emergency room (ED) evaluation secondary to concerns for fracture if R3 fell directly on R3's chin. On 3/14/22, R3 went to the hospital for a CT scan of the head. The hospital record dated 3/14/22 documents R3 arrived for an unwitnessed fall that happened yesterday, staff unaware of what time. Swelling and bruising noted to jaw area. Emergency Medical Services (EMS) noted abscess to inner lower lip. Spoke with HCPOA. HCPOA is unsure what was going on at the facility. R3 keeps reporting R3 was struck in the face. HCPOA was told that a door struck R3 in the face. On 3/28/22 at 2:17 PM, Surveyor spoke to NHA(Nursing Home Administrator)-A in regards to R3's incident. NHA-A stated NHA-A did not do a self-report because it was a 'witnessed fall'. Surveyor asked for all staff witness statements from the time of the incident. NHA-A stated NHA-A will have to look for statements. NHA-A stated R3 expressed the day after the incident that someone had hit R3, but NHA-A did not self report to the State Survey Agency because we already knew the story. On 3/28/22 at 2:50 PM, Surveyor shared the concern with NHA-A that R3's allegation of being hit had not been thoroughly investigated. NHA-A shared that NHA-A has no written statements from the staff member who allegedly witnessed R3's fall or from other staff members. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/30/22 at 10:45 AM, Surveyor interviewed Director of Nursing (DON-B) in regards to the incident. DON-B shared DON-B had worked that weekend and noted R3's left side of R3's jaw/chin area was bruised and swollen. DON-B asked questions of staff, but no one had answers. DON-B stated, DON-B was finally informed that R3 had slipped and fell and the staff member probably went to grab her. R3's bible was found outside of the west doorway. DON-B stated, R3 did say a man hit her. DON-B stated DON-B reported the incident to NHA-A. On 3/31/22 at 2:05 PM, Surveyor interviewed SW-C in regards to R3's incident. SW-C confirmed that SW-C heard R3 inform the NP that a man in a uniform had hit R3. SW-C stated SW-C spoke to staff about it, but did not document anything. SW-C stated, it may have happened to R3, but maybe at a different time. SW-C did not report it because it was a witnessed fall. SW-C stated SW-C initiated the NP visit because SW-C had concerns with R3's bruising. On 3/31/22 at 3:05 PM, Surveyor again shared concerns with NHA-A that R3's allegation of abuse had not been thoroughly investigated. NHA-A understands the concern and no further information was provided at this time. 2) R7 was admitted on [DATE] with diagnoses of Wernickes Encephalopathy, Guillain-Barre Syndrome, Alcohol Abuse with Intoxication, Unspecified Psychosis and Essential Hypertension. R7 is her own person. R7's Admission MDS (Minimum Data Set) dated 2/25/22 documents R7's BIMS (Brief Interview for Mental Status) score to be 15, indicating R7 is cognitively intact for daily decision making. R7's PHQ-9 score is 1, indicating minimal depression. R7 requires extensive assistance with bed mobility and dressing. R7 requires total assistance for transfers and bathing. Surveyor reviewed R7's comprehensive care plan and notes R7's care plan is incomplete. On 3/29/22 at 10:06 AM, Surveyor interviewed R7. R7 stated that on 3/17/22, R7 requested the bed pan. The nurse placed the bedpan next to R7's bed on the bedside table and walked out of the room. R7 turned the call light on again and waited 2 hours for assistance. R7 stated R7 had to call family in to assist R7. R7 stated during that time, R7 was cramping, in pain, and crying. R7 stated R7 informed SW -C of the incident. On 3/29/22 at 12:16 PM, Surveyor spoke with SW-C in regards to R7's allegation. SW-C stated SW-C did not write it up because SW-C felt it had been handled right away. SW-C had informed NHA-A of the allegation and the nurse was re-assigned to another unit at the time it was reported .I felt like it had been handled right away. SW-C stated that R7 had stated it took a long time to get the bedpan and that R7 had called R7's niece crying. SW-C stated SW-C did not feel it was abuse/neglect because a CNA (Certified Nursing Assistant) eventually came in R7's room. SW-C believes the incident occurred on 3/22/22 but has no documentation of the incident. On 3/29/22 at 3:01 PM, Surveyor shared the concern with NHA (Nursing Home Administrator)-A that R7's allegation of abuse/neglect had not been thoroughly investigated. NHA-A understands the concern and provided no further information at this time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) R17 was admitted on [DATE] with diagnoses of Major Depressive Disorder, Cerberal Infarction, End Stage Renal Disease, Metabolic Encephalopathy, Coagulation Defect, Bells Palsy, Type 2 Diabetes Mellitus, and Fibromyalgia. R17 is her own person. R17's last documented MDS dated [DATE] documents R17 has a BIMS of 15 indicating R17 is cognitively intact for daily decision making. R17's PHQ-9 score is 3, indicating minimal depression. R17 requires extensive assistance with bed mobility, transfers, dressing, and toileting. R17 is not steady with balance during transitions and walking. R17 has range of motion (ROM) impairment on 1 upper extremity and bilateral lower extremities. Surveyor notes there is no completed admission MDS for this recent admission from 3/7/22. Surveyor reviewed R17's comprehensive care plan and notes R17's care plan is incomplete. On 3/30/22 at 10:20 AM, Surveyor spoke with R17 in regards to an allegation that R17 slid from bed to the floor on 3/29/22 at approximately 10:40 AM. R17 alleges that as R17 was sliding off the bed, a CNA (R17 gave a specific description of CNA's hair) watched R17 slide from the bed, did not attempt to assist R17 and walked out R17's room. R17 stated that R17 had been reaching for R17's cell phone to call 911 to get help when R17 slid off the bed. On 3/30/22 at 11:30 AM, Surveyor informed NHA-A of R17's allegation that the CNA walked out on R17 as R17 was slipping out of bed. On 3/31/22 at 3:01 PM, Surveyor shared the concern with NHA-A that the allegation of the CNA walking out on R17 as R17 slid to the floor did not prompt a thorough investigation. No further information was provided at this time.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review, the facility did not ensure that the PASARR (Pre-Admission Screen and Resident Review) Level I screen was completed for 1 (R16) of 1 Resident reviewed with diagnosis of serious mental illness and/or developmental disability. *R16 was admitted to the facility on [DATE] and did not have a Level I PASARR screen completed. Findings Include: Surveyor reviewed the facility's Admission Criteria policy and procedure revised March 2019 and noted the following applicable: 9. All new admissions are readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review(PASARR) process. a. The facility conducts a Level 1 PASARR screen for all potential admissions, regardless of payer source to determine if the individual meets the criteria for a MD, ID, or RD. b. If the Level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he/she is referred to the state ASA representative for the Level II (evaluation and determination) screening process. 1. The admitting nurse notifies the social services department when a Resident is identified as having a possible (or evident) MD, ID, or RD. 2. The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the State ASA representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he/she needs, and whether placement is the facility is appropriate. d. The State PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential Resident that are outlined in the evaluation. f. Once a decision is made, the State PASARR representative, the potential Resident and his/her representative are notified. R16 was admitted on [DATE] with diagnoses of Huntington's Disease, Unspecified Dementia, Schizophrenia, Bipolar, Psychotic Disorder with Delusions, Unspecified Intellectual Disabilities, and Dysphagia. R16 has a legal guardian. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Admission MDS dated [DATE] documents R16's short and long term memory is impaired and R16 demonstrates severely impaired skills for daily decision making. R16's PHQ-9 score done by staff is a 8, indicating mild depression. There are no behaviors documented on R16's MDS. R16 is extensive assistance for bed mobility. R16 requires total dependence of 2 staff for transfers. R16 is total dependence for dressing, toileting, and bathing. R16 has both upper and lower bilateral range of motion impairment. R16 is always incontinent and requires tube feeding. Surveyor notes the only applicable measurable objective listed on R16's comprehensive care plan is the following: R16 has a behavior problem of liking to stand independently, liking to crawl on floor.-initiated 3/26/22 Surveyor reviewed R16's EMR and noted the multiple mental illness diagnoses as well as the unspecified intellectual disability diagnosis. Surveyor could not locate the required PASARR. On 3/29/22 at 1:52 PM, Admissions (ADM-G) confirmed that the facility did not have a PASARR Level 1 for R16. ADM-G stated, I have no idea where it would be. ADM-G stated ADM-G just started 3 weeks ago and is responsible for ensuring that every Resident admitted to the facility has a Level 1 completed. On 3/30/29 at 3:26 PM, Surveyor shared the concern with Administrator (NHA-A) that R16 did not have a completed Level 1 which potentially has prevented R16 from attaining or maintaining R16's highest practicable level or potentially has attributed to R16's decline in physical, mental, or psychosocial well-being while at the facility. No further information was provided at this time. On 3/31/22 at 2:05 PM, Surveyor spoke with Social Worker (SW-C) who informed Surveyor that SW-C did not call the group home where R16 lived previously to obtain background information. SW-C confirmed that R16 has not been evaluated by psychiatric services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on staff interview and record review, the Facility did not ensure 2 (R6 and R17) of 18 Residents who required a comprehensive care plan containing measurable objectives and interventions, had a comprehensive person-centered care plan developed in order to meet their medical, nursing, mental, and psychosocial need to facilitate attaining or maintaining the residents highest practicable physical, mental, and psychosocial well-being. * R6 was admitted on [DATE] and the care plan provided by the facility during the survey process contained only 2 measurable objectives, addressing nutrition and activity participation. R6's care plan is not comprehensive as it does not include measurable objectives for R6's tracheostomy status, medication status, oxygen, activities of daily living(ADLs), functional status, pain, psychosocial status, discharge planning, and/or code status. * R17 was admitted to the facility on [DATE] and the care plan provided by the facility during the survey process contained only 3 measurable objectives addressing nutrition, activity participation, and fall. Based on R17's diagnoses, Minimum Data Set (MDS) and assessments, Surveyor notes R17's care plan is not comprehensive as it does not include measurable objectives for R17's depression, dialysis diabetes, medication status, activities of daily living(ADLs), functional status, pain, psychosocial status, discharge planning, and/or code status. Findings Include: Surveyor reviewed the facility's 'Using the Care Plan' policy and procedure revised August 2006 and noted the following: Policy Statement The care plan shall be used in developing the Resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the Resident. Policy Interpretation and Implementation 1. Completed care plans are placed in the Resident's chart 2. The Nurse Supervisor uses the care plan to complete the CNA (Certified Nursing Assistant) daily/weekly work assignment sheets and/or flow sheets 3. CNAs are responsible for reporting to the Nurse Supervisor any change in the Resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. 4. Other staff noting a change in the Resident's condition must also report those changes to the Nurse supervisor and/or Minimum Data Set (MDS) Assessment Coordinator. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Changes in the Resident's condition must be reported to the MDS Assessment Coordinator so that a review of the Resident's assessment and care plan can be made. 6. Documentation must be consistent with the Resident's care plan. Surveyor also reviewed the facility's Comprehensive Assessment and the Care Delivery Process revised December 2016 and noted the following: Policy Statement Comprehensive assessments will be conducted to assist in developing person-centered care plans. Policy Interpretation and Implementation 1. Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions. 4. Decision making leading to a person-centered plan of care includes selecting and implementing interventions. 5. Monitoring results and adjusting interventions include continuing to define or refine the objectives of specific treatments as well as overall care and services. 6. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals. 1) R6 was admitted to the facility on [DATE] with diagnoses of Tracheostomy status, Autonomic Neuropathy, and Essential Hypertension. R6 is her own person. Surveyor notes there is not a completed MDS completed for R6. Surveyor reviewed R6's comprehensive care plan and notes there are only 2 measurable objectives: 1. R6 has nutritional problem or potential nutritional problem due to history of dyspegia requiring PEG placement-initiated 3/16/22 2. R6 will participate in activities of R6's own choosing-initiated 3/22/22 Surveyor also notes R6's care card effective as of 3/28/22 in incomplete. Based on R6's diagnoses, and assessments, R6's care plan is not comprehensive as it does not include measurable objectives for R6's tracheostomy status, medication status, oxygen, activities of daily living(ADLs), functional status, pain, psychosocial status, discharge planning, and/or code status. 2) R17 was admitted on [DATE] with diagnoses of Major Depressive Disorder, Cerberal Infarction, End Stage Renal Disease, Metabolic Encephalopathy, Coagulation Defect, Bells Palsy, Type 2 Diabetes Mellitus, and Fibromyalgia. R17 is her own person. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's last documented MDS dated [DATE] documents R17 has a BIMS of 15 indicating R17 is cognitively intact for daily decision making. R17's PHQ-9 score is 3, indicating minimal depression. R17 requires extensive assistance with bed mobility, transfers, dressing, and toileting,. R17 is not steady with balance during transitions and walking. R17 has range of motion (ROM) impairment on 1 upper extremity and bilateral lower extremities. Surveyor notes there is no completed admission MDS for this recent admission from 3/7/22. Surveyor reviewed R17's comprehensive care plan and notes there are only 3 measurable objectives initiated from this most recent admission. 1. R17 has a nutritional problem or potential nutritional problem due to ESRD, therapeutic diet, diabetes, history of metabolic encephalppathy, and altered mental status-imitated 3/8/22 2. R17 will participate in activities of R17's choosing-initiated 3/12/22 No interventions are documented 3. R17 has had an actual fall with no injury-initiated 3/10/22 Based on R17's diagnoses, MDS, and assessments, Surveyor notes R17's care plan is not comprehensive as it does not include measurable objectives for R17's depression, dialysis diabetes, medication status, activities of daily living(ADLs), functional status, pain, psychosocial status, discharge planning, and/or code status. On 3/28/22 at 3:05 PM, Surveyor shared with Administrator(NHA-A) the concern that both R6 and R17 did not have a comprehensive care plan developed to meet their physical, mental, and psychosocial needs. No further information was provided at this time.

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on observations, interviews and record reviews, the facility did not provide necessary cares and services to promote quality of life and assist 70 out of 70 residents maintain their highest practicable level of physical, mental, and psychosocial well-being. Residents stated that they felt scared and felt neglected and felt as if no one would help them because there was no staff. The governing body did not ensure and the facility did not provide an adequate level of staff to provide cares and services to residents of the facility for an extended period of time. This left residents to go without showers/ baths, daily personal hygiene, repositioning in the bed and chairs, proper treatment and assessments of pressure ulcers, prevention of falls and medications administered per physician orders and within required timeframes. The facility continued to admit new residents to the facility knowing that they were facing daily staffing shortages and providing necessary cares and services to the current residents proved to be incomplete. This pervasive disregard for residents' quality of life created a finding of immediate jeopardy that began on 2/28/22. Administrator- A and VP of Operations- L were notified of the immediate jeopardy on 4/4/22 at 4:45 p.m. As of the time of the partial extended survey exit on 4/14/22, the facility did not remove the Immediate Jeopardy. This is evidenced by: During this complaint investigation the following deficiencies were identified: 1. 70 residents were not free from neglect when the facility and governing body did not ensure that sufficient staff were deployed to care for residents. This resulted in a finding of immediate jeopardy and substandard quality of care. (Cross Reference F600) 2. 10 residents who are dependent of staff for activities of daily living did not receive weekly skin checks and showers/ baths and assistance with personal hygiene. The facility did not have accurate documentation/information to show R10, R5, R11, R8, R3, R7, R2, R4, R13, R14 received showers consistent with R's care plans, in addition skin checks were not always completed as per facility policy for R3, R7, R2, R4, R13, R14. R10 is not receiving weekly showers in accordance with R10's plan of care. R10 appeared very disheveled with dry, flaky skin and excessive facial hair when observed on 3/28/22 at 9:20 AM, 12:20 PM and 2:45 PM and on 3/29/22 at 7:45 AM. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R11 was observed in bed on 3/28/22 at 12:30 PM .R11's hair was very disheveled and appeared to be greasy as if not washed in some time. R11 is to have a shower at least weekly however no indication of a set day for the shower. The facility was unable to provide any evidence that R11 had been provided a shower for the months of February and March 2022. R4 was observed lying in the bed on 3/29/22 at 8:10 AM on her back with lips cracked and no moisture noted on dry mucous membranes and long beard hairs on chin. R4 stated liking to have her chin shaved and telling the nurses if they see anything on the face to take it off. Surveyor noted R4 had only one documented shower on 3/9/22 in the last 30 days. (Cross Reference F677) 3. 4 residents (R4, R10, R5, R18) did not receive the appropriate treatment and services to prevent/ heal pressure ulcers. This resulted in a finding of immediate jeopardy and substandard quality of care R4. On 2/14/22, R4 developed three unstageable pressure injuries. These combined into one unstageable wound that is now 56 times larger in area than when first identified (2.02 sq. cm. vs. 160 sq. cm). In addition, during 2 different wound care observations, R4 had developed two additional ischial wounds that were not addressed by the facility. R10 acquired an unstageable pressure injury while residing at the facility and was hospitalized , requiring intravenous antibiotic treatment for the infected pressure injury. R5 acquired a stage 4 pressure injury while residing at the facility and was hospitalized , requiring antibiotic treatment for the infected pressure injury. R18's pressure ulcer to the coccyx was not compressively assessed upon her original admission on 3/1/22 and then upon readmission on 3/22/22 and 3/23/22. R18 did not have a plan of care addressing the pressure ulcer with interventions put into place to aide in the healing of the pressure ulcer. The facility was unable to determine if the treatment they were applying daily to R18's coccyx was effective because they had no means to know if the area was healing or not. Facility nurses do not assess, measure or stage pressure injuries. This is left to the wound MD who makes rounds once a week. (Cross Reference F686) 4. 2 residents (R16 and R3) were not provided with care in supervision to prevent accidents, resulting in serious injuries. This resulted in a finding of immediate jeopardy and substandard quality of care. R16 has had 12 falls since admission on 2/18/22 to 4/3/22. The fall on 3/27/22 (which was the second fall that day) resulted in stitches above the right eyebrow. The fall on 3/26/22 resulted in staples to the back of the head. The fall on 4/2/22 resulted in a re-opening of the staples. The fall on 4/3/22 led to a laceration on the resident's face that required steri-strips. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	After review of nursing schedules with each of R16's falls, it is noted that based on census and 15 total Residents residing on the same unit as R16, there was an inadequate number of staff to provide supervision to R16 in order to prevent R16 from frequent falling. R16 is a [AGE] year-old who was admitted to the facility on [DATE] with diagnoses of Huntington's Disease, Unspecified Dementia, Schizophrenia, Bipolar, Psychotic Disorder with Delusions, Unspecified Intellectual Disabilities, and Dysphagia. R16 had been living at a group home prior to hospitalization . The facility was unable to locate any documentation from the hospitalization explaining R16's need for the hospitalization from the group home. The facility was not able to provide Surveyor any information in regard to R16's daily routine while at the group home. R16's Admission Minimum Data Set (MDS) dated [DATE] documents R16's short and long term memory is impaired and R16 demonstrates severely impaired skills for daily decision making. R16's PHQ-9 score done by staff is an 8, indicating mild depression. There are no behaviors documented on R16's MDS. R16 is extensive assistance for bed mobility. R16 requires total dependence of 2 staff for transfers. R16 is total dependence for dressing, toileting, and bathing. R16 has both upper and lower bilateral range of motion impairment. R16 is always incontinent and requires tube feeding. Surveyor notes, based on R16's diagnoses which required specialized care, the facility was unable to provide the care that R16 needed, resulting in multiple falls, some with major injury, and life-threatening significant weight loss as a Resident at the facility. According to the Huntington's Disease (HD) Society of America, The movement disorder of HD includes emergence of involuntary movements (chorea) and the impairment of voluntary movements, which result in reduced manual dexterity, slurred speech, swallowing difficulties, problems with balance, and falls. Despite knowing R16's diagnosis of Huntington's disease and knowing R16 had poor balance and poor comprehension and was constantly in motion, the facility did not do a thorough fall assessment on admission. The facility did not provide the supervision needed to prevent falls and did not assess or do a root cause analysis of each of R16's falls. There is documentation that R16's initiation to get out of bed or the broda chair was purposeful and with intent. R16 fell twelve times in six weeks, hitting R16's head a number of times and sustaining injuries that needed sutures or staples. R16 repeatedly hit R16's head and was not wearing a helmet, put R16 at risk of sustaining an epidural or subdural hematoma. Subdural hematomas can be serious and can lead to decreased quality of life or death. The facility discovered on 3/31/22 that R16 had worn a soft helmet daily while at the group home. On 3/20/22 R3 had a fall with injury and a fall assessment with a thorough root cause analysis, and Neuro checks was not completed. (Cross Reference F689) 5. 2 residents (R16 and R9) experienced significant weight loss without staff alerting the physician and following recommendations based on a comprehensive assessment from the Registered Dietician. This resulted in a finding of immediate jeopardy and substandard quality of care. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/31/22, R16's weight was obtained. RD-D documents R16's weight has declined to 72.6 pounds, an 18. 6% weight loss since admission. RD-D describes the weight as severely underweight and life-threatening. RD-D contacted the Nursing Home Administrator and recommended R16 be transferred to the hospital STAT. R16 was sent to the emergency room (ER) and returned to the facility on [DATE]. According to Nutritional management of individuals with Huntington's disease: nutritional guidelines, There is a high risk of rapid weight loss for many individuals [with Huntington's disease] . Rapid weight loss can result in loss of muscle mass, weakness, apathy, depression, susceptibility to infection and compromised chest status . Due to staff failure to maintain acceptable parameters of weight for R16, this resulted in an 18.6% weight loss in 39 days for R16. The facility did not weigh R16 as often as dictated by professional standards of practice, did not immediately increase R16's tube feedings when ordered by the dietitian, and did not get a speech therapy evaluation as ordered by the physician to determine to what extent R16 might be able to eat by mouth. Given R16's vulnerabilities (Huntington's disease) and its manifestations, and the need for immediate action, it was determined that repeated, systemic failure to assess and address R16's nutritional status and to implement pertinent interventions based on such an assessment resulted in continued significant or severe weight loss and functional decline for R16. R9 experienced a significant weight loss of 35.4 pounds (29.8%) from 11/15/21 to 1/31/22 without any compressive assessment or dietary intervention. (Cross Reference F692) 6. The governing body and the facility did not ensure there were sufficient staff to care for 70 residents. This resulted in a finding of immediate jeopardy. On 3/28/22, Surveyor noted only one nurse in facility for 70 residents. R4 did not receive meds, insulins not given, GT (Gastric Tube) feeding was not addressed and treatment was not done. On 3/28/22, at 12:50 PM, Surveyor interviewed CNA-R working on R4's unit who stated she was from agency and the facility just put us here with no guidance, no nurse, no way to chart except through others' login, and no care cards. On 3/28/22, at 12:55 PM, Surveyor interviewed CNA-S working on R4's unit who stated she was from agency and has come here before so we know the residents a little bit but there is no nurse today to check and confirm care. On 3/29/22, at 5:00 AM, Surveyor interviewed LPN-P who stated she is working 3 units (North, East, Vent) with 3 CNAs on Vent, Rehab, [NAME] units and care is not provided, rounds are not done, too hard to do it as staffing is horrible. LPN-P stated there are no care plans so the CNAs do not know what to do and how to transfer. LPN-P stated no charting by CNAs in the record so the nurses are unable to check care provided or not. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/30/22, at 7:00 AM, Surveyor interviewed LPN-P who stated she was the only nurse in the facility when the PM nurse who stayed to help night shift left around 4:00-5:00 AM. LPN-P stated there were only 2 CNAs overnight in the facility so not all care was possible because repositioning requires 2 people. (Cross Reference F725) 7. 12 residents did not receive their morning and noon medications on 3/28/22 when the facility had only 1 nurse in the building and could not complete the medication pass. Of the 12 residents, 6 residents experienced a significant medication error by not being administered their insulin, tube feeding or IV antibiotic. During the first shift on 3/28/22, the facility had only 1 Registered Nurse (RN) on duty with a census of 70 residents. Due to staffing shortages, the 3/28/22 morning and noon medications were not administered to the following residents (R8, R11, R18, R2, R4, R13, R14, R10, R3, R7, R16, and R17). The facility did not follow physician orders to administer medications within the required timeframe. The facility did not ensure that 7 (R2, R4, R13, R14, R10, R11, R18) of 8 residents reviewed were free from significant medication errors. (Cross Reference F755 and F760) 8. The governing body did not ensure that there was sufficient staff as laid out in the facility assessment-staffing plan. The governing body continued to direct the facility to take new admissions even after the Administration reported weekly about concerns for inadequate staffing levels to meet the needs of all the current residents. On 3/31/22 at 12:10 p.m., Surveyor interviewed Administrator- A regarding the facility's admission during the month of February and March 2022. Administrator- A provided Surveyor with a report that showed the facility accepted 47 new admissions during February and March 2022.This resulted in a finding of immediate jeopardy. (Cross Reference F837) 9. On 3/31/22 at 9:05 AM, Surveyor interviewed R17 in regard to R17's fall from bed during the night shift of 3/29/22. Surveyor noted there was only 2 CNAs and 2 nurses in the facility at the time of the fall per facility written schedule. R17 stated R17 had been reaching for R17's phone to call 911 in order to get assistance because R17's call light had been on for a long time. In the process of reaching for the phone, R17 slid out of bed and onto the floor. R17 believes R17 laid on the floor approximately 1 hour before a nurse came. R17 also stated that a CNA watched R17 slide out of bed and walked out of R17's room and did nothing to help stop R17 from sliding, provide any assistance, or go get help. R17 stated R17 has been at the facility 2 other times for rehabalitation and this is the worst experience yet. R17 stated R17 feels more sad and hopeless about everything. R17 is angry at the situation. R17 stated R17 is having more anxiety since the 3rd admission and is scared of not getting the help that R17 needs. R17 feels like R17 cannot talk to anyone about it. R17 stated that R17 is a RN and would and never treat anyone as R17 has been treated while at the facility. I am so fearful I will never get the help when I am laying in bed. During the interview, R17 was crying. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	10. On 3/31/22 at 8:45 AM, R7 informed Surveyor of the cares R7 has not been receiving in the facility. R7 explained that R7 had to call family in several times to come to the facility so R7 could get assistance with cares. R7 explained that R7's call light would be on for a long time, and no one would come to assist R7. R7 stated not getting cares is making R7 more sad while at the facility. R7 stated R7 cries when R7 cannot get the help, which is a lot. R7 explained it hurts because R7 has to rely on others for assistance because R7 struggles with the loss of being independent. 11. R18 was originally admitted to the facility on [DATE] with diagnoses that included end- stage renal disease, chronic pain syndrome, Type 2 diabetes, alcoholic cirrhosis of liver and end stage renal disease. Surveyor conducted a review of R18's medical record and noted that on 2/15/22, R18's Power of Attorney for Healthcare was activated while being treated at the hospital. On 3/31/22 at 8:40 a.m., Surveyor went to made observations of R18. It was noted that R18 was not in her room, the evening meal tray, with food still present, was on the overbed table as well as 2 pills in a medicine cup. On 3/31/22 at 8:44 a.m., Surveyor interviewed Licensed Practical Nurse (LPN)- F in regard to R18's whereabouts. LPN- F stated that she wasn't exactly sure where R18 was but got a written report that R18 had called 911 emergency services herself the night before on 3/30/22 at approximately 8:20 p.m. Surveyor asked LPN- F if she knew why R18 went to the hospital and LPN- F reviewed the electronic medical record and verified there was no nursing notes regarding the incident. LPN- F stated she was not provided any details, just that R18 had sent herself out. On 3/31/22 at 9:26 a.m., Surveyor interviewed Administrator- A in regard to R18 sending herself out to the hospital by calling 911 Administrator- A stated that she was not aware of this incident and would look into it. Surveyor told Administrator- A that the nurse on the unit did not know any details of the incident and that there was nothing written for communication within the nursing notes. Administrator- A verified that an agency nurse was working on 3/30/22 when R18 called 911 and she would need to contact the nurse for details. On 3/31/22 at 10:40 a.m., Administrator- A stated that she had heard R18 sent herself out to the emergency room after a family visit had concluded. Administrator- A stated she is still unaware what hospital R18 went to or any other details. Surveyor contacted R18's Healthcare Power of Attorney on 3/31/22 at 1:48 p.m. R18's AHCPOA stated that she was made aware that R18 wanted to go to the hospital because she was in an extreme amount of pain and could not get any assistance. R18 had reported to a family member she was just going to call 911 herself. AHCPOA (Activated Health Care Power of Attorney) for R18 stated that they had no idea what hospital R18 had went to and they had to call around to all of the local hospitals to find where R18 had been admitted . Failure to provide residents with the care and services necessary to promote quality of life and promote each resident's highest practicable physical, mental and psychosocial well-being created a reasonable likelihood for serious harm, thus creating a finding of Immediate Jeopardy. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	As of 4/14/22 at the time of the partial extended survey exit, the facility did not remove the Immediate Jeopardy.

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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** 42037 Based on interview and record review, the facility did not ensure that 10 (R10, R5, R11, R8, R3, R7, R2, R4, R13, R14) of 10 Residents reviewed who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good hygiene. * The facility did not have have accurate documentation/information to show R10, R5, R11, R8, R3, R7, R2, R4, R13, R14 receievd showers consistent with R's care plans, in addition skin checks were not always completed as per facility policy for R3, R7, R2, R4, R13, R14. * R10 is not receiving weekly showers in accordance with R10's plan of care. R10 appeared very disheveled with dry, flaky skin and excessive facial hair. * R5 was to have a showers on Tuesdays and Fridays. In January 2022, R5 received showers on 1/7/22 and 1/28/22. Surveyor could not identify R5 receiving any showers in February 2022. * R11 was observed in bed wih a sheet draped across his lower body and no clothing to the top half of his body. R11's hair was very disheveled and appeared to be greasy as if not washed in some time. R11 is to have a shower at least weekly however no indication of a set day for the shower. There was no indication that R11 had been refusing a shower or bath. The facility was unable to provide any evidence that R11 had been provided a shower for the months of February and March, 2022. * R8 has physician orders shows to have a weekly skin check completed every Monday evening when her shower takes place. On 1/31/22, R8 filed a grievance with the facility for not receiving a shower on 1/31/22, R8 was scheduled to have a shower during the day on Friday but it was said the staff person left early and no shower was given. The resolution to the grievance was that R8 was given a shower later that evening by a different staff member. On 3/30/31, Surveyor requested to review any documentation that would provide evidence that R8 was receiving a shower, at least weekly, or a bath. The facility was unable to provide any evidence that R8 had been provided a shower for the months of February and March, 2022. * R3's shower days are on Tuesday and Thursday. A skin check must be completed, signed and a skin screen should be completed on shower days. Surveyor was not able to locate any documentation for February and March of those completed skin checks for R3. Theer is no documentation that R3 received any showers in February. Surveyor notes documentation provided by the facility for March indicates R3 received ADL assistance on shower/bath day 6 times, however, does not document that R3 actually received a shower. The facility was unable to provide any completed skin checks on R3's shower days for February and March. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* R7 stated R7 has received 2 showers in 6 weeks. R7 was informed R7's shower day was on Fridays on day shift. R7 informed Surveyor that R7 would prefer a shower 2 times a week. R7 stated that of the 2 showers that R7 received, R7 got R7's hair washed 1 time because R7 asked to get it washed. R7 informed Surveyor that R7's family has come in to give R7 showers. Surveyor also shared that R7 has only received 2 showers since admission. * R2 stated going through hell and supposed to get a shower but since August (2021) have only had a few showers. R2 had only one documented shower on 3/7/22 in the last 30 days. The facility has no completed skin check sheets which are to be done with shower per facility policy for R2. * R4 was observed lying in the bed on her back with lips cracked and no moisture noted on dry mucous membranes and long beard hairs on chin. R4 stated liking to have her chin shaved, and telling the nurses if they see anything on the face to take it off. Surveyor noted R4 had only one documented shower on 3/9/22 in the last 30 days. * R13 had documented showers on 3/4/22, 3/9/22, 3/10/22 in the last 30 days. Documentation indicated R13 had not had a shower in 20 days. * R14 was admitted to the facility on [DATE]. R14 had no documented showers since admission for 12 days. Findings include: Surveyor reviewed the facility's policy and procedure Activities of Daily Living (ADL), Supporting revised March 2018 and noted the following applicable: 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. Surveyor also reviewed the Bath, Shower/Tub facility policy and procedure revised February 2018 and noted the following applicable: Purpose The purposes of this procedure are to promote cleanliness, provide comfort to the Resident and to observe the condition of the Resident's skin. Documentation 1. The date and time the shower/tub bath was performed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's care plan indicates that R5 requires daily assistance with ADLS (Activities of Daily Living). R5 requires extensive assistance of 2 staff with bed mobility, dressing, toileting, and personal hygiene. R5 requires total assistance of 2 staff with transfers and bathing. R5 has limited range of motion to bilateral upper and lower extremities. R5 was discharged from the facility on 3/8/22. Surveyor reviewed R5's medical record. Per medical record, R5 was to have a showers on Tuesdays and Fridays. On 3/31/22, Surveyor requested to review shower/bathing documentation that would provide evidence that R5 was receiving showers/baths per plan of care. In January 2022, R5 received showers on 1/7/22 and 1/28/22. Surveyor could not identify R5 receiving any showers in February 2022. 16584 3. R11 was admitted with diagnosis that included Hypertension, Chronic Heart Failure, Anxiety Disorder, Major Depressive Disorder, Chronic Kidney Disease, Diabetes Mellitus due to underlying condition with diabetic neuropathy and Peripheral Vascular Disease. A review of R11's plan of care showed that R11 requires assist with daily care needs due to weakness due to diagnosis of chronic heart failure and hypertension. R11 is an extensive assistance of two staff members for transfer, bed mobility and toileting. R11 has functional incontinence present. R11 requires cueing for task. Interventions included to assist R11 with activities of daily living. In addition, R11's plan of care states that R11 has a deficit in dressing and grooming. Interventions include to explain procedure, ensure privacy, gather all supplies and praise efforts. According to the annual Minimum Data Set (MDS), dated [DATE], R11 is totally dependent on staff for bathing and personal hygiene. R11 has impaired range of motion on one side, both upper and lower extremity. Surveyor made an observation of R11 lying in his bed on 3/28/22 at 12:39 p.m., R11 had a sheet draped across his lower body and no clothing to the top half of his body. R11's hair was very disheveled and appeared to be greasy as if not washed in some time. According to R11's medical record, R11 is to have a shower at least weekly. There was no indication of a set day for the shower. It was also noted that there was no indication that R11 had been refusing a shower or bath. On 3/30/31, Surveyor requested to review any documentation that would provide evidence that R11 was receiving a shower, at least weekly, or a bath. As of the time of exit, the facility was unable to provide any evidence that R11 had been provided a shower for the months of February and March, 2022. 4. R8 was admitted to the facility with diagnosis that included anxiety disorder, major depressive disorder, osteoarthritis, paraplegia, spinal stenosis, obesity and respiratory failure. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R8's plan of care shows that R8 requires assist with daily care needs due to bilateral lower extremity paraplegia, impaired right upper extremity range of motion due to rotator cuff tear. Listed interventions included to monitor for changes with daily care abilities and provide more or less assist if needed and two persons assist with Hoyer and wheelchair. The annual MDS, dated [DATE] documents that R8 needs extensive assistance of 1 person for personal hygiene and needs physical help in part of the bathing activity. A review of R8's physician orders shows that R8 is to have a weekly skin check completed every Monday evening when her shower takes place. Surveyor conducted a review of the facility's grievance log. It was noted that on 1/31/22, R8 filed a grievance due to not receiving a shower on 1/31/22, R8 was scheduled to have a shower during the day on Friday but it was said the staff person left early and no shower was given. The resolution to the grievance was that R8 was given a shower later that evening by a different staff member. On 3/30/31, Surveyor requested to review any documentation that would provide evidence that R8 was receiving a shower, at least weekly, or a bath. As of the time of exit, the facility was unable to provide any evidence that R8 had been provided a shower for the months of February and March, 2022. 38829 5. R3 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Encephalopathy, Bipolar, Cognitive Communication Deficit, Unspecified Dementia, Major Depressive Disorder, and Transient Cerebral Ischemic Attack. R3 has an activated Health Care Power of Attorney (HCPOA). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview for Mental Status (BIMS) score to be 5, indicating R3 demonstrates severely impaired skills for daily decision making. R3's Patient Health Questionnaire (PHQ-9) score is 8, indicating R3 has mild depression. R3 requires extensive assistance with bed mobility, locomotion on/off the unit, and transfers. R3 is not steady with balance during transitions and walking. R3 requires total assistance with bathing. Surveyor notes R3's care card as of 3/28/22 provides no information in regards to R3's scheduled shower days or instructions on required assistance R3 needs with bathing. Surveyor notes that R3 has measurable objective contained in R3's comprehensive care plan stating R3 has an ADL self care performance deficit but does not specifically document any interventions for bathing. Surveyor notes that per R3's Medication Administration Record (MAR), R3's shower days are on Tuesday and Thursday on day shift. Per MAR, a skin check must be completed, signed and a skin screen should be completed in R3's electronic medical record (EMR). Surveyor was not able to locate any documentation for February and March of those completed skin checks for R3. (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 further information from the facility in regards to R3's showers being provided for February and March. Surveyor notes the facility has no documentation that R3 received any showers in February. Surveyor notes documentation provided by the facility for March indicates R3 received ADL assistance on shower/bath day 6 times, however, does not document that R3 actually received a shower. The facility was unable to provide any completed skin checks on R3's shower days for February and March. 6. R7 was admitted on [DATE] with diagnoses of Wernickes Encephalopathy, Guillain-Barre Syndrome, Alcohol Abuse with Intoxication, Unspecified Psychosis and Essential Hypertension. R7 is her own person. R7's Admission MDS dated [DATE] documents R7's BIMS score to be 15, indicating R7 is cognitively intact for daily decision making. R7's PHQ-9 score is 1, indicating minimal depression. R7 requires extensive assistance with bed mobility and dressing. R7 requires total assistance for transfers and bathing. R7's MDS documents in response to the question, How important to choose between tub bath, shower, bed bath, R7's response is very important. Surveyor notes R7's care card as of 3/28/22 contains no documentation of when R7's shower/bath days are. Surveyor notes that R7 has measurable objective contained in R7's comprehensive care plan stating R7 has an ADL self care performance deficit but does not specifically document any interventions for bathing. Surveyor notes that per R7's Medication Administration Record (MAR), R7's shower days are on Friday on day shift. Per MAR, a skin check must be completed, signed and a skin screen should be completed in R7's electronic medical record (EMR). Surveyor was not able to locate any documentation for February and March of those completed skin checks for R7. Surveyor requested further information from the facility in regards to R7's showers being provided for February and March. Surveyor notes the facility has no documentation that R7 received any showers in February. Surveyor notes documentation provided by the facility for March indicates R7 received ADL assistance on shower/bath day 2 times, however, does not document that R7 actually received a shower. The facility was unable to provide any completed skin checks on R7's shower days for February and March. On 3/29/22 at 10:06 AM, Surveyor interviewed R7. R7 stated R7 has received 2 showers in 6 weeks. R7 was informed R7's shower day was on Fridays on day shift. R7 informed Surveyor that R7 would prefer a shower 2 times a week. R7 stated that of the 2 showers that R7 received, R7 got R7's hair washed 1 time because R7 asked to get it washed. R7 informed Surveyor that R7's family has come in to give R7 showers. On 3/29/22 at 3:01 PM, Surveyor shared the concern with Administrator (NHA-A) that R7 has indicates that R7 has only received 2 showers since admission and that Surveyor is requesting again for documentation that showers have been completed for R7. No further information was provided at this time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/30/22 at 10:50 AM, Surveyor interviewed Director of Nursing (DON-B) who stated the expectation is that skin sheets should be completed every time a Resident receives a shower. DON-B after looking at documentation provided on R3 and R7 is unable to confirm that R3 and R7 actually received a shower versus a bed bath. DON-B will look for skin sheets on R3 and R7. On 3/31/22 at 3:05 PM, Surveyor shared again the concern with NHA-A that the facility is unable to validate that R3 received showers on Tuesdays and Thursdays. Surveyor also shared that R7 has only received 2 showers since admission. Surveyor shared that per facility policy, skin sheets are expected to be completed on shower days and the facility has provided no skin sheets for R3 and R7. No further information was provided at this time. 41439 7. R2 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis and Osteoarthritis. R2's Quarterly 12/29/21 MDS indicated R2 was cognitively intact and required extensive assistance with 2 staff for bed mobility, transfer, and dressing. R2's Admission 7/13/21 MDS indicated R2 stated it was very important to choose a bath/shower. On 3/28/22, at 10:06 AM, Surveyor interviewed R2 who stated going through hell and supposed to get a shower but since August (2021) have only had a few showers. Surveyor noted R2 had only one documented shower on 3/7/22 in the last 30 days. On 3/30/22, at 10:55 AM, Surveyor requested DON-B provide any documentation regarding R2's showers or completed skin checks. The facility has no completed skin check sheets per facility policy for R2 8. R4 was admitted to the facility on [DATE] with diagnoses including Diabetes, Multiple Myeloma, and Hypertension. R4's Quarterly 3/7/22 MDS indicated R4 was cognitively intact and required extensive assistance with 2 staff for bed mobility, transfer with functional impairment of bilateral upper extremities and bilateral lower extremities. On 3/29/22, at 8:10 AM, Surveyor observed R4 lying in the bed on her back with lips cracked and no moisture noted on dry mucous membranes and long beard hairs on chin. R4 stated liking to have her chin shaved, and telling the nurses if they see anything on the face to take it off. Surveyor noted R4 had only one documented shower on 3/9/22 in the last 30 days. 9. R13 was admitted to the facility on [DATE] with diagnoses including Dementia, Agoraphobia, and Hypertension. R13's 2/28/22 Admission MDS indicated R13 was cognitively intact without functional impairments. Surveyor noted R13 had documented showers on 3/4/22, 3/9/22, 3/10/22 in the last 30 days. Documentation indicated R13 had not had a shower in 20 days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. R14 was admitted to the facility on [DATE] with diagnoses including Aortic Valve Vegetation, COPD (Chronic Obstructive Pulmonary Disease) exacerbation, and Morbid Obesity. R14's 3/18/22 Admission MDS was in progress. Surveyor noted R14 had no documented showers since admission for 12 days. The facility did not have accurate documentation that R2, R4, R13, R14 received showers on a consistent basis for March 2022. The facility did not provide any completed skin check sheets per facility policy for R2, R4, R13, R14. On 3/29/22, at 1:30 PM, Surveyor shared concerns regarding showers with NHA-A. On 3/30/22, at 3:15 PM, Surveyor reviewed complaints and concerns with NHA-A including the lack of showers for R2, R4, R 13, R14. No further information was provided.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on observation, interview, and record review the facility did not ensure that 4 of 5 (R4, R10, R5, R18) residents received the necessary care and treatment to prevent pressure injuries from developing, to prevent the worsening of pressure injuries, and to prevent the development of infection for residents who were at risk for the development of pressure injuries. The facility does not have a designated wound care nurse. No one from the facility measures or stages wounds. The facility, instead, relies on the notes from the wound physician, who does weekly rounds. A new pressure injury could go six days before being assessed, measured, staged and treated. * R4: On 2/14/22, R4 developed three unstageable pressure injuries. These combined into one unstageable wound that is now 56 times larger in area than when first identified (2.02 cm.2 vs. 160 cm.2). In addition, during 2 different wound care observations, R4 had developed two additional ischial wounds that were not addressed by the facility. The facility did not have the wound physician notes for March 2022 and, thus, did not know the status of R4's wound or the current treatment orders. The facility did not follow current treatment orders. The facility did not address repositioning in the resident's care plan or the CNA (Certified Nursing Assistant) care card. Agency CNAs stated they did not know they needed to reposition R4. Additionally, the facility did not always have the staff needed to reposition the resident assuming they knew R4 needed repositioning. The resident has not been out of bed and, during observations, remained flat on her back in bed. * R10 acquired an unstageable pressure injury while residing at the facility and was hospitalized , requiring intravenous antibiotic treatment for the infected pressure injury. The facility did not address R10's pressure injury interventions in R10'splan of care or consistently document treatments or weekly assessments of R10's pressure injury. *R5 acquired a stage 4 pressure injury while residing at the facility and was hospitalized , requiring antibiotic treatment for the infected pressure injury. The facility did not address R5's pressure injury interventions in their plan of care or consistently document treatments or weekly assessments of R5's pressure injury. There was no indication of dietary involvement. The facility's failure to assess and stage wounds at the time discovered, as evidenced by facility practice to wait for the wound MD's weekly rounds (conceivably delaying assessment and treatment for six days), its failure to revise care plans and/or to implement care planned approaches such as treatments and repositioning created a finding of Immediate Jeopardy beginning on 1/31/22 when R5 was identified as having a stage 4 pressure injury. NHA-A (Nursing Home Administrator) and VP-L (Vice President of Operations) were informed of the Immediate Jeopardy and substandard quality of care on 3/30/22 at 1:55 PM. Upon the completion of the partial extended survey on 4/14/22, the Immediate Jeopardy was not removed. The survey also identified noncompliance at the level of potential for more than minimal harm that is not immediate jeopardy, as evidenced by the following: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* R18's pressure ulcer to the coccyx was not compressively assessed upon her original admission on 3/1/22 and then upon readmission on 3/22/22 and 3/23/22. R18 did not have a plan of care addressing the pressure ulcer with interventions put into place to aide in the healing of the pressure ulcer. The facility was unable to determine if the treatment they were applying daily to R18's coccyx was effective because they had no means to know if the area was healing or not. Findings include: The facility policy, Pressure Ulcers/Skin Breakdown-Clinical Protocol, (dated 2001 Med-Pass, revised April 2018), indicated in part: Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's risk factors for developing pressure ulcers; for example immobility, recent weight loss, and a history of pressure ulcers. 2. In addition, the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width, depth, presence of exudates or necrotic tissue; pain assessment; resident's mobility status; current treatments including support surfaces; and all active diagnoses. 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. 4. The physician will assist the staff to identify the type and characteristics of an ulcer. Treatment/Management 1. The physician will order pertinent wound treatments including pressure reduction surfaces, wound cleansing and debridement approaches, dressings and application of topical agents. 2. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc. 3. The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors; for example: Healing/Prevention Likely, Healing/Prevention Possible, Healing/Prevention Unlikely. Monitoring 1. During resident visits, the Physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. R4 was admitted to the facility on [DATE] with diagnoses including Diabetes, Multiple Myeloma, CAD (Coronary Artery Disease), Hypertension, Atrial Fibrillation, and GT (Gastric Tube placed for enteral feeding). R4's Quarterly 3/7/22 MDS (Minimum Data Set) indicated R4 was cognitively intact with BIMS (Brief Interview Mental Status) score of 13 with no behaviors noted. R4 required extensive assistance with 2 staff for bed mobility and transfer with functional impairment of bilateral upper extremities and bilateral lower extremities. R4's last CAA (Care Area Assessment for skin) on 6/10/21 MDS indicated: After review of resident's medical record, and OBS of resident, resident is noted at risk for pressure ulcers, secondary to Inc (Incontinent) of B&B (Bowel & Bladder), Needs assist with transfers, mobility, ADLS (Activities of Daily Living), and a care plan will be in place to reduce risk factors, (at risk for falls, pain, infections, depression, decreased activity with isolation) and continue to monitor with current skin checks in place. R4's current and active 2/15/22 care plan in the current electronic medical record indicated R4 has potential/actual impairment to skin integrity of bilateral buttocks and sacrum due to fragile skin. Active Interventions included Encourage good nutrition and hydration in order to promote healthier skin (2/15/22), Follow facility protocols for treatment of injury (2/15/22), Identify /document potential causative factors and eliminate/resolve where possible (2/15/22), Obtain blood work such as CBC, Blood Cultures, and Culture of any open wounds as ordered by Physician (2/15/22), the resident needs (Specify: pressure relieving mattress, pillows, sheep skin padding etc) to protect the skin while up in chair (2/15/22), Use draw sheet or lifting device to move resident (2/15/22). *Surveyor noted repositioning of R4 was not addressed in R4's current and active care plan. R4's CNA (Certified Nursing Assistant) care card, dated 3/28/22, indicated: Pericare with each incontinence episode, Report areas of skin breakdown, skin tears, and redness, Treatment as ordered to Coccyx, Use commercial moisture barrier, Check for wetness on rounds during nights. Toileting-rising, before & after meals. *Surveyor noted repositioning of R4 was not addressed/listed in the active CNA care card for bedside caregivers. R4 had facility skin screens on Monday and Thursday in December 2021 with the last one documented 12/27/21 without skin concerns. The next day, on 12/28/21 at 6:18 AM, R4's progress notes indicated CNA reported R4 has an open area on coccyx added to the 24 hour board for wound nurse to look at the area. R4's Progress notes by the wound nurse on 12/28/21 at 10:48 AM indicated: Was asked to see patient regarding a new wound on her coccyx. Patient has developed an unstageable pressure injury to her coccyx. Updated family and MD-N who will manage care for wound. Pictured and measured wound and provided treatment of Xeroform and bordered foam daily and prn. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Facility 12/28/21 Skin and Wound Evaluation Form indicated R4 developed an in house acquired new wound: Coccyx -1.5 x 1.9 x 1.1 cm which is Unstageable with 100% slough, Moderate drainage. Treatment-Normal Saline cleanse, Xerofoam covered by border gauze. The facility provided a paper copy of a care plan initiated by the wound nurse on 12/28/21, which staff no longer had access to view or change, that indicated R4 has actual skin impairment with unstageable coccyx pressure injury. Interventions included: Address cause if possible, Educate R4 on MD orders for wound care, Educate R4 on the risks of infection and poor healing related to non-compliance, Ensure adequate food and fluid intake, Ensure proper body alignment, Monitor for Signs/Symptoms of Infection-odor, drainage, color, size; Observe and assess regularly, Provide skin care after each incontinent episode, Serve diet as ordered, Supplement with small shifts, Therapeutic mattress in bed and cushion in chair as appropriate, Treatment as ordered to coccyx, Use absorbent pads or briefs that wick and hold moisture, Use pressure redistribution surface if bed or chair bound. Consider pressure redistribution surface if: there is intractable pain or severe pain with turning or additional risk factors are present. *Surveyor noted R4's 12/28/21 closed care plan was no longer active in the facility electronic medical record and repositioning was not addressed with timing or a schedule. On 12/28/21, MD-N (Wound Care Physician) indicated R4's coccyx was Unstageable due to necrosis measuring 1.89 x 1.07 x no measurable depth with 100% slough. Treatment orders were Xerofoam sterile gauze covered by bordered foam daily. *Surveyor noted there were no documented treatments in R4's TAR (Treatment Administration Record) on Dec. 29, 30, 31 of 2021. R4 was hospitalized from 12/31/21 to 2/3/22. R4's 2/3/22 Hospital discharge records to the facility had orders for wound care of a worsened Coccyx wound measuring 3 x 1.7 x 0.3 cm, and a Left buttock wound measuring 0.7 x 0.4 x 0.1 cm. Treatment orders were Purasyn cleanse and soak 3-5 minutes, apply 3M Cavilon, Santyl, Mepiplex border *Surveyor noted the facility did not follow the hospital discharge instructions for wound care upon readmission on 2/3/22. R4's 2/3/22 readmission progress note by DON-B (Director of Nursing) indicated resolving area of MASD (Moisture Associate Skin Dermatitis) on Left buttock surrounding tissue smooth, slightly pink wound bed with no drainage present, covered with foam dressing for protection. *Surveyor noted R4 did not have treatment orders initiated upon 2/3/22 readmission. On 2/7/22, MD-N indicated R4's coccyx was Unstageable due to necrosis measuring 2 x 1 cm with 100% slough. MD-N debrided the necrotic wound and Treatment orders were Xerofoam sterile gauze covered by bordered foam daily. *Surveyor noted R4's coccyx wound treatment was documented as being done only on 2/6, 2/8, 2/12, 2/13, 2/14, 2/16, 2/17, 2/18 in the TAR (Treatment Administration Record). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/14/22, MD-N indicated R4's coccyx was Unstageable measuring 3 x 1 x 0.3 cm with 100% slough. MD-N debrided the necrotic wound and Treatment orders were Santyl daily covered by bordered foam daily. *Surveyor noted MD-N's order on 2/14/22 for Santyl treatment was not ordered until 2/19/22 5 days later and documented on 2/19 & 2/21 in the TAR. MD-N also indicated on 2/14/22: Unstageable DTI (Deep Tissue) Pressure Injury on the Right buttock measuring 9 x 4 cm x 0.1 cm with 80% dermis, 20% skin. Unstageable DTI Pressure Injury on the Left buttock measuring 8 x 4 x 0 cm with 80% dermis, 20% skin. MD-N stated Healing, unavoidable secondary of general decline. Treatment ordered was Zinc ointment application every shift. *Surveyor noted MD-N's 2/14/22 order for Zinc ointment was not documented in the TAR. On 2/21/22, MD-N indicated R4's Coccyx was Unstageable measuring 12 x 12 x 0.3 cm with 100% slough. DTIs resolved as now combined with Coccyx Pressure Injury. Treatment ordered: 1/2 strength Dakin's cleanse then Alginate/CA covered with border foam daily. R4's Physician order dated 2/21/22 Wound care to bilateral buttock & Sacrum. Normal Saline wash followed by Calcium Alginate to entire surface, cover with foam dressing. Change daily & prn (as needed) which was inaccurate in the TAR as MD-N had ordered 1/2 strength Dakin's cleanse not Normal Saline. R4 was hospitalized from 2/21-2/28/22. R4's 2/28/22 Hospital discharge records to the facility had wound care treatment orders for Calazime to Sacrum 2 times/day & as needed, Offload aggressively. R4's 2/28/22 Facility Progress notes upon readmission indicated R4 has continued Wound to sacrum in improved condition, Measures 11.3 cm x 8.3 cm, no drainage, has 2 islands of dry tissue to either side of sacrum, Treatment of Xeroform gauze cover with Border foam dressing change q (every) 3 days & prn reinstated, however this did not reflect the most recent MD-N's treatment orders. *No staging was noted. *Surveyor noted no treatments were documented on 2/28 or 3/1/22. *Surveyor noted at this point in MD-N's assessments, staging, measurements, and treatments despite visits by MD-N to R4 were not in R4's medical record or available to the nurses until 3/29/22 when Surveyor requested the documentation. Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A had to obtain access to the corporate MD-N's account. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/28/22, MD-N did not see R4 so there was no staging or measurements that week. On 3/7/22, MD-N indicated R4's Coccyx was Unstageable measuring 12 x 10 x 0.3 cm as a cluster wound with 90% slough 10% skin. Treatment ordered was 1/2 strength Dakin's cleanse, alginate/CA with border foam daily. On 3/14/22, MD-N indicated R4's Coccyx was Unstageable measuring 12 x 10 x 0.3 cm with 90 slough 10% skin. Treatment ordered was 1/2 strength Dakin's cleanse then alginate/CA covered with border foam daily. Treat surrounding MASD with House Barrier Cream. On 3/21/22, MD-N indicated R4's Coccyx was Unstageable measuring 12 x 10 x 0.3 cm with 80% slough, 10% granulation, 10% skin. Treatment was 1/2 strength Dakin's cleanse then alginate/CA covered with border foam daily. Treat surrounding MASD with House Barrier Cream. On 3/28/22, MD-N indicated R4's Coccyx was Unstageable measuring 10 X 16 x 0.3 cm with 60% slough 30% granulation tissue. Treatment ordered 1/2 strength Dakin's cleanse then alginate/CA covered with border foam daily. Treat surrounding MASD with House Barrier Cream. *Surveyor noted the active Physician order R4's medical record dated 2/21/22: Wound care to bilateral buttock & Sacrum. NS (Normal Saline) wash followed by Calcium Alginate to entire surface, cover with foam dressing. Change daily & prn. The facility was not following MD-N's order for 1/2 strength Dakin's cleanse for wound care since initial order on 2/21/22 and ongoing order since 3/7/22. Observations/Interviews: On 3/28/22, Surveyor noted only one nurse in facility for 70 residents. R4 did not receive meds, insulin's not given, GT (Gastric Tube) feeding was not addressed and treatment was not done. On 3/28/22 at 10:03 AM, Surveyor observed R4 lying flat on back on the air mattress with bilateral protective boots. On 3/28/22, at 12:50 PM, Surveyor interviewed CNA-R working on R4's unit who stated she was from agency and the facility just put us here with no guidance, no nurse, no way to chart except through others login, and no care cards. On 3/28/22, at 12:55 PM, Surveyor interviewed CNA-S working on R4's unit who stated she was from agency and has come here before so we know the residents a little bit but there is no nurse today to check and confirm care. On 3/28/22, at 1:08 PM, Surveyor observed R4 sitting up in bed with head of bed elevated. On 3/28/22, at 2:47 PM, Surveyor observed R4 remains in bed flat on her back. On 3/28/22, R4's treatment was not completed as no nurse available on R4's unit. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/29/22, at 5:00 AM, Surveyor observed R4 lying flat in bed. Surveyor interviewed LPN-P (Licensed Practical Nurse) who stated she was working overnight on 3 units (North, East, Vent) with 3 CNAs one each on the Vent, Rehab, and [NAME] units. LPN-P stated all the care was not provided as they were supposed to split the units, rounds were not done as it is too hard to do it when staffing is horrible. LPN-P stated no rounds done since residents went to bed last night and she planned to look for one of the CNAs to she can help him start. LPN-P stated there are no care plans so the CNAs do not know what care to provide and how to transfer residents. LPN-P stated no charting by CNAs in the electronic medical record so the nurses are unable to check if care was provided or not. On 3/29/22, at 5:15 AM, Surveyor interviewed CNA-U working on R4's unit who stated she has worked here since 2/22 and regrets it as there is terrible care provided in this facility. CNA-U stated she could go on and on about the residents' needs. CNA-U stated one resident needed to be changed when she came in at 10 PM but she had to wait as until 12:30 AM for help to turn and reposition. CNA-U stated the facility does not provide the proper linen to clean and change people. CNA-U stated she is unable to get any assistance to turn residents so no repositioning for some residents and rounds are hard to do, to change residents without help. On 3/29/22, at 6:53 AM, Surveyor interviewed DON-B who stated that for Pressure Injuries I just document what I see, not Wound Certification so no staging. DON-B stated nurses don't measure, only describe, where, what, approximate size but no measurements but stated an RN could stage. DON-B has not seen MD-N notes for over 2 weeks regarding his assessments, measurements, and treatments. DON-B stated she is trying to get access to his corporate notes [VOHRA]. On 3/29/22, at 8:10 AM, Surveyor observed R4 lying in the bed on her back. On 3/29/22, at 9:50 AM, Surveyor interviewed LPN-J who stated they were always short-staffed, always what she has to go through every day. LPN-J stated the CNAs were cleaning and changing R4 now for the first time so Surveyor could observe R4's wound treatment. On 3/29/22, at 9:54 AM, Surveyor observed wound care treatment being provided to R4 and noted R4 has no dressing on coccyx wound. Nurse completed a Normal Saline wash, had 2 types Calcium/Alginate available (1 type had Silver impregnation). Surveyor observed a large wound area across coccyx and buttocks with scattered slough 75% and granulation 25%. Surveyor observed 2 small left ischial wounds covered with slough, not addressed by the nurse. LPN-J placed regular Calcium/Alginate across the coccyx/buttocks region. LPN-J placed a dressing that did not cover the entire coccyx/buttocks wound, then folded 4 x 4 in half and taped it over part of the wound in order to cover it as the proper size dressing was not available. *Surveyor noted LPN-J cleansed R4's wound with Normal Saline as R4's orders were not current and updated per MD-N's treatment orders. MD-N's treatment orders were for the 1/2 strength Dakin's cleanse for wound care. LPN-J did not address R4's 2 observable ischial wounds by staging, measuring, or any treatment to prevent further decline. On 3/29/22, at 12:54 PM, Surveyor interviewed DON-B who stated the facility doesn't do their own separate staging and measurements, only MD-N stages and measures wounds. DON-B stated she was doing a little bit of everything and has not seen the Wound Physician notes for 2 weeks therefore unable to address any questions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/30/22, at 7:00 AM, Surveyor interviewed LPN-P who stated she was the only nurse in the facility when the PM nurse who stayed to help night shift left around 4:00-5:00 AM. LPN-P stated there were only 2 CNAs overnight in the facility so not all care was possible because repositioning requires 2 people. On 3/30/22, at 7:10 AM, Surveyor observed R4 in bed lying flat on back. R4 stated she has not seen any staff all night and her door was closed. On 3/30/22, at 11:43 AM, Surveyor observed R4 being changed and a new dressing placed on sacral/buttocks wound which is loose not adherent to the intact skin and does not cover the wound. Surveyor asked LPN-Q about R4's 2 ischial wounds and LPN-Q stated she will address the ischial wounds. LPN-Q stated this is her 2nd day as the facility wound care nurse and she plans to become wound care certified soon. LPN-Q stated she will get some tape to hold R4's dressing down or find a larger dressing to fit the size of the wound. On 3/30/22, at 8:57 AM, Surveyor interviewed MD-N who stated R4's wound has been there for 86 days & continues to get worse as it is a significant wound. MD-N stated initially with any wound, they get worse to a peak before the wound gets better with treatment. MD-N stated R4's stooling continues to impact the wound. MD-N stated when R4 came back from the hospital, the wound had improved in the hospital. MD-N stated R4's condition improved so the wound should heal easier. MD-N stated he did not see R4's left ischial wounds on Monday 3/28/22 when he made rounds probably because it was outside of the wound he was assessing/measuring. MD-N stated typically if he can find a nurse or utilize an aide to assist with rounds but sometimes there is no one to assist so he has to make rounds by himself. MD-N stated Repositioning definitely should happen. MD-N stated he touches base with DON-B when he comes so he knows what patients to see but DON-B is not always available for follow-up. MD-N confirmed R4's current and accurate treatment ordered per his 3/28/22 note. The facility provided a closed electronic medical record paper copy of R4's 3/24/17 care plan that had been resolved and staff no longer had access to view/change. The facility provided a paper copy of R4's closed care plan which was no longer active (dated 3/24/17, revised 3/19/18) indicated Skin at risk for impairment due to immobility, incontinence which had interventions including: Assist and encourage resident to turn and reposition every one to two hours and PRN (3/24/17), Dietary Supplements as ordered (3/24/17), Educate resident on the risks of infection and poor healing related to non-compliance (3/24/17), Ensure adequate food and fluid intake (3/24/17), Monitor closely for sensory impairment (3/24/17), Monitor for adequate food and fluid intake (3/24/17), Monitor weights and labs (3/24/17), (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Notify MD of abnormal findings (3/24/17), Protect heels (3/24/17), Provide skin care after each incontinence episode (3/24/17), RD to assess and recommend (3/24/17), Skin Assessment Weekly (3/24/17), Use lift sheet to move patient (3/24/17). Daily diabetic foot check (4/18/19), Use absorbent Pads or briefs that wick and hold moisture (4/26/19), Use commercial moisture barrier (4/26/19) Quarterly Bradens and PRN (5/28/19), *Facility has not accessed [NAME] notes since February 2022. *Facility nurses are not staging or measuring, just describing so the facility is totally reliant on MD-N for staging and measurements. When MD-N is not available, wound care assessments can be delayed with potential for adverse outcomes. *Facility was not following current treatment orders. *Facility did not address repositioning in the resident's care plan or the CNA care card. Agency CNAs stated they did not know they needed to reposition her. Additionally, the facility did not always have the staff needed to reposition the resident assuming they knew she needed repositioning. The resident has not been out of bed and, during observations, remained flat on her back in bed. This resident on 2/14/22 developed three unstageable pressure injuries. These combined into one unstageable wound that is now 56 times larger in area than when first identified (2.02 square cm. vs. 160 square cm.). In addition, during 2 different wound care observations, R4 had developed two additional ischial wounds that were not addressed by the facility. 42037 2. R10 was admitted to the facility on [DATE] with diagnoses of Dementia, Diabetes Mellitus type 2, failure to thrive and encephalopathy. R10's Minimum Data Set (MDS) assessment dated [DATE] indicates Resident has a BIMS (Brief Interview of Mental Status) score of 00, indicating R10 is unable to participate in daily decision making. Resident requires extensive assistance of 1 staff with bed mobility, dressing, toileting, personal hygiene and bathing. The MDS indicates R10 is at risk for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/4/21, nurse progress notes indicate resident has an open area to the sacrum. No measurements or assessment of the open area to the sacrum were conducted on 12/4/21 or 12/5/21. On 12/6/21, R10 was initially seen by Wound MD-N. Wound is documented as: Unstageable sacrum full thickness, 5 x 2 x 0.2 cm, 30% necrotic tissue, 70% granulation tissue. A treatment was ordered for Xeroform gauze to the wound bed covered with foam dressing daily. On 12/13/21, R10 was seen by Wound MD-N. Wound is documented as: Unstageable sacrum full thickness, 4.5 x 2 x 0.2 cm, 30% slough tissue, 30% granulation tissue and 40% skin. Xeroform gauze dressing daily continued at this time. The wound was surgically debrided by Wound MD-N. On 12/20/21, R10 was seen by Wound MD-N. Wound is documented as: Unstageable sacrum full thickness, 4.5 x 2 x 0.2 cm, 30% slough tissue, 30% granulation tissue and 40% skin. Xeroform gauze dressing daily continued at this time. The wound was surgically debrided by Wound MD-N. On 12/27/21, R10 was seen by Wound MD-N. Wound is documented as: Unstageable sacrum full thickness, 9 x 6 x 0.2 cm, 30% slough tissue, 30% granulation tissue and 40% skin. Orders were initiated for a Calcium Alginate treatment with foam border dressing changed daily. The wound was surgically debrided by Wound MD-N. On 1/3/22, R10 was seen by Wound MD-N. Wound is documented as: Unstageable sacrum full thickness, 9 x 6 x 0.2 cm, 30% slough tissue, 50% granulation tissue and 20% skin. Treatment orders continued for Calcium Alginate treatment with foam border dressing changed daily. The wound was surgically debrided by Wound MD-N. On 1/10/22, R10 was seen by Wound MD-N. Wound is documented as: Unstageable sacrum full thickness, 8 x 4 x 0.2 cm, 30% slough tissue, 50% granulation tissue and 20% skin. Treatment orders continued for Calcium Alginate treatment with foam border dressing changed daily. The wound was surgically debrided by Wound MD-N. From 1/13/22 to 2/1/22, R10 was hospitalized due to Altered Mental status and hypoglycemia. On 2/1/22, R10 was seen by Wound MD-N via telemedicine visit. Wound is documented as: Unstageable sacrum full thickness, 7 x 8.3 x 0.2 cm, 100% slough tissue. Treatment order was initiated for Dakin's solution soaked gauze with foam border dressing changed daily. The sacrum was debrided at this time. Pressure injury to the left heel was documented as: unstageable necrosis, left heel 1 x 2 x 0.1 cm 90% slough tissue, 10% granulation. Treatment order continues for Xeroform gauze and border foam dressing daily. On 2/7/22, R10 was seen by Wound MD-N. Wound is documented as: Unstageable sacrum full thickness, 7 x 9 x 0.2 cm, 30% slough tissue, 50% granulation tissue and 20% skin. Treatment order was initiated for Santyl, a topical debriding ointment with foam border dressing changed daily. An additional pressure injury to the left heel was documented as: Stage 2, left heel 2.5 x 1.3 x UTD (unable to determine). Treatment order was initiated for Xeroform gauze and border foam dressing daily. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R10 was hospitalized [DATE]-[DATE] due to worsening of sacrum wound which required treatment with intravenous antibiotics due to infection. Surveyor did not identify any wound assessments conducted by facility or Wound MD-N from 3/14/22 to 3/31/22. Surveyor reviewed R10's TAR (Treatment Administration Record) from December 2021-March 2022. Surveyor could not identify any documented wound treatments on December 2021 TAR for 12/15/21, 12/17/21, 12/25/21, 12/25/21, 12/27/21. Surveyor could not identify any documented treatments on January 2022 TAR for 1/2/22, 1/5/22, 1/7/22, 1/10/22, and 1/12/22. Surveyor could not identify any documented treatments on February 2022 TAR for 2/1/22 or 2/2/22 for R10's sacrum. No documented treatments were noted for R10's Left heel pressure injury until 2/6/22. Surveyor could not identify any documented treatments on March 2022 TAR for sacrum or left heel pressure injuries. R10's skin integrity care plan indicates that R10 requires an alternating air mattress, repositioning every 2 hours and weekly skin assessments. On 3/28/22 at 9:20 AM, R10 was observed in bed in a hospital gown laying on back. R10 does not have an alternating air mattress in place on the bed. R10's heels are noted resting directly on the bed. On 3/28/22 at 12:20 PM, R10 was observed in bed in a hospital gown laying on R10's back. R10 does not have an alternating air mattress in place on the bed. R10's heels are noted resting directly on the bed. On 3/28/22 at 2:45 PM, R10 was observed in bed in a hospital gown laying on back. R10 does not have an alternating air mattress in place on their bed. R10's heels are noted resting directly on the bed. On 3/29/22 at 7:45 AM, R10 was observed in bed in a hospital gown laying on R10's back. R10 does not have an alternating air mattress in place on their bed. R10's heels are noted resting directly on the bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/4/22 at 8:30 AM, Surveyor conducted an interview with Wound MD-N. Wound MD-N recalls treating R10's pressure injury to the sacrum. Wound MD-N remembered seeing R10's sacrum and debriding the wound bed on multiple occasions. Wound MD-N reports only seeing R10's left heel pressure injury once or twice. Surveyor asked if Wound MD-N would expect residents who are at risk for pressure injuries to have their heels floated while in bed. Wound MD-N told Surveyor they would expect this as part of nursing care. Surveyor asked if Wound MD-N would expect residents who are at risk for pressure injuries be repositioned at least every 2 hours. Wound MD-N responded Yes. Surveyor asked if Wound MD-N would expect residents with unstageable pressure injuries to have an alternating air mattress in place on their bed. Wound MD-N responded, If the resident can use an air mattress safely and is dependent on staff for repositioning, I think they should have an air mattress. Surveyor asked Wound MD-N if they are not in the facility to conduct wound assessments whether or not the facility should assess wounds independently. Wound MD-N responded he would expect someone at the facility to assess and measure wounds if he is unavailable. On 4/4/22 at 11:00 AM, Surveyor conducted interview with Director of Nursing (DON)-B. Surveyor asked DON-B who is responsible for weekly wound assessments. DON-B said she had been acting as the facility's wound nurse but has gotten behind. Surveyor asked DON-B why the facility does not conduct their own wound assessments. DON-B responded they do not personally feel comfortable staging pressure injuries so Wound MD-N con [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 38829 Based on observations, record review and staff interviews, the facility did not ensure that 3 of 5 Residents (R16, R3, & R17) reviewed who were at risk for falls received the necessary services/interventions and supervision to prevent an injury from a fall. *R16 was admitted on [DATE] with a diagnosis of Huntington's Disease (exhibited with involuntary movements and impairment of voluntary movements, which can result in reduced manual dexterity, slurred speech, swallowing difficulties, problems with balance, and falls). R16's diagnosis (Interdisciplinary team noted R16 is very restless and is in constant state of movement) and R16's fall while hospitalized prior to admission put R16 at risk for falls. There was no fall assessment upon R16's admission into the facility on [DATE] and no falls care plan until after R16's first fall. R16 has had 12 falls since admission on 2/18/22 to 4/3/22. The fall on 3/27/22 (which was the second fall that day) resulted in stitches above the right eyebrow. The fall on 3/26/22 resulted in staples to the back of the head. The fall on 4/2/22 resulted in a re-opening of the staples. The fall on 4/3/22 led to a laceration on the resident's face that required steri-strips. R16's electronic medical record (EMR) does not contain documentation that an incident report and fall assessment including root cause analysis was completed for R16's falls. Per documentation, it is unclear what fall interventions were in place at the time of each fall. R16's care plan was updated after only 5 of the 12 falls that R16 had, and then it is not clear that new care plan interventions were always implemented. The facility was unable to provide documentation that Neuro checks and vitals, as well as physician notifications were completed with R16's falls. The facility did not contact R16's group home where R16 had previously lived to discuss R16's safety needs, until after Surveyor questioned the facility regarding R16's falls. The facility did not know R16 wore a soft helmet at the group home until the group home brought it to the facility. After review of nursing schedules with each of R16's falls, it is noted that based on census and 15 total Residents residing on the same unit as R16, there was an inadequate number of staff to provide supervision to R16 in order to prevent R16 from frequent falling. R16 is a high risk for falls and based on inadequate staffing, the facility did not provide adequate supervision and services to prevent R16 from frequent falling. The facility's failure to identify R16's risk factors for falls, its failure to comprehensively assess R16 by completing an initial fall risk assessment and developing a fall risk care plan with revisions for each fall, its failure to complete a root cause analysis of each fall, to complete a thorough assessment including Neuro checks after each fall, and its failure to update the physician with all falls, and to provide care, treatment, and supervision necessary to prevent accidents created a finding of Immediate Jeopardy. (continued on next page)

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Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy began on 2/18/22. Surveyor notified Nursing Home Administrator-(NHA-A) of the immediate jeopardy on 4/4/22 at 4:45 P.M. At the conclusion of the partial extended survey on 04/14/22, the immediate jeopardy had not yet been removed. Noncompliance that created a potential for more than minimal harm that is not immediate jeopardy was identified with R3 and R17. *On 3/20/22 R3 had a fall with injury and a fall assessment with a thorough root cause analysis, and Neuro checks was not completed. *On 3/29/22 R17 slid from the bed to the floor and no fall assessment with any root cause analysis was completed, including no documented vitals and Neuro checks being initiated, and no care plan update. Findings include: Surveyor reviewed the facility's Fall and Fall Risk, Managing policy and procedure revised March 2018 and noted the following: Policy Statement: 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. Policy Interpretation and Implementation: Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with input of the attending physician, will implement a Resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each Resident at risk or with a history of falls. 2. If a systematic evaluation of a Resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. 3. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. Monitoring Subsequent Falls and Fall Risk: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The staff will monitor and document each Resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed. 3. If the Resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue to change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. 1. R16 was admitted on [DATE] with diagnoses of Huntington's Disease, Unspecified Dementia, Schizophrenia, Bipolar, Psychotic Disorder with Delusions, Unspecified Intellectual Disabilities, and Dysphagia. R16 has a legal guardian. According to the Huntington's Disease (HD) Society of America, The movement disorder of HD includes emergence of involuntary movements and the impairment of voluntary movements, which result in reduced manual dexterity, slurred speech, swallowing difficulties, problems with balance, and falls. R16's Admission Minimum Data Set (MDS) dated [DATE] documents R16's short and long term memory is impaired and R16 demonstrates severely impaired skills for daily decision making. R16's PHQ-9 score done by staff is a 8, indicating mild depression. There are no behaviors documented on R16's MDS. R16 requires extensive assistance for bed mobility, and is total dependence of 2 staff for transfers. R16 requires total dependence for dressing, toileting, and bathing. R16 has both upper and lower bilateral range of motion impairment. R16 is always incontinent and requires tube feeding. Surveyor requested R16's hospital discharge summary and history and physical that facility would have reviewed for R16's admission to the facility. The facility was unable to provide this documentation. On 2/18/20 at 9:21 PM, it is documented that R16 was admitted to the facility at 3:00 PM. R16 was a hospital admission from group home. R16 fell at the hospital on 2/15/22 with negative CT scan of head. Bed in low position due to fall risk. Given that R16 fell in the hospital prior to admission on 2/15/22, and with R16's diagnosis of Huntington's Disease, this would have put R16 at risk for falls. Despite this, there was no fall risk assessment completed upon R16's admission into the facility on [DATE]. Surveyor reviewed R16's progress notes located in R16's EMR and notes the following falls: 2/26/22 1:57 PM CNA found R16 on floor on left side of bed with pillow under R16's head and half of body. Assessed movement of all extremities, obtained vital signs and performed skin check. R16 transferred in bed with assistance of CNA. Bed was placed in lowest position with pillows on both sides of R16 and mat placed on floor on side of bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No documented injury. Surveyor notes both physician and guardian were updated with the fall. Care Plan updated to place bed in lowest position, mat next to bed. Facility was unable to provide Neuro checks. The Facility unable to provide an incident report with statements, a fall assessment, or a root cause analysis of fall, including noting if bed was in low position at time of fall. Per nursing schedule provided by the facility, 1 nurse and 1 CNA were assigned to unit Surveyor notes R16's bed should have already been in low position based on admission note. 2/27/22 11:46 AM R16 found on floor on right side of bed with head lying against the bed in sitting position. Obtained vital signs, performed skin check, assessed for pain and movement of extremities. R16 transferred in bed with assistance of CNA. Bed was placed in lowest position. No documented injury. Surveyor notes both physician and guardian were updated with the fall. Care Plan updated to provide pillows for boundaries. Facility unable to provide Neuro checks. Facility unable to provide an incident report with statements, a fall assessment, and noting if R16's bed was in low position at time of fall. Root cause documented is that R16 is restless and or involuntary movements in bed with all current diagnoses, immediate intervention is to have therapy screen and social services to check on order from hospital for a hospice referral. Per nursing schedule provided by the facility, 1 nurse and 1 CNA assigned to unit. Surveyor notes R16's bed should have already been in low position based on admission note. Facility was unable to provide the therapy screen. Surveyor notes that social services did not follow up on a hospice referral. On 4/4/22 at 8:47 AM, Surveyor observed R16 in bed. Surveyor notes R16's bed was in low position, mat next to bed, and a mat between the wall and the bed. Bed placed next to wall. Surveyor notes there is no bolster or pillows around R16, as identified in the updated care for the 2/27/22 fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/28/22 8:45 AM R16 noted lying on mat on floor next to low bed, is alert and able to follow writer with eyes. Baseline is non-verbal. No outward signs/symptoms of pain or discomfort, no medial or internal rotation of lower extremity per normal and body check negative for injury and cran check negative. No documented injury. Surveyor notes both physician and guardian were updated with the fall. Care Plan updated with Neuro checks, attempt to relocate R16 to highly populated area for close staff supervision, physical therapy (PT) consult for strength and mobility, vital signs in first 24 hr. Facility unable to provide Neuro checks. Facility unable to provide an incident report with statements, a fall assessment including noting if pillows were in place at time of fall. Root cause documented is R16 is unable to remain comfortable. Immediate intervention was to add pillows and/or bolsters to assist in making comfortable. Surveyor notes this intervention of adding pillows was already documented as the intervention on 2/27/22. Per nursing schedule provided by facility, there was no CNA assigned to R16's unit. Surveyor validated this with Scheduler (SC-I) on 4/4/22 at 8:37 AM. Facility was unable to provide the physical therapy consult. 3/2/22 5:29 PM R16 seen lying on floor next to bed in fetal position. R16 appears to have rolled out of bed. Alert and oriented. Vitals taken. Assisted off of floor, 2 assist via Hoyer lift. Neuro check negative. No obvious injuries. Range of motion (ROM) within normal limits. Denies pain. No documented injury. Surveyor notes both physician and guardian were not updated with the fall. Care Plan updated to relocate R16 to room with roommate to allow increased socialization. Facility unable to provide Neuro checks. Facility unable to provide an incident report with statements, a fall assessment including noting if bed was in low position with pillows in place at time of fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Root cause was that R16 came from a group home and is in a private room. R16 unable to make needs known. Root cause is R16 is still anxious most likely due to change from group home to private room and med changes via hospital. Will move R16 to semi private room, attempted to have R16 out of bed in Broda chair, however, R16 did not like the chair as evidenced by R16 wiggling to get out chair. Will continue to have therapy evaluation, will continue other interventions. Surveyor notes observations of R16 during the survey process to be in a room by R16's self with no roommate for socialization and R16 was gotten up in Broda chair and would frequently move around in the Broda chair. Per nursing schedule provided by the facility, 1 nurse and 1 CNA assigned to unit. Surveyor was not provided a therapy evaluation by the facility. On 3/4/22, Social Worker (SW-C) documents that R16's guardian has requested R16 to be seen by psychiatric services. Facility was unable to provide documentation this had been done. 3/8/22 10:30 AM Unwitnessed fall. Observed R16 lying on floor left side prone positioned. No skin breakdown, no raised areas on head. Neuro checks negative. Assist with Hoyer and 2 CNAs from floor back into bed. No signs/symptoms internal or external rotation of legs. No documented injury. Surveyor notes physician was updated with the fall, guardian was not updated. Care Plan updated to update MD to follow up medication review and schedule neurology follow-up. Facility unable to provide Neuro checks. Facility unable to provide an incident report with statements, a fall assessment, a root cause analysis of the fall including noting if bed was in low position with pillows in place at time of fall. Per nursing schedule provided by the facility, 1 nurse and 1 CNA assigned to unit Surveyor notes facility was unable to provide a documented medication review or neurology follow-up. 3/21/22 1:00 AM R16 lying on floor, g tube out, called ambulance to transport R16 to emergency room (ER). R16 tried to walk and fell out of bed. R16 is no longer ambulatory due to R16's disease. CT scan negative, abrasion to left side of forehead. Surveyor notes both physician and guardian were not updated with the fall. No Care Plan revision for fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Neuro checks provided by facility are incomplete. Facility unable to provide an incident report with statements, a fall assessment, a root cause analysis of the fall including noting if bed was in low position with pillows in place at time of fall. Per nursing schedule provided by facility, 1 CNA was assigned to R16's unit and 2 nurses for all Residents residing in facility. 3/22/22 Interdisciplinary Team (IDT) met to review fall. R16 does not communicate well and is very restless and is in constant state of movement. Previous intervention in place, bed in low position, mat on floor, R16 receiving medications as ordered. Tried assisting R16 to chair and R16 immediately began to slide out of chair. Assist bars on bed, will remove to prevent injury. Care Plan updated. Surveyor notes R16's fall care plan was not updated. 3/26/22 8:29 PM R16 found on floor in doorway lying on R16's back with blood on mat. Performed skin check, obtained vital signs and assessed for pain. R16 transferred in bed with assistance of CNA. Laceration to back of head noted, area cleansed and dressing applied. R16 sent to ER and received four staples to occipital area. Surveyor notes both physician and guardian were updated with the fall. No Care Plan revision for fall. Neuro checks provided by facility are incomplete. Facility unable to provide an incident report with statements, a fall assessment, a root cause analysis of the fall including noting if bed was in low position with pillows in place at time of fall. Per nursing schedule provided by facility, there was no CNA assigned to R16's unit, and only 3 CNAs for all Residents residing in facility. 3/27/22 11:30 AM R16 lying on floor next to bed prone position. Denies hitting head. No active bleeding. No skin breakdown present, able to move four extremities well. No internal or external rotation of lower legs. Transferred back to bed via staff. No documented injury. Surveyor notes both physician and guardian were not updated with the fall. No Care Plan revision for fall. Neuro checks provided by facility are incomplete. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility unable to provide an incident report with statements, a fall assessment, a root cause analysis of the fall including noting if bed was in low position with mat next to bed with pillows in place at time of fall. Per nursing schedule provided by facility, there was no CNA assigned to R16's unit and only 3 CNAs for all Residents residing in facility Per documentation, Nurse Practitioner (NP) was contacted at 1:40 PM concerning R16's being agitated and restless. Order to discontinue Haldol 10 mg and increased to start Haldol 20 mg 3 times a day. It is documented at 2:22 PM that Haldol 20 mg is outside the recommended dose for this drug. The Haldol also triggered a possible drug interaction with Tramadol HCl 50 mg which increases risk of seizures when co-administered. Surveyor reviewed R16's medication administration record (MAR) for March and notes on 3/27/22 R16 received Haldol 10 mg at 8AM and 12 PM, and received Tramadol HCl 50 mg. 3/27/22 9:53 PM R16 observed in hallway on knees. Staff tried to help R16 and R16 laid on floor and started to roll around and hit R16's face yelling that R16 wanted cake. Staff tried to calm R16 down as R16's body continued to jerk and roll around on the floor. 911 was called and transported R16 to ER. R16 received stitches to right eyebrow laceration. X-ray of left humerus demonstrated a subtle lucency in the proximal to mid humerus. It is important that R16 follows up with DR regarding this. Surveyor notes both physician and guardian were not updated with the fall. No Care Plan revision for fall. Neuro checks provided by facility are incomplete. Facility unable to provide an incident report with statements, a fall assessment, a root cause analysis of fall. Per nursing schedule provided by facility, there were only 3 CNAs for all Residents residing in facility. Surveyor requested and facility was unable to provide documentation that R16 had follow-up on humerus. 3/29/22 8:25 PM On 3/29/22 at 8:25 AM, Surveyor heard screaming from the conference room. Surveyor went to investigate and observed R16 in the hallway outside R16's door on R16's knees and yelling. Surveyor observed Admissions (AD-G) who is a CNA pick R16 up and place R16 in Broda chair, without first having a nurse assess R16. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/29/22 at 10:20 AM, Surveyor observed R16 in Broda chair, alone in room, sleeping. Broda chair was leaned back, footrest fully extended up. Pillow on left side of R16. Pillow behind head. Gripper socks on. On 3/31/22 at 8:15 AM, Surveyor observed R16 in Broda chair by nurse's station. The Nurse was down the hallway administering medication within eyesight of R16. Surveyor notes above R16's right eye is still swollen. The Broda chair is slightly reclined. R16 has black non-skid shoes on. Surveyor was approached by Licensed Practical Nurse (LPN-J) who stated to Surveyor, Thanks for staying with her, I can't watch her, I have med pass. At 8:21 AM, Dietary Manager came to get R16 in order to obtain a weight. On 3/31/22 at 2:05 PM, Surveyor interviewed SW-C in regard to R16. SW-C confirmed that R16 has not been evaluated by psychiatric services. SW-C informed Surveyor that SW-C did not follow-up on a hospice referral. SW-C also informed Surveyor that SW-C did not call R16's group home to obtain information in regard to R16's daily routine including physical set up of environment, R16's behaviors, and R16's safety needs. SW-C stated that SW-C firmly believes R16's falls are related to R16 needing help and R16 has intent when attempting to get out bed. SW-C stated that on 3/29/22 when R16 was in the hallway, R16 was yelling I need help. 4/2/22 7:00 PM On 4/2/22 at 7:00 PM, it is documented that R16 was at nurses station during tube feeding sitting in Broda chair. R16 stood up from Broda chair yelling I want cake, I want cake, I want to eat like them as evening supper was brought to the unit, and R16 fell to floor hitting R16's head, re-opening 4 staples located to back of head. R16 began to have seizure activity. 911 was called and transported to ER. On 4/3/22 at 6:58 AM, it is documented that R16 was refusing to sit down or lay in bed and got out bed and chair several times, hard to redirect, asking for cake. (Cross reference F692. Dietitian had asked for a speech therapy evaluation to determine if R16 could swallow, but this was never done.) 4/3/22 9:02 AM On 4/3/22 at 9:02 AM, R16 got up from Broda chair went down to floor on hands and knees repeatedly hitting R16's face/head on the floor yelling, Give me cake, I want some cake. R16 obtained a laceration on R16's left cheek bone, 3cm x 1cm. Bleeding controlled and applied steri strips. On 4/3/22 at 12:35 PM, R16 is observed by staff banging head onto ground after being told R16 could not have cake. R16 then took helmet off and repeatedly banged head onto ground re-opening an injury above R16's right eye. R16 sent out to ER. On 4/4/22 at 8:47 AM, Surveyor observed R16 in bed with a pink soft helmet on. Bed is low position, mat next to bed, no pillows around R16 as per the 2/27/22 care plan intervention. No prevalon boots on. Surveyor observed dry smeared blood on the wall next to bed. Certified Nursing Assistant (CNA-K) sitting in chair in R16's room. CNA-K explained that CNA-K is 1:1 to R16. CNA-K explained that R16 has a 1:1 because Surveyors are in the building. Surveyor asked CNA-K about R16's helmet. CNA-K stated CNA-K was informed by SW-C that the helmet came from the group home (after Surveyor interviewed SW-C on 3/31/22) and R16 is to wear it all times. CNA-K stated R16 likes to wear the helmet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/4/22 at 4:45 PM, NHA-A was informed that facility failed to comprehensively assess R16 on admission as being a high fall risk including not completing a root cause analysis of each of R16's falls including interventions in place at the time of each fall. The facility was unable to provide documentation that Neuro checks and vitals, as well as physician notifications were completed with R16's falls. Surveyor requested the facility's neuro check policy and procedure from Administrator (NHA-A) and was not provided the policy. After review of nursing schedules with each of R16's falls, it is noted that based on census and 15 total Residents residing on the same unit as R16, there was inadequate amount of staff to provide supervision to R16 in order to prevent R16 from frequent falling. R16 is a high risk for falls and based on inadequate staffing, the facility did not provide adequate supervision and services to prevent R16 from frequent falling. These facility's failure to identify R16's risk factors for falls and to comprehensively assess R16's fall risk on admission, to contact R16's group home to discuss safety needs and the facility not being aware of R16 wearing a soft helmet at the group home, to complete a root cause analysis and assessments of R16's falls, to not always update R16's care plan with safety interventions, and to provide the staffing supervision necessary to prevent falls from occurring created a reasonable likelihood for serious harm, which resulted in a finding of immediate Jeopardy. The facility's Immediated Jeopardy was not removed at the time of the partial extended survey exit on 4/14/22. Further noncompliance is evidenced by: 2. R3 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Encephalopathy, Bipolar, Cognitive Communication Deficit, Unspecified Dementia, Major Depressive Disorder, and Transient Cerebral Ischemic Attack. R3 has an activated Health Care Power of Attorney (HCPOA). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview for Mental Status (BIMS) score to be 5, indicating R3 demonstrates severely impaired skills for daily decision making. R3's Patient Health Questionnaire (PHQ-9) score is 8, indicating R3 has mild depression. R3 requires extensive assistance with bed mobility, locomotion on/off the unit, and transfers. R3 is not steady with balance during transitions and walking. Surveyor reviewed R3's comprehensive care plan and noted the following: 1. R3 is at risk for elopement due to cognitive deficits secondary to dementia and exit seeking behavior-initiated 8/25/20. 2. R3 displays behavioral symptoms related to paranoia and are manifested by feeling people are talking about her and being afraid to sleep at night, paranoid that R3 won't wake up-initiated 10/28/20. 3. R3 is at high risk for falls secondary to functional deficits, dementia and history of falls-initiated 8/25/20 with revision 10/25/21. All interventions are dated 9/25/20 other than 2 revisions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Fall 8/30/21-Encourage R3 to participate as tolerated in activities during day that promote rest at bedtime. 10/4/21-Psych assessment with medication change. Surveyor was unable to locate any fall risk assessment in R3's EMR. Surveyor notes per incident report, R3 had a witnessed fall on 3/12/22 where R3 slipped in the hallway, hitting R3's chin on the floor. Documentation in R3's progress notes located in R3's electronic medical record (EMR) dated 3/14/22 stated the root cause of R3's fall was R3 was combative during redirection and lost balance and fell hitting R3's face. On 3/14/22, the nurse practitioner (NP) evaluated R3. R3's chin is severely bruised, edematous. NP recommended emergency room (ED) evaluation secondary to concerns for fracture if R3 fell directly on R3's chin. On 3/14/22, R3 went to the hospital for a CT scan of the head. The hospital record dated 3/14/22 documents R3 arrived for an unwitnessed fall that happened yesterday, staff unaware of what time. Swelling and bruising noted to jaw area. Emergency Medical Services (EMS) noted abscess to inner lower lip. On 3/30/22 at 10:45 AM, Surveyor interviewed Director of Nursing (DON-B) in regard to the incident. DON-B shared DON-B had worked that weekend and noted R3's left side of R3's jaw/chin area was bruised and swollen. DON-B asked questions of staff, but no one had answers. DON-B stated, DON-B was finally informed that R3 had slipped and fell and the staff member probably went to grab her. R3's bible was found outside of the west doorway. Surveyor notes that R3's fall risk care plan was not updated after the 3/12/22 fall. Surveyor also notes that non-pharmacological interventions were not in place at time of the fall. The 3/12/22 incident report does not document what interventions were in place at the time. On 3/31/22 at 3:05 PM, Surveyor shared with NHA-A the concern that R3's 3/12/22 had not been comprehensively assessed and R3's care plan did not contain any revisions related to the fall. No further information was provided at this time. 3. R17 was admitted on [DATE] with diagnoses of Major Depressive Disorder, Cerebral Infarction, End Stage Renal Disease, Metabolic Encephalopathy, Coagulation Defect, Bells Palsy, Type 2 Diabetes Mellitus, and Fibromyalgia. R17 is her own person. R17's last documented MDS dated [DATE] documents R17 has a BIMS (Brief Interview for Mental Status) of 15 indicating R17 is cognitively intact for daily decision making. R17's PHQ-9 score is 3, indicating minimal depression. R17 requires extensive assistance with bed mobility, transfers, dressing, and toileting. R17 is not steady with balance during transitions and walking. R17 has range of motion (ROM) impairment on 1 upper extremity and bilateral lower extremities. Surveyor notes there is no completed admission MDS for this recent admission from 3/7/22. Surveyor was unable to locate a fall risk assessment for R17. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R17's comprehensive care plan and notes R17 had an actual fall on 3/10/22 with no injury. The following interventions were put into place on 3/10/22: 1. Check range of motion 2. Continue interventions on the at-risk plan 3. For no apparent acute injury, determine and address causative factors for the fall 4. Re-educate on use of call light and safety precautions On 3/30/22 at 10:20 AM, Surveyor spoke with R17 in regard to an allegation that R17 slid from bed to the floor on 3/29/22 at approximately 10:40 AM. R17 stated that R17 did slide off the bed to the floor. R17 stated that R17 had been reaching for R17's cell phone to call 911 to get help when R17 slid off the bed. R17 stated that a nurse was informed by a visitor R17 was on the floor. The nurse placed R17 back into bed and completed vitals. Surveyor noted there is no fall assessment with any root cause analysis completed. There is no documentation of the vitals, Neuro checks, notification to physician, assessment, or incident report in R17's EMR of the incident. On 3/30/22 at 3:05 PM, Surveyor informed NHA-A of the concern that there is no documentation that R17 had slid from bed to the floor, with no comprehensive fall assessment with a root cause analysis completed and care plan update. No further information was provided at this time.

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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** 41439 Based on observation and record review, the facility did not provide catheter care according to the Resident's physician orders, care plan and according to professional standards of practice for 2 of 2 (R2, R10) residents reviewed with catheters. * The facility did not provide Foley Catheter Care according to physician's orders and according to R2's care plan. The Facility did not provide Foley Catheter Care every shift, did not empty the Foley Catheter bag ever shift, did not monitor output, and did not Flush the Foley Catheter with 100 ml normal saline every day. * On 3/28/22 at 9:20 AM, 12:20 PM and 2:45 PM and on 3/29/22 at 7:45 AM, R10 was observed in bed in a hospital gown laying on their back. R10's catheter bag was noted lying directly on the floor next to their bed without a privacy cover. Standards of Practice care instruction for an Indwelling Catheter indicate catheter bags should not be put on the floor. Throughout these observations R10's catheter bag contains approximately 400 cc's to 925cc's of urine. Findings include: 1. R2 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, Osteoarthritis, and Foley catheter due to neuromuscular dysfunction of the bladder. R2's Quarterly 12/29/21 MDS (Minimum Data Set) indicated R2 was cognitively intact and required extensive assistance with 2 staff for bed mobility, transfer, and dressing. R2's MDS indicated an indwelling urinary catheter. R2's Physician orders indicated on: 7/6/21 Foley Catheter Care every shift. 12/22/21 Flush Foley Catheter with 100 ml normal saline every day. R2's Care Plan Urinary/Foley: R2 utilizes an indwelling Foley catheter for neuromuscular dysfunction of bladder, staff monitors signs/symptoms of UTI (Urinary Tract Infection), CNAs' (Certified Nursing Assistant) perform cath care every shift, initiated 7/10/21. Interventions included Empty Foley bag every shift and as needed, Keep drainage bag lower than level of bladder, initiated 7/10/21. R2's CNA Care card, dated 3/28/22 indicated keep drainage bag lower than level of bladder. R2's CNA Care card did not indicate catheter care to be done every shift or emptying of the Foley bag every shift. On 3/28/22, at 10:06 AM, Surveyor observed R2 lying in the bed with a Foley and R2 who stated going through hell as supposed to get showers, in bed 24 hours/day, no one to get me up, no Foley care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/22, at 12:50 PM, Surveyor interviewed CNA-R working on R2's unit who stated she was from agency and the facility just put us here with no guidance, no nurse, no way to chart except through others login, and no care cards. On 3/28/22, at 12:55 PM, Surveyor interviewed CNA-S working on R2's unit who stated she was from agency and has come here before so we know the residents a little bit but there is no nurse today to check and confirm care. On 3/29/22, at 5:00 AM, Surveyor interviewed LPN-P who stated she is working 3 units (North, East, Vent) with 3 CNAs on Vent, Rehab, [NAME] units and care is not provided, rounds are not done, too hard to do it as staffing is horrible. LPN-P stated there are no care plans so the CNAs know what to do and how to transfer. LPN-P stated no charting by CNAs in the record so the nurses are unable to check care provided or not. Surveyor reviewed R2's task records for the last 30 days and noted CNA documentation for urinary output by emptying Foley bag every shift was documented 3/2/22 on one shift, 3/3/22 on 2 shifts, 3/4/22 on 2 shifts, 3/5/22 on 2 shifts, and 3/7/22 on one shift. Facility did not monitor output or have documentation of the emptying of R2's catheter bag. Surveyor reviewed R2's task records for the last 30 days and noted CNA documentation for catheter care every shift was documented 3/1/22 on one shift, 3/2/22 on one shift, 3/3/22 on 2 shifts, 3/4/22 on 2 shifts, 3/5/22 on 2 shifts, 3/6/22 on 2 shifts, 3/7/22 on 1 shift, and 3/8/22 R2 refusal. Surveyor reviewed R2's March MAR (Medication Administration Record)/TAR (Treatment Administration Record) which indicated nurses initialed almost every shift in March on the 7/6/21 Physician order for Foley Catheter Care every shift despite the lack of documentation in the CNA task record, interviews with nurses and CNAs that the rounds and care were not being provided and facility indication that CNAs provided catheter care. Surveyor reviewed R2's March MAR and noted there were no initials and no documentation of the 12/22/21 Physician order to Flush Foley Catheter with 100 ml normal saline every day. The order was transcribed to the MAR but no time was designated for the daily flush and it was not completed. On 3/29/22, at 1:30 PM, Surveyor shared concerns regarding catheter care with NHA-A. On 3/30/22, at 3:15 PM, Surveyor reviewed the lack of R2's catheter care and output documentation with NHA-A. No further information was provided. 42037 2. R10 was admitted to the facility on [DATE] with diagnoses of Dementia, Diabetes Mellitus type 2, failure to thrive and encephalopathy. R10's Minimum Data Set (MDS) assessment dated [DATE] indicates R10 has a BIMS (Brief Interview of Mental Status) score of 00, indicating R10 is unable to participate in daily decision making. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's care plan indicates that R10 requires daily assistance with ADLS (Activities of Daily Living). R10 requires extensive assistance of 1 staff with bed mobility, dressing, toileting, personal hygiene and bathing. R10 has limited range of motion to bilateral lower extremities. R10 has a urinary catheter in place. On 3/28/22 at 9:20 AM, R10 was observed in bed in a hospital gown laying on their back. R10's catheter bag is noted lying directly on the floor next to their bed without a privacy cover. R10's catheter bag contains approximately 400 cc's of urine at this time. On 3/28/22 at 12:20 PM, R10 was observed in bed in a hospital gown laying on their back. R10's catheter bag is noted lying directly on the floor next to their bed without a privacy cover. R10's catheter bag contains approximately 550 cc's of urine at this time. On 3/28/22 at 2:45 PM, R10 was observed in bed in a hospital gown laying on their back. R10's catheter bag is noted lying directly on the floor next to their bed without a privacy cover. R10's catheter bag contains approximately 925 cc's of urine at this time. On 3/29/22 at 7:45 AM, R10 was observed in bed in a hospital gown laying on their back. R10's catheter bag is noted lying directly on the floor next to their bed without a privacy cover. R10's catheter bag contains approximately 450 cc's of urine at this time. On 3/31/22 at 3:30 PM Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. No additional information was provided to Surveyor at this time.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interviews, the facility did not always ensure that 2 of 2 Residents (R16 and R9) reviewed for weight loss and overall general decline in condition received care and treatment based on a comprehensive assessment and in accordance with professional standards of practice, particularly assessment, diagnosis and coordination of care. R16 was admitted to the facility on [DATE]. No comprehensive assessment was completed regarding R16's tube feeding history, reason for use, or evaluation to determine if R16 was a candidate for oral intake. On admission, the facility obtained a weight of 89.2 pounds. There is no documentation of how the weight was obtained. On 3/20/22 the Registered Dietitian (RD-D) documented R16's weight to be 82.2 pounds, a 7.9% unplanned weight loss in 30 days. There is no documentation of how the weight was obtained. There is no documentation R16's physician (DR-H) was notified of the significant weight loss. RD-D recommended to increase the tube feeding and water flushes. R16's tube feeding was not increased until 3/25/22, 5 days after the recommendation. The facility did not follow up on RD-D's 3/20/22 recommendation to increase water flushes as the Medication Administration Record and physician's order continued to reflect 100 ml 4 times a day (400ml). Upon returning to the facility after an emergency room visit on 4/1/22 the water flushes were increased. On 2/18/22, the physician ordered Speech Therapy (ST) screen, evaluate and treat. The facility did not follow through with this order. On 3/25/22, RD-D recommended a speech therapy evaluation and diet evaluation for R16. There is no documentation the ST referral and evaluation was completed. On 4/3/22, RD-D indicates R16 is requesting to eat orally and again documents ST consult ordered and recommend ST evaluate swallow. The physician's order for ST from 2/28/22 has still not been followed through on. On 3/31/22, in the morning, the dietary manager attempted to weigh R16 in the broda chair, but the scale was broken. In the evening of 3/31/22, R16's weight was obtained. RD-D documents R16's weight has declined to 72.6 pounds, an 18.6% weight loss since admission. There is no documentation of how the weight was obtained. RD-D describes the weight as severely underweight and life-threatening. On 3/31/22, RD-D contacted the Nursing Home Administrator and recommended R16 be transferred to the hospital STAT. R16 was sent to the emergency room (ER) and returned to the facility on [DATE]. RD-D recommended another tube feeding change to increase the amount of calories and water R16 should receive. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/2/22, R16 was placed at nurse's station during tube feeding time, stood up, and yelled repeatedly R16 wanted cake after observing other Residents eating meals on the unit. R16 then repeatedly hit R16's face and head on floor, while yelling that R16 wanted cake, obtaining a laceration to left cheek bone. On 4/3/22, RD-D documents R16 is requesting to eat orally and again recommends a ST evaluation for swallowing with diet texture. Per Social Worker (SW-C) R16 was able to obtain 2 cups of water and drank both of them. Social Worker (SW-C) took the water from R16 as R16 stated R16 was thirsty and wanted more water. SW-C documented SW-C would follow-up on a ST evaluation. On 4/3/22, R16 again is observed to bang R16's head onto the ground after being told R16 could not have cake. R16 re-opened the injury above R16's right eye and was transported to the emergency room (ER). The facility's failure to comprehensively assess R16's nutritional status upon admission, failure to complete and obtain a speech therapy evaluation, failure to obtain a swallow study, failure to monitor R16's weights in a consistent manner, and a repeated, systemic failure to assess and address R16's nutritional status and to implement pertinent interventions based on such an assessment resulted in continued and severe weight loss that created a finding of Immediate Jeopardy. The Immediate Jeopardy began on 2/18/22. Surveyor notified Nursing Home Administrator- A of the Immediate Jeopardy on 4/4/22 at 4:45 P.M. At the time of the facility exit on 4/14/22, the Immediate Jeopardy has not yet been removed. Noncompliance was also found at a severity level of potential for more than minimal harm that is not immediate jeopardy, as evidenced by: * R9 experienced a significant weight loss of 35.4 pounds (29.8%) from 11/15/21 to 1/31/22 without any compressive assessment or dietary intervention. R9 continued to lose weight and on 2/3/22, the Dietician requested that a dietary supplement be added to R9's daily oral intake twice a day and that R9 be weighed in a consistent method. The facility did not fill the order for the dietary supplement until 2/22/22 and continued to use various methods to weigh R9, which could cause an inadequate weight to be documented. This is evidenced by: Surveyor reviewed the facility's Enteral Nutrition policy and procedure revised November 2018 and noted the following: Policy Statement Adequate nutritional support through enteral nutrition is provided to Residents as ordered. Policy Interpretation and Implementation (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The IDT (Interdisciplinary Team), including the dietitian, conducts a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings. The assessment includes: a. Evaluation of the Resident's current clinical and nutritional status b. Relevant functional and psychosocial factors c. A review of interventions to maintain oral intake prior to the use of a feeding tube and the Resident's response to them . 6. If the Resident has a feeding tube place prior to admission, the provider and the IDT will review the rationale for the placement of the feeding tube, the Resident's current clinical and nutritional status, and the treatment goals and wishes of the Resident . 8. The dietitian monitors Residents who are receiving enteral nutrition, and make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. 9. The nursing staff and provider monitor the Resident for signs and symptoms of inadequate nutrition, altered hydration. The nursing staff and provider also monitor the Resident for worsening of conditions that place the Resident at risk for the above. Surveyor reviewed the facility's Nutritional Assessment policy and procedure revised October 2017 and noted the following: Policy Statement As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each Resident. Policy Interpretation and Implementation 1. The dietitian in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each Resident upon admission and as indicated by a change in condition that places the Resident at risk for impaired nutrition. 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the Resident at risk for or with impaired nutrition. Surveyor reviewed the facility's Weight Assessment and Intervention policy and procedure revised September 2008 and noted the following applicable: Policy Statement The IDT will strive to prevent, monitor, and intervene for undesirable weight loss for our Residents. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy Interpretation and Implementation Weight Assessment 1. The nursing staff will measure Resident weights on admission, the next day, and weekly for 2 weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 2. Weights will be recorded in each unit's Weight Record chart. 3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 4. The Dietitian will respond within 24 hors of receipt of written notification. 6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month-5% weight loss is significant; greater than 5% is severe b. 3 months-7.5% weight loss is significant; greater than 7.5% is severe c. 6 months-10% weight loss is significant; greater than 10% is severe Care Planning 1. Care planning for weight loss or impaired nutrition will be a IDT effort and will include the physician, nursing staff, dietitian, consultant pharmacist, and the Resident or Resident's legal surrogate. 2. Individualized care plans shall address, to the extent possible: a. The identified causes of weight loss b. Goals and benchmarks for improvement c. Time frames and parameters for monitoring and reassessment 1. R16 was admitted on [DATE] with diagnoses of Huntington's Disease, Unspecified Dementia, Schizophrenia, Bipolar, Psychotic Disorder with Delusions, Unspecified Intellectual Disabilities, and Dysphagia. R16 has a legal guardian. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the Nutritional management of individuals with Huntington's disease; nutritional guidelines, There is a high risk of rapid weight loss for many individuals [with Huntington's disease] .Rapid weight loss can result in loss of muscle mass, weakness, apathy, depression, susceptibility to infection and compromised chest status .The risks may change during the progression of the condition but both unmanaged weight loss or weight gain will be problematic. For this reason weight should be carefully managed . https://www.futuremedicine.com/doi/10.2217/nmt.11.69 R16's Admission MDS (Minimum Data Set) dated 2/25/22 documents R16's short and long term memory is impaired and R16 demonstrates severely impaired skills for daily decision making. R16's PHQ-9 score done by staff is an 8, indicating mild depression. There are no behaviors documented on R16's MDS. R16 is extensive assistance for bed mobility. R16 requires total dependence of 2 staff for transfers. R16 is total dependence for dressing, toileting, and bathing. R16 has both upper and lower bilateral range of motion impairment. R16 is always incontinent and requires tube feeding. Surveyor requested R16's hospital discharge summary and history and physical that the facility would have reviewed prior to R16's admission to the facility. The facility was unable to provide this documentation. Surveyor notes there is no documentation of the history of R16's G-tube placement and reason for use. Surveyor was not able to locate an admission tube feeding or nutritional assessment in R16's EMR, and the facility was not able to provide documentation of both assessments. Surveyor reviewed R16's comprehensive care plan and notes R16 requires tube feeding due to Dysphagia, chewing problems, Huntington's Disease, Dementia, Severe protein-calorie malnutrition, very low BMI, skin impairment, weight loss since admission.-initiated 2/20/22 and revised 3/20/22 On 2/18/22, R16's admission summary refers to R16 tube feeding being Osmolite 1.5 300 ml 4 times a day via gravity with NPO (nothing by mouth) status. Water flush 100 ml 4 times a day (400 ml per day). Surveyor notes that the facility obtained R16's admission weight on 2/18/22 of 89.2 pounds and 3/18/22 of 82.2 pounds and recorded those weights in R16's EMR. On 3/24/22, the dietary manager weighed R16 and R16's weight was 84.2 pounds There is no documentation of how R16's weights were obtained. Surveyor notes that the facility did not obtain R16's weights weekly 1 time a week for 4 weeks after admission based on standards of practice. Surveyor notes that R16's physician has an order dated 2/18/22 (day of admission) for R16 to have a ST screen, evaluate, and treat on admission and as indicated. On 3/20/22 the Registered Dietitian (RD-D) documented R16's weight to be 82.2 pounds, a 7.9% unplanned weight loss in 30 days. There is no documentation of how the weight was obtained. There is no documentation R16's physician (DR-H) was notified of the significant weight loss. RD-D recommended to increase the tube feeding and water flushes is warranted to prevent any further weight loss and support weight gain. RD-D recommendations: Osmolite 1.5-360 ml-5 times a day. Provides 2700 calories, 1772 ml water, and 113 g protein. Recommend additional water flushes per physician. Recommend check CBC, complete metabolic profile, phosphorous, and magnesium as soon as possible. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R16's tube feeding was not increased until 3/25/22, 5 days after the recommendation. On 3/21/22, SW-C documented SW-C received email from RD-D requesting tube feeding change. SW-C presented this to the Interdisciplinary team (IDT). On 3/22/22, SW-C documented SW-C received email from RD-D stating RD-D did not see updates and orders per recommendations. SW-C presented this to the IDT. On 3/23/22, SW-C documented SW-C received email from RD-D stating R16's orders and recommendations has not been done. SW-C presented this issue in clinical. On 3/23/22 at 6:23 PM, RD-D documents that nursing was notified of R16's weight loss and new tube feed recommendations/lab requests. No changes in tube feeding order yet. No labs scanned in EMR to assess. RD-D informed, SW-C, and NHA-A regarding R16's significant weight loss and new tube feeding recommendations. On 3/24/22, SW-C documents that R16's tube feeding orders were still not completed. On 3/25/22 at 10:35 AM, RD-D documents that tube feeding has not yet been increased and contacted SW-C. RD-D requested a weight check. Per SW-C, goal is to introduce oral feeding with R16. RD-D recommended ST evaluation and diet per ST recommendations. At 2:48 PM, RD-D documents that R16's weight is 84.2 pounds, but there is no documentation of how that weight was obtained and was not documented in R16's EMR. RD-D again documents that ST is consulted to assess swallow and diet. Surveyor reviewed R16's current physician orders as of 3/31/22 and notes R16's new tube feeding order recommended by RD-D had a start date of 3/25/22. Water flush as of 2/18/22 was for 100 ml four times a day. Surveyor notes this is a discrepancy from RD-D recommendation to increase water flushes on 3/20/22. Surveyor reviewed R16's Medication Administration Record (MAR) and notes the same order as on the physician's orders (100ml 4 times a day). On 3/27/22 at 9:53 PM, it is documented that R16 was observed in the hallway on R16's knees and started to roll around and R16's face on the floor yelling that R16 wanted some cake. On 3/30/22 at 8:21 AM, RD-D documents that RD-D is unable to review labs due to not being scanned into R16's EMR. RD-D requested weight check today and 2 times weekly is recommended. Requested labs be scanned into R16's EMR. On 3/31/22 at 12:22 PM, RD-D requested R16's weight be obtained. On 3/31/22 at 3:30 PM, it is documented that R16's weight was 72.6 pounds via standing independently with 2 staff assist. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/31/22 at 8:43, RD-D documents that R16's weight has declined to 72.6 pounds, 18.6% (or 16.6 pound) weight loss since admission on 2/18/22 (in 42 days) and R16 is severely underweight and life-threatening. RD-D contacted NHA-A and recommended R16 be transferred to the hospital STAT. On 4/1/22 at 7:44 AM, RD-D noted R16 returned from the hospital. RD-D recommended tube feeding be changed to 2 CAL HN-360 mL-5 times daily. Increase water flushes to 180 mL-4 times a day. Provides 3600 calories, 150 g protein and 1980 mL water. On 4/1/22 at 1:13 PM, nursing documents the new order for enteral feeding and flush for R16. On 4/2/22 at 8:15 AM, RD-D documents NHA-A informed RD-D of R16's weight on 4/1/22 was 85 pounds which has not been entered into R16's EMR. Surveyor notes there is no documentation of where or how R16's weight was obtained. RD-D emailed recommendations to SW-C, NHA-A, and Director of Nursing (DON-B) for weights to be obtained on Monday and Friday and to administer medications with scheduled 180 mL water flush. RD-D had attempted to reach the nurse's station 3 times to communicate the recommendations On 4/2/22 at 2:15 PM, it is documented that R16's weight was 81.0 pounds. Surveyor notes there is no documentation of how R16's weight was obtained. On 4/2/22 at 7:00 PM, it is documented that R16 was at nurses station during tube feeding sitting in broda chair. R16 stood up from broda chair yelling I want cake, I want cake, I want to eat like them as evening supper was brought to the unit, and R16 fell to floor hitting R16's head, re-opening 4 staples located to back of head. R16 began to have seizure activity. 911 was called and transported to ER. On 4/3/22 at 6:58 AM, it is documented that R16 was refusing to sit down or lay in bed and got out bed and chair several times, hard to redirect, asking for cake. On 4/3/22 at 9:02 AM, R16 got up from broda chair down to floor on hands and knees repeatedly hitting R16's face/head on the floor yelling, Give me cake, I want some cake. R16 obtained a laceration on R16's left cheek bone, 3cm x 1cm. Bleeding controlled and applied steri strips. On 4/3/22 at 9:23 AM, RD-D documents that R16 is requesting to eat orally. ST consult has been ordered (was originally ordered on 2/18/22 day of admission and not followed through on) and recommend ST evaluate swallow. Recommend diet texture and liquid consistency according to ST recommendations. On 4/3/22 at 11:44 AM, SW-C documents R16 was able to obtain 2 cups of water and drank both of them. SW-C took the water from R16 as R16 stated R16 was thirsty and wanted more water. SW-C documented SW-C would follow-up on a ST evaluation. On 4/3/22 at 12:35 PM, R16 is observed by staff banging head onto ground after being told R16 could not have cake. R16 then took helmet off and repeatedly banged head onto ground re-opening an injury above R16's right eye. R16 sent out to ER. (Note: There has been no ST evaluation to determine if R16 could eat orally.) On 4/3/22 at 1:18, RD-D notes that R16 drank water and is thirsty despite increase in water provided in both the tube feeding formula and water flushes. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/30/22 at 2:20 PM, Surveyor spoke to RD-D via telephone interview in regard to R16. RD-D stated RD-D communicated R16's significant weight loss on 3/20/22 to NHA-A, SW-C, and DON-B. RD-D stated RD-D was so upset that the recommendation to increase tube feeding and water flushes had not been followed through with. RD-D stated RD-D had to beg every day to get the change made for R16. RD-D stated RD-D sent high alerts to NHA-A and calling daily to get the change made. RD-D stated RD-D checked on R16 daily and R16 was RD-D's number one priority. RD-D stated RD-D cannot review labs because they are not scanned in, which is a big issue for RD-D's comprehensive review. RD-D confirmed it took 5 days (from 3/20 until 3/25/22) for R16's tube feeding to be increased. RD-D stated the method that the facility obtains weights should be consistent. RD-D stated RD-D has been very worried about R16's nutritional status and weight. RD-D stated the weight that was obtained on 3/24/22 and not recorded was by the dietary manager (DM-E) who offered to help RD-D out. On 3/31/22 at 7:05 AM, Surveyor spoke to Dietary Manager (DM-E) who confirmed DM-E obtained R16's weight by self. DM-E stated RD-D needed the weight and DM-E was not going to leave until it got done. DM-E stated DM-first weighed R16 in the broda chair, and then weighed the broda chair separately. DM-D recalls having concerns of how frail R16 appeared to be and notified RD-D on 3/19/22 who planned on sending an email to NHA-A. On 3/31/22 at 8:21 AM, Surveyor observed DM-E attempt to weigh R16 in the broda chair. Once DM-E got R16 on the scale, the weight was not able to be obtained because the scale did not work, and DM-E was going to inform maintenance. On 3/31/22 at 2:05 PM, SW-C confirmed that it took 5 days for R16's tube feeding increase to start. SW-C stated SW-C was in on the weekend and had noticed how thin R16 was and requested DM-E give RD-D's contact information. SW-C stated, If I hadn't come in, I truly believe nothing would have been done in regard to R16's nutritional status. On 4/4/22 at 9:40 AM, Surveyor left a message for R16's physician (DR-H). On 4/5/22 at 12:11 PM, DR-H confirmed that DR-H had not been updated on R16's significant weight loss on 3/20/22. On 4/4/22 at 4:45 PM, NHA-A was informed that facility failed to comprehensively assess R16's nutritional status upon admission, failed to complete and obtain a speech therapy evaluation, failed to obtain a swallow study, failed to monitor R16's weights in a consistent method, failed to follow facility policies ad procedures, failed to notify R16's physician of R16's severe weight loss, and failed in a repeated, systemic manner to assess and address R16's nutritional status and to implement pertinent interventions based on such assessment. These failures resulted in continued and severe weight loss, which RD-D stated was life threatening. These failures created a reasonable likelihood for serious harm, and thus created a finding of Immediate Jeopardy. Noncompliance was also found at a severity level of potential for more than minimal harm that is not immediate jeopardy, as evidenced by: 16584 2. R9 was admitted to the facility on [DATE] with diagnoses that included Dysphasia, Dementia with behavioral disturbance, anxiety disorder and major depressive disorder. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The admission Minimum Data Set (MDS), dated [DATE], documented that R9 has a BIMS (brief interview for mental status) of 3- severely impaired cognitive skills. The MDS also stated that R9 needs extensive assistance with activities of daily living and needs supervision/ 1-person physical assistance with eating. R9's weight is documented at 148 pounds and there is no noted weight loss or gain at the time of this assessment. On 11/1/21, the facility developed a plan of care for R9 stating that R9 is at risk for complications with weight and nutrition due to dementia, dysphasia, texture modified diet, GERD, anemia, weight fluctuations and variable meal intakes. The quarterly MDS, dated [DATE] indicates R9's weight is at 150 pounds and there has been no weight loss or gain. It is also documented that R9 does not have any swallowing concerns. Nutrition review dated 11/15/21 states that R9 weights are: 10/25 150# 11/1 173.2# and 11/15 173#'s. 15% - or 23-pound weight gain in 1 month. Snacks between meals. Intake on admission 26-50%, now improved 76-100%. Receives 120 cc Med Plus three times daily, recommendation made to discontinue. Monitor weight. Quarterly MDS, dated [DATE], documents that R9's weight is at 138 pounds and incorrectly states there has been no weight loss or gain notes. R9 remains needing extensive assist of 1 person/ physical assistance for eating. The following weights were noted in R9's medical record and method of weight taken: 10/25/21 150 pounds- wheelchair 11/01/21 173.2 pounds- wheelchair 11/15/21 173 pounds - wheelchair 11/29/21 166.8 pounds- wheelchair 12/01/21 162 pounds- method not identified 12/13/21 161.7 pounds - wheelchair 12/10/21 163.2- wheelchair 12/20/21 163.2 pounds- wheelchair 01/16/22 144.8 pounds- method not identified 01/31/22 137.6 pounds- mechanical lift (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	02/14/22 137 pounds- wheelchair 02/28/22 137.9 pounds- Hoyer 03/07/22 139 pounds- wheelchair- (This weight represents a 23-pound weight loss or 14.2% weight loss since 12/10/21) Dietary progress note dated 2/3/22 stated, will notify nursing regarding large discrepancy in weights and weighing methods. Recommend consistent weight method be utilized to accurately track weight trends. Recommended Med Pass 2.0- 120 mL two times daily due to some variability in meal intakes. Will need to monitor weights utilizing consistent weighing method to determine if additional nutritional interventions are warranted. It was noted that the next 3 weights (2/14/22, 2/28/22 and 3/7/22) obtained by the facility were not consistent in method. The nutrition plan of care was revised on 2/3/22 to add the interventions of monitoring weights and labs and to utilize consistent weighing method. In addition, Med Pass 2.0- 120 mL two times daily was added. Dietary note dated 2/18/22; R9's weight is 137 pounds, weight has decreased 5.7 % in 30 days and decreased 8.3% in 180 days. R9 does have a diagnosis dementia which has the potential to have a negative impact on appetite and weight. Meal intake- 51-75%. Med Pass 2.0- 120 mL twice daily had not been ordered. Will notify nursing regarding significant weight loss and will request initiation of Med Pass 2.0- 120 mL twice daily again. Review of the physician orders for R9 showed that the order for Med Pass 2.0- 2 twice daily was not ordered until 2/22/22. The dietician had originally requested this to be ordered on 2/3/22. Dietary note dated 3/5/22 states that R9's weight has slightly increased to 137.9 pounds. Recommend continue with current nutritional plan of care. Goals include weight maintenance or weight gain to reach 145 pounds. Will tolerate diet and R9 will accept 75% average at meals. The nutrition plan of care was updated on 3/5/22 stating R9 has a nutritional problem or potential nutritional problem due to dementia, dysphasia, texture modified diet, GERD, anemia, weight loss and history of variable meal intakes. Interventions included the addition of the Med Pass supplement, and Dietician to evaluate and make diet change recommendations. R9's family requested that R9 be sent to the hospital for evaluation on 3/18/22. R9 did not return to the facility after this hospitalization . On 3/29/22 at 3:07 p.m., Surveyor interviewed Administrator- A in regard to R9 not being evaluated by a dietician from 11/15/21 to 2/3/22 even though R9 was documented to have experienced a 35.4 pound or 20. 5% weight loss from 11/15/21 to 1/31/22. Administrator- A stated that the facility was without a dietician from the end of November 2021 until 1/22/22 when the facility was able to hire an interim dietician on contract. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/30/22 at 2:20 p.m., Surveyor interviewed Dietician- D in regards R9's significant weight loss. Dietician - D stated that the nursing staff is to update her on any weight changes. When Dietician- D first started she re-assessed each resident over a period of 14 days. Dietician- D noted a huge weight discrepancy with R9 but despite the weight discrepancies she could see a downward trend. Dietician- D stated she recommended the Med Pass supplement to be given twice daily and then upon her assessment on 2/18/22, she noted the Med Pass was never ordered by the nursing staff. Dietician- D stated that she stressed the importance of using the same method to weigh residents each time so that an accurate picture can be given of any weight loss/ gain. Dietician- D stated that she often communicated via email and telephone to the nursing staff anytime she had concerns, need a weight to be taken or any orders to be given to the physician. Dietician- D stated that often she would have to ask multiple times and felt the issue came down to not enough staff or consistent staff to follow through on recommendations.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not ensure that 1 out of 1 residents (R11) reviewed for the use of a CPAP (Continuous positive airway pressure) machine, was provided with the necessary respiratory care to treat chronic sleep apnea. * R11 has a diagnosis of Obstructive Sleep Apnea. On 1/19/22, R11's physician ordered to Please provide R11 with a CPAP (Continuous positive airway pressure). Settings: 5-15 auto set. Diagnosis: sleep apnea. As of 4/4/21, R11 has not received a CPAP machine. This is evidenced by: R11 was originally admitted to the facility on [DATE] with diagnosis that included Obstructive Sleep Apnea. R11 was readmitted to the facility, from the hospital post fall, on 1/19/22. A review of the physician orders showed that on 1/19/22 there was an order for CPAP(Continuous positive airway pressure) settings: 5-15 auto set. Please provide R11 with CPAP. Diagnosis: sleep apnea. The Medication Administration Record (MAR) was reviewed for January, February and March, 2022. The MAR indicated CPAP setting: 5- 15 auto set- please provide R11 with CPAP machine. Diagnosis sleep apnea. For each date, a X was documented in the box. No staff initials were documented that the CPAP was in use. Nurse Practitioner progress note dated 3/7/22 states R11 is seen lying in bed in no acute distress. R11 does not yet have his CPAP. Assessment and Plan: Sleep apnea' CPAP nightly. Surveyor conducted a review of R11's individual plan of care did not show that R11 has sleep apnea and there is a need for the use of a CPAP machine nightly. On 3/28/22 at 10:55 a.m., Surveyor interviewed DON (Director of Nursing)- B in regard to R11 not having a CPAP machine for nightly use. DON- B stated that she does not have any settings for the CPAP machine and would need to get those from the Physician. Surveyor reviewed the order with DON- B from 1/19/22 that states CPAP settings: 5-15 auto set- please provide R11 with CPAP machine. DON- B stated she was not aware there were instructions for the settings. DON- B stated she would have to let Administrator- A know so she could get a CPAP machine ordered for R11. On 3/28/22 at 1:07 p.m., Surveyor interviewed DON- B who stated the reason R11 does not have a CPAP machine is because they are on recall. DON- B could not give any further details on what type of CPAP machine was to be used or when they were made aware the machine had been recalled. DON- B stated she spoke with the Nurse Practitioner, and they would be sending R11 out to a Pulmonologist consultation to get a CPAP machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing note dated 3/30/22 states- Writer (DON- B) attempted to obtain CPAP machine for R11. Company states they are on recall. Writer communicated this to Nurse Practitioner who gave order to send R11 to (Name of Hospital) Hospital - Pulmonary Clinic for CPAP. R11 has not been seen there since 2015 and will require a referral, referral obtained with signature from Nurse Practitioner, faxed to clinic. As of the time of exit on 4/4/22, the facility did not provide any additional information as to why R11 did not receive a CPAP, per physician order, on 1/19/22.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on observation, interview and record review, the facility did not provide sufficient staffing to meet the needs of 70 out of 70 residents living in the facility. The survey team entered the building on 3/28/22 at 8:00 a.m. Staff interview was conducted, and it was confirmed that there was only 1 Registered Nurse and 5 Certified Nursing Assistants to care for 70 residents. Facility staff stated that the morning medication pass would not be completed and the only Registered Nurse had to stay on the Vent unit, leaving the other 4 units without a licensed nurse. A review of the facility staff schedules for the month of March 2022 showed that the facility was often understaffed causing staff to work on more than one unit and at times working without the assistance of another staff member on their assigned unit. Because there was inadequate staff, residents were left in their rooms and in bed, did not receive showers/baths, did not receive assistance with daily hygiene, were not provided with enough supervision to prevent falls, residents who were at risk for skin breakdown were not turned and repositioned to prevent skin breakdown, did not receive medications timely, and did not receive scheduled treatments. Residents stated that they felt scared and felt neglected and felt as if no one would help them because there was no staff. Inadequate staffing was a root cause contributing to the six other immediate jeopardy citations issued following this survey. The failure to provide adequate staffing created a finding of Immediate Jeopardy that began on 2/28/22. Nursing Home Administrator- A, and Chief Operating Officer/Vice President of Operations (VPO) L were notified of the immediate jeopardy on 4/4/22 at 4:45 p.m. As of 4/14/22 at the time of the exit for the partial extended survey, the Immediate Jeopardy had not been removed. Findings include: According to the Facility Assessment Tool, last updated on 1/24/2022, the facility is licensed to provide care for 87 residents. The average daily census is 71 residents. Services and care that [NAME] of [NAME] Village offer based on resident's needs includes: activities of daily living, pressure injury prevention and care, management of medical conditions, administration of medications, pain management, therapy, nutrition, person- centered/directed care, and psycho/ social /spiritual support. The Facility Assessment documents; 3.2) Staffing plan: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[NAME] of [NAME] provides adequate staffing to meet its residents' daily needs, preferences, and routines in order to help each resident attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. This includes services of a registered nurse for at least eight (8) consecutive hours a day, 7 days a week, a designated licensed nurse to serve as a charge nurse on each tour of duty and adequate staffing on each shift to ensure that our residents' needs are met by registered and licensed nursing staff, certified/ state tested nursing assistants, and other support services that include, but are not limited to, dietary, activities/ recreational, social, therapy and environmental services. Respiratory Therapists will be on staff for the ventilator unit 24 hours a day. During extreme events such as a pandemic if the facility is not able to maintain the minimum number of qualified staff to meet the needs of the residents, all staff will assist with ensuring basic cares are met as the facility is in crisis staffing modes. The non- qualified staff will assist with answering call [NAME], serving meals, making beds, duties which you do not need to be certified to perform. [NAME] of [NAME] consistently reviews adequate staffing based on census, acuity, and diagnoses of our resident population to ensure staffing is sufficient with the appropriate skills and competencies to carry out the needs, care and services of our residents at any given time. The facility is composed of five units (East, West, North, Rehab and the Vent unit). According to the Resident Census and Condition Report (Centers for Medicare and Medicaid- Form 672) for the facility, the facility's 70 residents have the following personal care needs: Bathing: Assist of 1 or 2 staff - 49 residents Dependent (require total assistance) - 21 residents Dressing: Assist of 1 or 2 staff - 54 residents Dependent - 10 resident Transferring: Assist of 1 or 2 staff - 37 residents Dependent - 23 residents Toilet use: Assist of 1 or 2 staff - 47 residents Dependent - 17 residents Eating: Assist of 1 or 6 staff - 22 residents Dependent - 8 residents On 3/29/22, at 10:45 AM, Surveyor interviewed SCH-I (CNA). SCH-I stated she staffs by census and acuity but mostly census. SCH-I stated for a census of 70, the plan is: Days & PMs-3 nurses and a Med Tech or 4 nurses. 6-7 CNAs. Nights-3 nurses and 4 CNAs. Always a nurse in the vent unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	SCH-I stated there is not always an RN on the weekends. On 3/28/22, at 11:36 AM, SCH-I (Scheduler) stated we try to have a CNA on each unit if we have enough, but we are understaffed as we need 2 assist with 2 person transfers. The schedules provided indicated short staffing on multiple days across multiple shifts, as evidenced by: Friday March 4th night shift had 2 CNAs; not 4 CNAs. Saturday March 5th night shift had 1 CNA; not 4 CNAs. Wednesday March 9th PM shift had 4 CNAs; not 6-7 CNAs. Friday March 11th night shift had 2 CNAs; not 4 CNAs. Saturday March 12th night shift had 2 CNAs; not 4 CNAs Sunday March 13th night shift had 2 CNAs; not 4 CNAs. Monday March 14th night shift had 2 nurses; not 3 nurses. Wednesday March 16th night shift had 2 nurses, 2 CNAs; not 3 nurses and 4 CNAs. Saturday March 19th night shift had 1 nurse and 2 CNAs; not 3 nurses and 4 CNAs. Sunday March 20th night shift had 1 nurse and 1 CNA; not 3 nurses and 4 CNAs. Tuesday March 22nd night shift had 2 nurses, 2 CNAs; not 3 nurses and 4 CNAs. Wednesday March 23rd night shift had 2 nurses, 2 CNAs; not 3 nurses and 4 CNAs. Friday March 25th night shift had 2 CNAs, not 4 CNAs. Saturday March 26th night shift had 2 CNAs; not 4 CNAs. Sunday March 27th day shift had 3 CNAs, PM shift had 3 CNAs; not 6-7 CNAs. Monday March 28th day shift had 1 nurse (not 3 nurses), PM shift had 2 nurses (not 3 nurses), night shift had 2 nurses (not 3 nurses), 3 CNAs (not 4 CNAs). Census is now 70. Tuesday March 29th night shift had 1 nurse with the PM nurse remaining over until 4-5 AM and only 2 CNAs; not 3 Nurses and 4 CNAs. (continued on next page)

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Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	As of 4/14/22, the facility continued to have ongoing staffing issues with obtaining and retaining CNAs and licensed nursing staff. According to Administrator A, the facility owes staffing agencies money which limits their ability to get staff. On 3/28/22 at 8:00 a.m., Surveyors entered the facility to conduct complaint investigations. It was noted that the facility census was 70 residents, 11 of these residents resided on the Vent unit. The Survey team requested the daily schedule for 3/28/22 and was provided with a schedule for the AM Shift that showed the facility only had 1 Registered Nurse working on the Vent unit (11 residents) and no other licensed nursing staff for the other 59 residents. It was also noted that there was only 5 Certified Nursing Assistants working for the entire facility. On 3/28/22 at 11:40 a.m. Surveyor interviewed Scheduler- I in regard to the staffing for the AM shift for 3/28/22. Scheduler- I stated that there is currently no nurse passing medications to the residents and that the 1 registered nurse on duty is Director of Nursing (DON)- B and she is assigned to work on the Vent Unit which requires its own nurse for each shift. Scheduler- I stated that she is working on getting more staff in and has called all the agencies they have contracts with for staff. Scheduler- I stated she has called every other staff and they either have other jobs or are in school. Scheduler- I stated that there was a Medication Technician that had called in sick, leaving just 1 registered nurse on the shift. Scheduler- I stated that Administrator- A is aware. 1. The facility failed to ensure that it had adequate staffing to meet the needs of its 70 residents. Due to inadequate staffing levels, residents did not receive personal cares such as showers/baths, adequate supervision to prevent falls, and care and treatment of pressure ulcers. Medications were not administered timely, some of which are significant to residents' health. One resident admitted herself into a hospital as was in an extreme amount of pain and was not getting assistance. Dietitian and Physician or dietitian recommendations for residents' weight loss were not implemented. As a result, there were residents who experienced falls, some of them with injury, worsening pressure injuries, development of new pressure injuries, medication errors, resident weight loss, and residents expressing feelings of being neglected because there is not enough staff to take care of their needs. The facility failure to ensure residents were free from neglect, created a finding of immediate jeopardy and Substandard Quality of Care. (Cross Reference F600) 2. On 3/28/22, 12 residents (R2, R3, R4, R7, R8, R10, R11, R13, R14, R16, R17 and R18) did not receive their morning and noon medications when the facility only had 1 nurse in the building and could not complete the medication pass. Of the 12 residents, 6 (R2, R4, R10, R11, R13 and R14) residents experienced a significant medication error by not being administered their insulin, tube feeding or IV antibiotic. (Cross Reference F755 and F760) 3. The facility failed provide sufficient staff to ensure 10 residents (R2, R3, R4, R5, R7, R8, R10, R11, R13, R14) who are dependent on staff for activities of daily living received weekly skin checks and showers/ baths and assistance with personal hygiene. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R10 is not receiving weekly showers in accordance with R10's plan of care. R10 appeared very disheveled with dry, flaky skin and excessive facial hair when observed on 3/28/22 at 9:20 AM, 12:20 PM, and 2:45 PM, and on 3/29/22 at 7:45 AM. R11 was observed in bed on 3/28/22 at 12:30 PM .R11's hair was very disheveled and appeared to be greasy as if not washed in some time. R11 is to have a shower at least weekly however no indication of a set day for the shower. The facility was unable to provide any evidence that R11 had been provided a shower for the months of February and March 2022. R4 was observed on 3/29/22 at 8:10 AM lying in bed on her back with lips cracked and no moisture noted on dry mucous membranes and long beard hairs on chin. R4 stated liking to have her chin shaved and telling the nurses if they see anything on the face to take it off. Surveyor noted R4 had only one documented shower on 3/9/22 in the last 30 days. (Cross Reference F677) 4. The facility failed to provide sufficient staff to ensure that 4 residents (R4, R5, R10 and R18) received the appropriate treatment and services to maintain or promote the healing of their pressure ulcers. These 4 residents were not provided comprehensive assessments of their pressure ulcers, not provided with appropriate wound treatments, and not always provided with additional interventions such as pressure relief and repositioning while in the chair or bed. This resulted in a finding of immediate jeopardy and substandard quality of care R4. On 2/14/22, R4 developed three unstageable pressure injuries. These combined into one unstageable wound that is now 56 times larger in area than when first identified (2.02 sq. cm. vs. 160 sq. cm). In addition, during 2 different wound care observations, R4 had developed two additional ischial wounds that were not addressed by the facility. Staff was not aware R4 needed repositioning. On 3/30/22, at 7:10 AM, Surveyor observed R4 in bed lying flat on back. R4 stated she has not seen any staff all night and her door was closed. R10 acquired an unstageable pressure injury while residing at the facility and was hospitalized , requiring intravenous antibiotic treatment for the infected pressure injury. R5 acquired a stage 4 pressure injury while residing at the facility and was hospitalized , requiring antibiotic treatment for the infected pressure injury. R18's pressure ulcer to the coccyx was not compressively assessed upon her original admission on 3/1/22 and then upon readmission on 3/22/22 and 3/23/22. R18 did not have a plan of care addressing the pressure ulcer with interventions put into place to aide in the healing of the pressure ulcer. The facility was unable to determine if the treatment they were applying daily to R18's coccyx was effective because they had no means to know if the area was healing or not. As documented in F686, there were multiple occasions where staff did not provide ordered treatments. (Cross Reference F686) (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	5. The facility failed to provide sufficient staff to ensure that 2 residents (R16 and R3), who were at risk for falls and had fallen previously in the facility were provided with enough supervision to prevent accidents, resulting in serious injuries. This resulted in a finding of immediate jeopardy and substandard quality of care. R16 has had 12 falls since admission on 2/18/22 to 4/3/22. The fall on 3/27/22 (which was the second fall that day) resulted in stitches above the right eyebrow. The fall on 3/26/22 resulted in staples to the back of the head. The fall on 4/2/22 resulted in a re-opening of the staples. The fall on 4/3/22 led to a laceration on the resident's face that required steri-strips. After review of nursing schedules with each of R16's falls, it is noted that based on census and 15 total Residents residing on the same unit as R16, there was an inadequate number of staff to provide supervision to R16 in order to prevent R16 from frequent falling. At times there was no CNA assigned to R16's unit. On 3/20/22 R3 had a fall with injury and a fall assessment with a thorough root cause analysis, and Neuro checks was not completed. (Cross Reference F689) 6. The facility failed to provide sufficient staff to ensure that 2 residents (R16 and R9) who experienced significant weight loss were provided with the necessary care and services to maintain their nutritional status. Staff did not alert the physician and follow recommendations based on a comprehensive assessment from the Registered Dietician. This resulted in a finding of immediate jeopardy and substandard quality of care. On 3/31/22, R16's weight was obtained. RD-D documents R16's weight has declined to 72.6 pounds, an 18. 6% weight loss since admission. RD-D describes the weight as severely underweight and life-threatening. RD-D contacted the Nursing Home Administrator and recommended R16 be transferred to the hospital STAT. R16 was sent to the emergency room (ER) and returned to the facility on [DATE]. R9 experienced a significant weight loss of 35.4 pounds (29.8%) from 11/15/21 to 1/31/22 without any compressive assessment or dietary intervention. (Cross Reference F692) 7. The facility did not provide necessary cares and services to promote quality of life and assist 70 out of 70 residents with the necessary care and services for Residents to attain or maintain the highest practical physical, mental, and psychosocial well-being. This resulted in a finding of immediate jeopardy and substandard quality of care. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R18 had called 911 emergency services herself the night before on 3/30/22 at approximately 8:20 p.m. Administrator- A stated that she had heard R18 sent herself out to the emergency room after a family visit had concluded. Administrator- A stated she is still unaware what hospital R18 went to or any other details. R18's AHCPOA stated that she was made aware that R18 wanted to go to the hospital because she was in an extreme amount of pain and could not get any assistance. R18 had reported to a family member she was just going to call 911 herself. AHCPOA (Activated Health Care Power of Attorney) for R18 stated that they had no idea what hospital R18 had went to and they had to call around to all of the local hospitals to find where R18 had been admitted to. On 3/31/22 at 8:45 AM, R7 informed Surveyor of the cares R7 has not been receiving in the facility. R7 explained that R7 had to call family in several times to come to the facility so R7 could get assistance with cares. R7 explained that R7's call light would be on for a long time, and no one would come to assist R7. R7 stated not getting cares is making R7 more sad while at the facility. R7 stated R7 cries when R7 cannot get the help, which is a lot. R7 explained it hurts because R7 has to rely on others for assistance because R7 struggles with the loss of being independent. On 3/31/22 at 9:05 AM, Surveyor interviewed R17 in regard to R17's fall from bed during the night shift of 3/29/22. Surveyor noted there was only 2 CNAs and 2 nurses in the facility at the time of the fall per facility written schedule. R17 stated R17 had been reaching for R17's phone to call 911 in order to get assistance because R17's call light had been on for a long time. In the process of reaching for the phone, R17 slid out of bed and onto the floor. R17 believes R17 laid on the floor approximately 1 hour before a nurse came. R17 also stated that a CNA watched R17 slide out of bed and walked out of R17's room and did nothing to help stop R17 from sliding, provide any assistance, or go get help. R17 stated R17 has been at the facility 2 other times for rehabilitation and this is the worst experience yet. R17 stated R17 feels more sad and hopeless about everything. R17 is angry at the situation. R17 stated R17 is having more anxiety since the 3rd admission and is scared of not getting the help that R17 needs. R17 feels like R17 cannot talk to anyone about it. R17 stated that R17 is a RN and would and never treat anyone as R17 has been treated while at the facility. I am so fearful I will never get the help when I am laying in bed. During the interview, R17 was crying. (Cross Reference F675) On 3/30/22 at 3:30 p.m., Surveyor interviewed Administrator - A regarding the staffing shortage that the facility is experiencing. Administrator- A stated that the Corporate Human Resources Department is running several ads to hire employees. Administrator- A stated that several interviews are set-up and then people don't show up for the actual appointment. Administrator - A provides a weekly orientation to new staff and has found that for whatever reason staff don't stay on as employees after orientation. Administrator- A acknowledged that there are many open positions for nursing and certified nursing assistant staff and that Corporate level staff are aware. Administrator- A stated that she reports weekly to VPO L where the facility is at with staffing levels. Administrator- A confirmed that DON- B is wishing to step-down and just work on the Vent Unit and this will leave an opening for a Director of Nursing as well as there is an opening for a MDS (Minimum Data Set) Nurse. Administrator - A stated that the facility has a contract with 3 different staffing agencies, and often this can be challenge because the staffing agencies are short on staff. Administrator- A stated that the Corporation was going to send a Regional Nurse to assist, but the nurse fell ill and was unable to travel. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/31/22 at 12:10 p.m., Surveyor interviewed Administrator- A regarding the facility's admission during the month of February and March 2022. Administrator- A provided Surveyor with a report that showed the facility accepted 47 new admissions during February and March 2022. Administrator- A stated that she was aware of the staffing shortages and would report this to the Corporation weekly. Administrator- A states she was told the facility should continue to take new admissions during this time. (Cross reference F837) 41439 8. On 3/28/22, at 9:30 AM, Surveyor observed R14 who was sitting up in the bed. R14 stated she was uncomfortable but had no rail to assist with turning and no staff to provide assistance. On 3/29/22, at 8:15 AM, Surveyor interviewed R14 who stated no medications were administered yesterday as R14 was told there was no licensed person to give them. 9. On 3/28/22, at 10:06 AM, Surveyor observed R2 lying in the bed with a Foley. R2 stated she was going through hell as she was supposed to get showers, left in the bed 24 hours/day as no one to get her up, no Foley care. On 3/29/22, at 5:35 AM, Surveyor observed R2's call light remained on and unanswered. On 3/29/22, at 5:49 AM, Surveyor observed R2's call light was answered at change of shift. On 3/29/22, at 8:20 AM, Surveyor interviewed R2 who stated she had a good night but the staff did not get me up as assigned (R2 is a night shift get up-early AM). R2 stated she was waiting. R2 stated she did not know why the staff even believe she refuses as the call light was on. On 3/28/22, at 10:30 AM, Surveyor interviewed DON-B (Director of Nursing) who was the vent unit nurse. DON-B stated she was also the facility Infection Preventionist, Wound Care Nurse, and acting DON on paper. On 3/28/22, at 12:00 PM, DON-B stated she tried to do most of the residents' blood sugars but no insulins or IV medications were given as there was no time. DON-B stated she would try to do her best to get the noon blood sugars done but she did not know if she could as she needed to be in the vent unit. On 3/28/22, at 12:27 PM, NHA-A stated she did a blanket call to physicians to notify them that medications were not given and stated insulins and tube feedings were not done. On 3/28/22, at 12:50 PM, Surveyor interviewed CNA-R (Certified Nurse Assistant) working on R2, R4, and R14's unit who stated she was from agency and the facility just put us here with no guidance, no nurse, no way to chart except through others login, and no care cards. On 3/28/22, at 12:55 PM, Surveyor interviewed CNA-S working on R2, R4, and R14's unit who stated she was from agency and has come here before so we know the residents a little bit but there is no nurse today to check and confirm care. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/28/22, at 2:47 PM, Surveyor interviewed MT-O (Med Tech) who stated she was passing medications for 34 residents. MT-O stated she will not give the missing AM medications as it is not in the plan as it is too late and too far out. On 3/29/22, at 5:00 AM, Surveyor interviewed LPN-P (Licensed Practical Nurse) who stated she was working overnight on 3 units (North, East, Vent) with 3 CNAs one each on the Vent, Rehab, and [NAME] units. LPN-P stated all the care was not provided as they were supposed to split the units, rounds were not done as it is too hard to do it when staffing is horrible. LPN-P stated no rounds done since residents went to bed last night and she planned to look for one of the CNAs to she can help him start. LPN-P stated there are no care plans so the CNAs know what care to provide and how to transfer residents. LPN-P stated no charting by CNAs in the electronic medical record so the nurses are unable to check if care was provided or not. LPN-P stated the example of no charting on eating so she is unable to tell families about the residents. LPN-P stated no showers are given by CNAs as there is no staff. Surveyor noted R2's call light was on at 5:00 AM when Surveyor began interviewing LPN-P. When Surveyor called attention to the long period of time that R2's call light was on, LPN-P stated See, I don't even know where to start because there is so much to do. R2's call light remained unanswered as LPN-P distributed paper bags of pharmacy medications to each nursing cart. LPN-P stated she needed to go to the rehab unit and login the agency nurse into the electronic medical record under LPN-P's name. LPN-P stated the agency nurse does not have a login to chart so it has to be done under LPN-P's name. On 3/29/22, at 5:15 AM, Surveyor interviewed CNA-U working on R2, R4, and R14's unit who stated she has worked here since 2/22 and regrets it as there is terrible care provided in this facility. CNA-U stated she could go on and on about the residents' needs. CNA-U stated one resident needed to be changed when she came in at 10 PM but she had to wait as until 12:30 AM for help to turn and reposition. CNA-U stated the facility does not provide the proper linen to clean and change people. CNA-U stated she is unable to get any assistance to turn residents so no repositioning for some residents and rounds are hard to do, to change residents without help. CNA-U stated she tries her best but there is no staff and sometimes night staff leave and come back at 5:30 AM or just sleep during the night. On 3/29/22, at 5:24 AM, Surveyor interviewed RT-V (Respiratory Therapist) who stated she works from 6:30 PM until 7:00 AM in the vent unit. RT-V stated there is a CNA assigned to work in the vent unit. RT-V stated the nurse comes to vent unit back and forth during the night. On 3/29/22, at 9:50 AM, Surveyor interviewed LPN-J who stated they were always short-staffed, always what she has to go through every day. LPN-J stated the CNAs were cleaning and changing R4 now for the first time so Surveyor could observe R4's wound treatment. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/29/22, at 10:45 AM, Surveyor interviewed SCH-I (CNA). SCH-I stated she started in August but since then the facility shut down a staffing program which made staffing easier. SCH-I stated she needed to find a new way to post the nursing hours. SCH-I stated she does not train the new staff but assigns someone to train them. SCH-I stated the agency staff do not get orientation but a quick [NAME] and electronic medical record access. SCH-I stated LPN-P called her at 9:00 PM last night to state the vent nurse called in and SCH-I requested an agency nurse but did not know who it would be so SCH-I would not be able to assign electronic medical record access. SCH-I stated there were nights with only 1 nurse in the facility including 3/20/22. On 3/30/22, at 7:00 AM, Surveyor interviewed LPN-P who stated she was the only nurse in the facility when the PM nurse who stayed to help night shift left around 4:00-5:00 AM. LPN-P stated there were only 2 CNAs overnight in the facility so not all care was possible because repositioning requires 2 people. LPN-P stated there was a fall but she did not have time to document, computer not working, and she was returning to the facility at 3:00 PM. LPN-P stated the PM nurse completed the blood sugars prior to leaving in the early AM. LPN-P indicated concerns about minimum standards for staffing. Surveyor observed R14's call light was on and LPN-P stated she did not know the time of call light initiation. On 3/30/22, at 8:57 AM, Surveyor interviewed MD-N (Wound Physician) who stated typically if he can find a nurse or use an aide to make rounds with him but sometimes there is no staff to assist so he has to go by himself. MD-N stated repositioning definitely should happen. MD-N stated he touches base with DON-B so he knows which residents to see but DON-B is not always available for follow-up. On 3/30/22, at 3:00 PM, Surveyor observed R14's PICC line which had a 3/18/22 admitted d dressing. Surveyor noted R14 had a 3/25/22 Physician order to change PICC line dressing every 7 days. R14's MAR (Medication Administration Record) indicated initials and documentation of dressing change on 3/25/22 at 8:00 AM. Surveyor notified DON-B of the dated 3/18/22 dressing and the conflicting documentation in R14's MAR. DON-B stated she will assess and change the dressing, rewrite the order then educate the nurse. Staffing continues to be an issue even after informing the facility of having an Immediate Jeopardy for staffing 4/4/22. On 4/11/22 from 9:00 PM to 10:00 PM there was only 2 CNAs and 2 nurses for the building. According to Administrator A, on 4/11/22 Scheduler I came in and informed Administrator A, VPO (Vice President of Operations) -L and RN (Corporate RN Consultant)-BB of concerns with lack of staffing. Administrator A stated on 4/11/22 they were piece-[NAME] the evening shift and they couldn't get anyone else. VPO-L and Corporate RN BB were in the building and aware of the staffing shortage. (On 4/14/22 Scheduler I provided surveyors with a written statement verifying this information). Administrator A stated VPO L and Corporate RN BB are both RNs. Administrator A stated neither VPO L or RN BB went to assist with Resident care. Administrator A stated VPO L and Corporate RN BB left the building at 9:00 PM. The failure to provide adequate staff to meet the needs of the residents created a reasonable likelihood that serious harm could occur, resulting in a finding of Immediate Jeopardy. As of 4/14/22 at the time of the partial extended survey exit, the facility had not removed the Immediate Jeopardy.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36161 Based on interview and record review, the facility did not complete a performance review at least once every 12 months for 5 of 5 CNAs (Certified Nursing Assistant) reviewed. Findings include: 1. CNA-W was hired on 3/20/19. During the time period 3/20/21 to 3/20/22, CNA-W did not have a performance review in order for the facility to provide in-service training for identified areas of weakness. 2. CNA-X was hired on 7/28/19. During the time period 7/28/20 to 7/28/21, CNA-X did not have a performance review in order for the facility to provide in-service training for identified areas of weakness. 3. CNA-Y was hired on 12/19/19. During the time period 12/19/20 to 12/19/21, CNA-Y did not have a performance review in order for the facility to provide in-service training for identified areas of weakness 4. CNA-Z was hired on 10/12/11. During the time period 10/12/20 to 10/12/21, CNA-Z did not have a performance review in order for the facility to provide in-service training for identified areas of weakness. 5. CNA-AA was hired on 3/16/21. During the time period 3/16/21 to 3/16/22, CNA-AA did not have a performance review in order for the facility to provide in-service training for identified areas of weakness. On 4/14/22 at 10:29 a.m., Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. Surveyor asked NHA-A if the facility completed a performance review for the above CNAs that evaluated for areas of weaknesses in order to provide in-service training. Surveyor also requested NHA-A verify the hire dates of the above CNAs provided to Surveyor. NHA-A informed Surveyor that the hire dates of the above CNAs provided to Surveyor were accurate. NHA-A informed Surveyor that the facility did not complete performance reviews on the above CNAs. No additional information was provided as to why the facility did not complete annual performance reviews on CNA-W, CNA-X, CNA-Y, CNA-Z and CNA-AA.

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Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on observation, interview, and record review the Facility did not ensure pharmaceutical services including accurate acquiring and administering of medications to meet the needs of each Resident for 12 (R8, R11, R18, R2, R4, R13, R14, R10, R3, R7, R16, and R17) of 12 Residents reviewed. During the first shift on 3/28/22, the facility had only 1 Registered Nurse (RN) on duty with a census of 70 residents. Due to staffing shortages, the 3/28/22 morning and noon medications were not administered to the following residents (R8, R11, R18, R2, R4, R13, R14, R10, R3, R7, R16, and R17). The facility did not follow physician orders to administer medications within the required timeframe. This is evidence by: Surveyor reviewed the facility's Administering Medications policy and procedure revised December 2012 and noted the following applicable: Policy statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation states in part: 3. Medications must be administered in accordance with the orders, including any required timeframe. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals). 18. If a drug is withheld, refused, or given at a time other the scheduled time, the individual administering the medication shall initial and circle the MAR (medication administration record) space provided for that drug and dose. On 3/28/22 at 12:00 p.m., Surveyor interviewed Administrator-A regarding only 1 registered nurse being on the morning shift for 3/28/22. Administrator- A stated she was aware of the staffing shortage, and she was aware that the morning medications were not going to be passed to the residents due to this staffing shortage. Administrator- A stated the facility has not updated any of the resident's physician's yet about the missed medication pass but planned to let them all know. 1. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R8. It was noted that the following medications were not initialed on 3/28/22 at 8:00 a.m. as being administered: Gilpizide XL tablet, give 10 mg for DM (diabetes mellitus) type 2 in the morning Lasix 40 mg, give 1 tablet by mouth 1 time daily (8:00 a.m.) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Metformin 1000 mg, give 1 tablet by mouth in the morning for DM Metoprolol 50 mg, give 1 tablet by mouth one time a day for HTN (8:00 a.m.) Vitamin B12 tablet, give 1000mcg by mouth one time daily (8:00 a.m.) Lovenox Solution 30 mg, inject 30 mg subcutaneous 2 times daily (8:00 a.m.) Baclofen 5 mg, give 1 tablet 3 times daily for spasms (8:00 a.m.) Lyrica 100 mg, 1 cap every 8 hours for Neuropathy (8:00 a.m.) Magnesium 400 mg, give by mouth 3 times daily related to weakness (8:00a.m.) Sucralfate 1 gm, give 1 tablet by mouth 3 times daily (8:00 a.m.) 2. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R11. It was noted that the following medications were not initialed on 3/28/22 at 8:00 a.m. as being administered: Aspirin 81 mg in the morning for cardiac health Lasix 40 mg by mouth in the morning for edema Lidoderm patch apply to right knee on in the morning, off evening for pain Norvasc 5 mg, 1 tablet by mouth in the morning for HTN Pepcid AC 10 mg, 1 tablet a day for GERD (8:00 a.m.) Potassium Chloride 10 meq, 1 tablet twice daily for supplement (8:00 a.m.) Catapres 0.2 mg, 1 tablet by mouth 3 times daily (8:00 a.m.) 3. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R18. It was noted that the following medications were not initialed on 3/28/22 at 8:00 a.m. as being administered: Nicotine patch 7 mg/24 hour- apply 1 patch in the morning for smoking cessation Omeprazole 20 mg, give 2 caps by mouth 1 time daily for GERD (8:00 a.m.) Vit D tablet, give 1 tablet by mouth daily for supplement (8:00 a.m.) Carvedilol 3.125 mg tablet every 12 hours for HTN (8:00 a.m.) Calcium Acetate 667 mg, give 1 cap by mouth 3 times daily (8:00 a.m.) Nepro 4 oz. 4 times daily (8:00 a.m. and Noon) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41439 On 3/28/22, Surveyor reviewed the daily staffing schedule provided by the facility and noted Director of Nursing (DON)-B was listed as assigned to the vent unit and the only nurse in the facility. On 3/28/22, at 11:36 AM, Scheduler (SCH)-I stated there was only one nurse in the building and Nursing Home Administrator (NHA)-A was aware of staffing concerns. On 3/28/22 at 11:56 AM, NHA-A stated she was aware of staffing concerns as she had been notified at 6:20 AM and DON-B was the only nurse in the facility despite offering $200 bonuses and calling agencies. NHA-A stated medications were not passed. NHA-A stated the shortage of nurses does not happen often and usually manage to get things passed. On 3/28/22 at 12:00 PM, DON-B stated she tried to do most of the residents' blood sugars but no insulins were given or IV medications given as there was no time. DON-B stated she would try to do her best to get the noon blood sugars done but she did not know if she could as she needed to be in the vent unit. On 3/28/22 at 12:27 PM, NHA-A stated she did a blanket call to physicians to notify them that medications were not given and stated insulins and tube feedings were not done. On 3/28/22 at 2:47 PM, Surveyor interviewed Med Tech (MT)-O who stated she was passing medications for 34 residents. MT-O stated she will not give the missing AM medications as it is not in the plan as it is too late and too far out. 4. R2 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis and Osteoarthritis. R2's Quarterly 12/29/21 MDS indicated R2 was cognitively intact. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R2. It was noted that the following medications were not initialed as being administered on 3/28/22 at 8:00 a.m. as scheduled per MAR: Ascorbic Acid tablet 500 mg-Give 1 tablet by mouth one time a day. Biotin Forte 3 mg-Give 1 tablet by mouth one time a day. Cranberry Capsule-Give 1 tablet by mouth one time a day. Folic Acid tablet 1 mg- Give 1 tablet by mouth one time a day. Phenytek Capsule 300 mg- Give 1 tablet by mouth one time a day for seizures/convulsions. Anusol-HC Cream 2.5%-Apply to rectum topically 2 times/day. Calcium-Vitamin D tablet 500-125 mg-Give 1 tablet by mouth 2 times/day. Guaifenesin Liquid 100 mg/5 ml-Give 10 ml by mouth 2 times/day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R4 was admitted to the facility on [DATE] with diagnoses including Diabetes, Multiple Myeloma, and Hypertension. R4's Quarterly 3/7/22 MDS indicated R4 was cognitively intact. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R4. It was noted that the following medications were not initialed as being administered on 3/28/22 at 8:00 a.m. as scheduled per MAR: Amlodipine Besylate tablet 5 mg-Give 0.5 tablet via PEG-tube 1 time/day. Aspirin tablet Chewable 81 mg-Give 1 tablet via PEG-tube 1 time/day. Calcium-Carbonate-Vitamin D Min tablet 600-400mg Unit- Give 1 tablet via PEG-tube 1 time/day. Cholecalciferol tablet 1000 unit- Give 1 tablet via PEG-tube 1 time/day. Hydrocortisone tablet 20 mg- Give 1 tablet via PEG-tube 1 time/day. Flonase Suspension 50 mcg/ACT-2 spray in each nostril 1 time/day. Furosemide Solution 10 mg/ml-Give 4 ml via PEG-tube 1 time/day. Lisinopril 30 mg- Give 1 tablet via PEG-tube 1 time/day. Miralax Powder 17 gm/scoop-Give 1 scoop via PEG-tube 1 time/day. Multivitamin/Minerals tablet- Give 1 tablet via PEG-tube 1 time/day. Protonix packet 40 mg-Give 1 packet via PEG-tube 1 time/day. Senna-S tablet 8.6-50 mg-Give 1 tablet via PEG-tube 1 time/day. Enteral Feed order 2 times/day Glucerna 1.5 at 85 ml/hour x 14 hours-off at 0700, on at 1700. *Surveyor had observations on 3/28/22 of R4's enteral feeding being on and infusing at 9:30 AM, 1:08 PM, and 2:47 PM. Metoprolol Tartrate tablet 100 mg-Give 1 tablet via PEG-tube every 12 hours. Proheal-2 times/day via PEG-tube or po. Acidophilus Capsule-Give 1 capsule via PEG-tube 3 times/day. Acyclovir Suspension 200 mg/5 ml-Give 10 ml via PEG-tube 2 times/day. Bactrim DS tablet 800-160 mg-Give 1 tablet via PEG-tube 2 times/day every Mon, Wed, Fri. Clonidine HCL tablet 0.3 mg-Give 1 tablet via PEG-tube every 12 hours. Humalog Kwik-Pen solution pen injector 100 unit/ml (Insulin Lispro)-Inject as per sliding scale subcutaneously 3 times/day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Surveyor noted that R4's blood sugars and insulin was not documented for either scheduled times of 0800 and 1200. 6. R13 was admitted to the facility on [DATE] with diagnoses including Dementia, Agoraphobia, and Hypertension. R13's 2/28/22 Admission MDS indicated R13 was cognitively intact without functional impairments. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R13. It was noted that the following medications were not initialed as being administered on 3/28/22 at 8:00 a.m. as scheduled per MAR: Cetirizine HCL 10 mg- Give 1 tablet by mouth 1 time/day. Cholecalciferol tablet- Give 1000 IU by mouth 1 time/day. Famotidine tablet 20 mg- Give 1 tablet by mouth 1 time/day. Miralax Powder 17 gm/scoop-Give 1 scoop by mouth 1 time/day. Zoloft 25 mg-Give 1 tablet by mouth 1 time/day. Divalproex Sodium tablet delayed release 500 mg-Give 1 tablet by mouth every 12 hours. Dorzolamide HCL solution 2%-Instill 1 drop in both eyes every 12 hours. Olanazapine tablet 2.5 mg-Give 1 tablet by mouth 2 times/day. Timolol Maleate solution 0.5%-Instill 1 drop in both eyes every 12 hours. 7. R14 was admitted to the facility on [DATE] with diagnoses including Aortic Valve Vegetation, COPD (Chronic Obstructive Pulmonary Disease) exacerbation, and Morbid Obesity. R14's 3/18/22 Admission MDS was in progress. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R14. It was noted that the following medications were not initialed as being administered on 3/28/22 at 8:00 a.m. as scheduled per MAR: Buproprion HCL ER-Give 450 mg by mouth 1 time/day. Celexa tablet 40 mg-Give 1 tablet by mouth 1 time/day. Digoxin 125 mcg-Give 1 tablet by mouth 1 time/day. Ferrous Sulfate tablet 325 mg-Give 1 tablet by mouth 1 time/day. Potassium Chloride ER 20 MEQ-Give 1 tablet by mouth 1 time/day. Vitamin D3 tablet-Give 2000 units by mouth 1 time/day. Eliquis 5 mg-Give 1 tablet 2 times/day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lasix tablet 80 mg-Give 1 tablet 2 times/day. Metoprolol Tartrate tablet-Give 12.5 mg by mouth 2 times/day. Cefazolin Sodium solution-Use 2 gm intravenously every 8 hours. Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 ml-1 vial inhale orally 4 times/day. Surveyor noted the vial (medication) was not documented for either scheduled times of 0800 and 1200. Monitor PICC line to RUE (Right Upper Extremity) site every shift for S/S (Signs/Symptoms) of infection every shift. On 3/29/22, at 8:15 AM, Surveyor interviewed R14 who stated no medications were administered yesterday (3/28/22) as R14 was told there was no licensed person to give them. On 3/29/22, at 1:30 PM, Surveyor shared concerns regarding medications not being provided to the residents on 3/28/22 with NHA-A. On 3/30/22, at 3:15 PM, Surveyor shared with NHA-A regarding medications not being provided on 3/28/22. No further information was provided. 42037 8. R10 was admitted to the facility on [DATE] with diagnoses of Dementia, Diabetes Mellitus type 2, failure to thrive and encephalopathy. R10's Minimum Data Set (MDS) assessment dated [DATE] indicates R10 has a BIMS (Brief Interview of Mental Status) score of 00, indicating R10 is unable to participate in daily decision making. Surveyor notes that R10 did not receive the following medications per R10's MAR on 3/28/22: 1. Furosemide 20 mg - did not receive 8 AM dose. 2. Pro-heal supplement- did not receive 8 AM dose. 3. Namenda 5 mg- did not receive 8 AM dose. 4. Insulin Detemir 10 units subcutaneously- did not receive 8 AM dose. 5. Aspirin 81 mg- did not receive 8 AM dose. 6. Tube Feeding: Jevity solution 1.5 cal (calorie) per mL (milliliter) 70 mL per hour-Did not receive tube feeding for AM shift (6-2 PM). 7. Water flush: 100 mL five times daily-did not receive Noon water flush. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/28/22 at 11:45 AM, Surveyor asked NHA (Nursing Home Administrator)-A about R10 not receiving their medications or tube feeding this morning. NHA-A responded that there was only 1 nurse in the building and that the only residents that have received their medications so far were on the ventilator unit. R10 resides on the East Unit. NHA-A confirmed that R10 has not received their medications or tube feeding in accordance with plan of care. On 3/28/22 at 3:30 PM, Surveyors made NHA-A aware of concerns related to R10 not receiving medications or tube feeding in accordance with their care plan on 3/28/22. No additional information was provided by the facility at this time. 38829 9. R3 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Encephalopathy, Bipolar, Cognitive Communication Deficit, Unspecified Dementia, Major Depressive Disorder, and Transient Cerebral Ischemic Attack. R3 has an activated Health Care Power of Attorney (HCPOA). R3's Quarterly Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview for Mental Status (BIMS) score to be 5, indicating R3 demonstrates severely impaired skills for daily decision making. R3's Patient Health Questionnaire (PHQ-9) score is 8, indicating R3 has mild depression. R3 requires extensive assistance with bed mobility, locomotion on/off the unit, and transfers. R3 is not steady with balance during transitions and walking. Surveyor notes that R3 did not receive the following medications per R3's Medication Administration Record(MAR) on 3/28/22 1. Med Pass 2.0 3 times a day-did not receive 8 AM and 12 PM dose 2. Buspirone HCl 10 MG-3 times a day-did not receive 8 AM and 12 PM dose 3. Vitamin B1-1 tablet 1 time a day-did not receive 8 AM dose 4. High calorie frozen dessert-give 2 times a day-did not receive 12 PM dose 5. Olopatadine HCl Solution-instill 1 drop both eyes 2 times a day-did not receive 8 AM dose 6. Plavix 75 MG-did not receive 8 AM dose 7. Potassium Tablet-1 time a day-did not receive 8 AM dose 8. Multivitamin Plus-1 tablet 1 time a day-did not receive 8 AM dose 9. Namenda 15 MG-1 tablet 1 time a day-did not receive 8 AM dose 10. Omeprazole 10 MG-1 capsule 1 time a day-did not receive 8 AM dose 12. Lexapro 10 MG-1 time a day-did not receive 8 AM dose (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. R7 was admitted on [DATE] with diagnoses of Wernickes Encephalopathy, Guillain-Barre Syndrome, Alcohol Abuse with Intoxication, Unspecified Psychosis and Essential Hypertension. R7 is her own person. R7's Admission Minimum Data Set (MDS) dated [DATE] documents R7's Brief Interview for Mental Status (BIMS) score to be 15, indicating R7 is cognitively intact for daily decision making. R7's Patient Health Questionnaire(PHQ-9) score is 1, indicating minimal depression. R7 requires extensive assistance with bed mobility and dressing. R7 requires total assistance for transfers and bathing. Surveyor notes that R7 did not receive the following medications per R7's MAR on 3/28/22 1. Magnesium Oxide Tablet 400 MG- 2 times a day-did not receive 8 AM dose 2. Vitamin B12 Tablet 100 MCG-1 tablet 1 time a day-did not receive 8 AM dose 3. Gabapentin Capsule 300 MG-1 capsule 2 times a day-did not receive 8 AM dose 4. Omeprazole Capsule Delayed Release 20 MG-give 2 capsules 1 time a day-did not receive 8 AM dose 5. Thiamine HCl Tablet 100 MG-1 tablet 1 time a day-did not receive 8 AM dose 6. Multivitaimin Tablet-1 tablet 1 time a day-did not receive 8 AM dose 7. Duloxetine HCl 60 MG-did not receive 8 AM dose 8. Folic Acid 1 MG-1 tablet 1 time a day-did not receive 8 AM dose 9. Aspirin 81 MG-1 tablet 1 time a day-did not receive 8 AM dose 11. R16 was admitted on [DATE] with diagnoses of Huntington's Disease, Unspecified Dementia, Schizophrenia, Bipolar, Psychotic Disorder, Unspecified Intellectual Disabilities, and Dysphagia. R16 has a legal guardian. R16's Admission MDS dated [DATE] documents R16's short and long term memory is impaired and R16 demonstrates severely impaired skills for daily decision making. R16's PHQ-9 score done by staff is a 8, indicating mild depression. There are no behaviors documented on R16's MDS. R16 is extensive assistance for bed mobility. R16 requires total dependence of 2 staff for transfers. R16 is total dependence for dressing, toileting, and bathing. R16 has both upper and lower bilateral range of motion impairment. R16 is always incontinent and requires tube feeding. Surveyor notes that R16 did not receive the following medications per R16's MAR on 3/28/22: 1. Haloperidol 20 MG- 1 tablet 3 times a day-did not receive 8 AM and 12 PM dose 2. Multivitamin- 1 tablet via peg tube 1 time a day-did not receive 8 AM dose 3. Senna Tablet 8.6 MG suspension-give 1 tablet via peg tube 1 time a day-did not receive 8 AM dose (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Folic Acid 1 MG-give 1 tablet via peg tube 1 time a day-did not receive 8 AM dose 5. Midodrine HCl 10 MG-give 1 tablet via peg tube 3 times a day-did not receive 8 AM and 12 PM dose 6. Robinul 1 MG-give 1 tablet via peg tube 3 times a day-did not receive 8 AM and 12 PM dose 12. R17 was admitted on [DATE] with diagnoses of Major Depressive Disorder, Cerberal Infarction, End Stage Renal Disease, Metabolic Encephalopathy, Coagulation Defect, Bells Palsy, Type 2 Diabetes Mellitus, and Fibromyalgia. R17 is her own person. R17's last documented MDS dated [DATE] documents R17 has a BIMS of 15 indicating R17 is cognitively intact for daily decision making. R17's PHQ-9 score is 3, indicating minimal depression. R17 requires extensive assistance with bed mobility, transfers, dressing, and toileting,. R17 is not steady with balance during transitions and walking. R17 has range of motion (ROM) impairment on 1 upper extremity and bilateral lower extremities. Surveyor notes there is no completed admission MDS for this recent admission from 3/7/22. Surveyor notes that R17 did not receive the following medications per R17's MAR on 3/28/22: 1. Amlodipine 10 MG-1 tablet in the morning-did not receive 8 AM dose 2. Clopidogrel 75 MG- 1 tablet 1 time a day-did not receive 8 AM dose 3. Cyanocobalamin 500 MG-1 tablet 1 time a day-did not receive 8 AM dose 4. Ergocalciferol 1.25 capsule-1 capsule 1 time a day every Monday-did not receive 8 AM dose 5. Hydroxychloroquine 200 MG-1 tablet 1 time a day-did not receive 8 AM dose 6. Levetiracetam 750 MG-1 tablet 1 time a day-did not receive 8 AM dose 7. Lisinopril 40 MG-1 tablet 1 time a day-did not receive 8 AM dose 8. Omeprazole 20 MG-2 capsules 1 time a day-did not receive 8 AM dose 9. Sertraline HCl 50 MG-1 tablet 1 time a day-did not receive 8 AM dose 10. Oxybutynin Chloride Extended Release 10 MG-1 tablet 2 times a day-did not receive 8 AM dose 11. Calcium Acetate 667 MG-3 tablets 3 times a day-did not receive 8 AM and 12 PM dose

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on observation, interview, and record review the facility did not ensure that 7 (R10, R2, R4, R13, R14, R11, R18) of 8 residents reviewed were free from significant medication errors. According to the State Operations Manual, Appendix PP-Guidance t Surveyors for Long Term Care Facilities, (11/22/17), A Significant medication error means one which causes the resident discomfort or jeopardizes his or her health and safety . * On 3/28/22, R10 did not receive their scheduled tube feeding, gastronomy tube water flush, blood glucose monitoring and insulin. On 3/14/22, R10's after hospital visit summary ordered for R10 to receive scheduled detemir insulin 10 units each morning and regular insulin per sliding scale based off of R10's glood sugar readings. The regular insulin order per sliding scale based off of blood sugar readings was not transcibed into R10's readmission orders on 3/14/22, and was not transcribed into the March's 2022 physician orders. R10 did not receive regular insulin based off of blood sugar readings since no blood sugar checks were done since readmission on 3/14/22, with the exception of the 3/30/22 nurses note. On 3/30/22, R10 was admitted into the hospital. According to the nurses notes, R10 had been sent to the emergency room due to altered mental status and a blood sugar reading of 500 mg (milligrams)/dL (deciliter). * On 3/28/22, R2 did not receive their scheduled seizure medication. * On 3/28/22, R4 did not receive blood pressure medications, a diuretic, 2 antibiotics, blood glucose monitoring and sliding scale insulin. * On 3/28/22, R13 did not receive blood pressure medications, a diuretic, 2 antibiotics, blood glucose monitoring and sliding scale insulin. * On 3/28/22, R14 did not receive blood pressure medications, a diuretic, an anticoagulant, intravenous antibiotic, and inhaled respiratory medications. * On 3/28/22, R11 did not receive their scheduled blood glucose monitoring at 8 AM and 12 PM. R11 did not receive their scheduled insulin. * On 3/28/22, R18 did not receive their scheduled blood glucose monitoring at 8 AM and 12 PM. R18 did not receive their sliding scale insulin. Example 1 involving R10 rises to a scope and severity level of harm/isolated. Findings include: On 3/28/22, Surveyor reviewed the daily staffing schedule provided by the facility and noted Director of Nursing (DON)-B was listed as assigned to the vent unit and the only nurse in the facility. (continued on next page)

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	525498	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/28/22 at 11:36 AM, Scheduler (SCH)-I stated there was only one nurse in the building and Nursing Home Administrator (NHA)-A was aware of staffing concerns. On 3/28/22 at 11:56 AM, NHA-A stated she was aware of staffing concerns as she had been notified at 6:20 AM and DON-B was the only nurse in the facility despite offering $200 bonuses and calling agencies. NHA-A stated medications were not passed. NHA-A stated the shortage of nurses does not happen often and usually manage to get things passed. On 3/28/22, at 12:00 PM, DON-B stated she tried to do most of the residents' blood sugars but no insulins were given or IV medications given as there was no time. DON-B stated she would try to do her best to get the noon blood sugars done but she did not know if she could as she needed to be in the vent unit. On 3/28/22 at 12:27 PM, NHA-A stated she did a blanket call to physicians to notify them that medications were not given and stated insulins and tube feedings were not done. On 3/28/22 at 2:47 PM, Surveyor interviewed Med Tech (MT)-O who stated she was passing medications for 34 residents. MT-O stated she will not give the missing AM medications as it is not in the plan as it is too late and too far out. 1. R10 was admitted to the facility on [DATE] with diagnoses of Dementia, Diabetes Mellitus type 2, failure to thrive and encephalopathy. R10's Minimum Data Set (MDS) assessment dated [DATE] indicates R10 has a BIMS (Brief Interview of Mental Status) score of 00, indicating R10 is unable to participate in daily decision making. Surveyor notes that R10 did not receive the following medications per R10's MAR on 3/28/22: 1. Furosemide 20 mg - did not receive 8 AM dose. 2. Insulin Detemir 10 units subcutaneously- did not receive 8 AM dose. 3. Tube Feeding: Jevity solution 1.5 cal (calorie) per mL (milliliter) 70 mL per hour-Did not receive tube feeding for AM shift (6-2 PM). 4. Water flush: 100 mL five times daily-missed 12 PM dose. On 3/28/22 at 11:45 AM, Surveyor asked NHA (Nursing Home Administrator)-A about R10 not receiving their medications or tube feeding this morning. NHA-A responded that there was only 1 nurse in the building and that the only residents who received their medications so far were on the ventilator unit. R10 resides on the East Unit. NHA-A confirmed that R10 has not received their medications or tube feeding in accordance with plan of care. On 3/28/22 at 3:30 PM, Surveyor made NHA-A aware of concerns related to R10 not receiving medications or tube feeding in accordance with their care plan on 3/28/22. No additional information was provided by the facility at this time. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R10's nurse progress notes from 3/30/22. Surveyor noted that R10 had been sent out to the emergency room due to altered mental status and a blood sugar reading of 500 mg (milligrams)/dL (deciliter). Additionally, Surveyor reviewed R10's hospital after visit summary from 3/14/22. Surveyor notes orders for R10 to receive scheduled detemir insulin 10 units each morning and regular insulin per sliding scale based off of R10's blood sugar readings. Order from 3/14/22 reads: insulin regular 100 unit/mL injection, Blood glucose low dose Correction, blood glucose <70 Assess patient for symptoms. Administer hypoglycemia meds if indicated. Call Physician .blood glucose 70-149 No action, blood glucose 150-200 2 unit, blood glucose 201-250 3 units, blood glucose 251-300 4 units, blood glucose 301-350 6 units, blood glucose 351-400 8 units, blood glucose >400 Obtain STAT blood glucose, give 8 units and call physician. Surveyor reviewed R10's physician's orders for March 2022. Surveyor could not identify any orders for R10 to receive regularly scheduled blood sugar monitoring. No additional blood sugar monitoring was identified in R10's medical record with the exception of R10's 3/30/22 reading. Surveyor attempted to review R10's admission assessment dated [DATE]. No admission assessment was noted in R10's medical record. On 4/4/22, Surveyor conducted interview with DON (Director of Nursing)-B. Surveyor asked DON-B which nurse had readmitted R10 to the facility on [DATE]. DON-B could not identify which nurse had readmitted R10 to the facility on [DATE] but knows that they had been an agency staff member. Surveyor asked DON-B how a nurse would know what medications a resident should receive when they are readmitted from the hospital. DON-B told Surveyor that they would review the resident's discharge paperwork from the hospital and confirm the medications with the resident's attending physician. DON-B showed Surveyor an admission check list that the admitting nurse should be using to make sure all necessary tasks are performed when a resident is readmitted . Surveyor asked why R10's sliding scale insulin order and blood sugar readings had not been transcribed as part of R10's readmission orders on 3/14/22. DON-B responded that the admitting nurse must have not seen the order and that it had gotten missed. On 4/4/22 at 1:15 PM, Surveyor shared concern with NHA-A that R10 had not been receiving regular blood sugar monitoring or sliding scale insulin in accordance with their physician's orders. No additional information was provided at this time. 2. R2 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis and Osteoarthritis. R2's Quarterly 12/29/21 Minimum Data Set (MDS) indicated R2 was cognitively intact. On 3/29/22, Surveyor reviewed the Medication Administration Record (MAR) for March 2022 for R2. It was noted that the following significant medications were not initialed as being administered on 3/28/22 at 8:00 a. m. as scheduled per MAR: Phenytek Capsule 300 mg (Phenytoin Sodium Extended)-Give 1 tablet by mouth one time a day for seizures/convulsions. *Phenytoin is an anticonvulsant which is administered to treat and prevent seizures. Phenytoin blood levels are monitored and missing a single dose could alter that level which could precipitate a seizure. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	3. R4 was admitted to the facility on [DATE] with diagnoses including Diabetes, Multiple Myeloma, and Hypertension. R4's Quarterly 3/7/22 MDS indicated R4 was cognitively intact. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R4. It was noted that the following medications were not initialed as being administered on 3/28/22 at 8:00 a.m. as scheduled per MAR: Amlodipine Besylate tablet 5 mg-Give 0.5 tablet via PEG-tube 1 time/day. Furosemide Solution 10 mg/ml-Give 4 ml via PEG-tube 1 time/day. Metoprolol Tartrate tablet 100 mg-Give 1 tablet via PEG-tube every 12 hours. Acyclovir Suspension 200 mg/5 ml-Give 10 ml via PEG-tube 2 times/day. Bactrim DS tablet 800-160 mg-Give 1 tablet via PEG-tube 2 times/day every Mon, Wed, Fri. Clonidine HCL tablet 0.3 mg-Give 1 tablet via PEG-tube every 12 hours. Humalog Kwik-Pen solution pen injector 100 unit/ml (Insulin Lispro)-Inject as per sliding scale subcutaneously 3 times/day. *Surveyor noted that R4's blood sugars and insulin was not documented for either scheduled times of 0800 and 1200. *R4 missed blood pressure medications, a diuretic, 2 antibiotics, and the blood sugar checks with insulin which had a high potential for R4 to have adverse consequences. 4. R13 was admitted to the facility on [DATE] with diagnoses including Dementia, Agoraphobia, and Hypertension. R13's 2/28/22 Admission MDS indicated R13 was cognitively intact without functional impairments. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R13. It was noted that the following medications were not initialed as being administered on 3/28/22 at 8:00 a.m. as scheduled per MAR: Divalproex Sodium tablet delayed release 500 mg-Give 1 tablet by mouth every 12 hours. *Divalproex is an anticonvulsant in which blood levels are monitored and missing a single dose could alter that level. 5. R14 was admitted to the facility on [DATE] with diagnoses including Aortic Valve Vegetation, COPD (Chronic Obstructive Pulmonary Disease) exacerbation, and Morbid Obesity. R14's 3/18/22 Admission MDS was in progress. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R14. It was noted that the following medications were not initialed as being administered on 3/28/22 at 8:00 a.m. as scheduled per MAR: Digoxin 125 mcg-Give 1 tablet by mouth 1 time/day. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*Digoxin is used to treat certain heart conditions. Digoxin blood levels are monitored and missing a single dose could alter that level which could precipitate heart conditions. Eliquis 5 mg-Give 1 tablet 2 times/day. *Eliquis is used to prevent blood clots and missing a single dose could lead to an adverse consequence. Lasix tablet 80 mg-Give 1 tablet 2 times/day. *Lasix is diuretic intended to remove excess fluid and missing a single dose could lead to an adverse consequence including an electrolyte imbalance. Metoprolol Tartrate tablet-Give 12.5 mg by mouth 2 times/day. *Metoprolol is a heart rate and blood pressure medication and missing a single dose could lead to an adverse consequence. Cefazolin Sodium solution-Use 2 gm intravenously every 8 hours. *R14 was receiving Cefazolin IV for aortic valve vegetation and missing a single dose would change the blood concentration could lead to an adverse consequence. Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 ml-1 vial inhale orally 4 times/day. Surveyor noted the vial (medication) was not documented for either scheduled times of 0800 and 1200. *R14 missed 2 doses of an inhaled medication designed to assist with breathing and could lead to respiratory distress. Monitor PICC (Peripherally Inserted Central Catheter) line to RUE (Right Upper Extremity) site every shift for S/S (Signs/Symptoms) of infection every shift. On 3/29/22, at 8:15 AM, Surveyor interviewed R14 who stated no medications were administered yesterday (3/28/22) as R14 was told there was no licensed person to give them. On 3/30/22, at 3:00 PM, Surveyor observed R14's PICC line which had a 3/18/22 admitted d dressing. Surveyor noted R14 had a 3/25/22 Physician order to change PICC line dressing every 7 days. R14's MAR indicated initials and documentation of dressing change on 3/25/22 at 8:00 AM. Surveyor notified DON-B of the dated 3/18/22 dressing and the conflicting documentation in R14's MAR. DON-B stated she will assess and change the dressing, rewrite the order then educate the nurse. On 3/29/22, at 1:30 PM, Surveyor shared concerns regarding significant medications not being provided on 3/28/22 with NHA-A. 16584 6. R11 was admitted with diagnosis that included Diabetes Mellitus due to underlying condition with diabetic neuropathy. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A review of R11's physician orders documented that R11 is to receive Humalog Kwikpen Solution 100 unit, inject 10 unit subcutaneous three times daily. In addition, R11 is to receive Humalog Kwikpen Solution 100 unit, inject as per sliding scale: if 100-150= 1 unit, 151-200= 2 units, 201-250= 3 units, 251-300= 4 units, 301-400= 5 units, 401-450= 6 units, subcutaneous three times a day (8:00 a.m., Noon and 4:00 p.m.) for Diabetes Mellitus, notify MD if greater than 450. On 3/29/22, Surveyor reviewed the MAR for March 2022 for R11. It was noted that on 3/28/22, R11 did not receive his noon (12:00) dose of Humalog Kwikpen Solution 100 unit, inject 10 unit subcutaneous and the Humalog Kwikpen Solution 100 unit, inject as per sliding scale: if 100-150= 1 unit, 151-200= 2 units, 201-250= 3 units, 251-300= 4 units, 301-400= 5 units, 401-450= 6 units, subcutaneous. It was also noted that R11's blood sugars were not checked at noon as well. 7. R18 was originally admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus. A review of R18's physician orders documented that R18 is to receive Humalog Kwikpen Solution 100 unit, inject as per sliding scale: if 150-199=3 units, 150 or less, 0 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units and 350 or greater give 15 units and notify MD three times daily (8:00 a.m., Noon and 4:00 p.m.) On 3/29/22, Surveyor reviewed the MAR for March 2022 for R18. It was noted that R18 did not have her blood sugars checked at 8:00 a.m. or Noon (12:00) and was not administered the Humalog Kwikpen Solution 100 unit, inject as per sliding scale: if 150-199=3 units, 150 or less, 0 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units and 350 or greater give 15 units at 8:00 a.m. or Noon on 3/28/22. 42037

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review, observations and staff interviews, the governing body did not implement policies regarding the management and operation of the facility to ensure residents received care that attained or maintained their highest practicable level of physical, mental, and psychosocial well-being. This resulted in 7 Immediate Jeopardy citations being issued at Resident Neglect (F600), Resident Quality of Life (F675), The prevention and treatment of pressure injuries (F686), Free of Accident Hazards, (F689), Nutrition/hydration (F692), Sufficient staffing (F725) and Governing Body (F837). The governing body was made aware that the facility was experiencing significant staffing shortages, yet the administrator indicated she was directed to continue taking new admissions. Forty-seven (47) residents were admitted in February and March 2022. The governing body did not ensure that the plan set forth in the facility's assessment was followed. The governing body should have been aware, that due to the lack of staff, they could not meet the needs of the 70 residents, who were dependent on the facility staff to provide both care and treatments and an overall good quality of life. The governing body's failure to implement policies to ensure the facility had the resources to meet resident needs created a finding of immediate jeopardy that began on 2/28/22. Administrator A and VP of Operations L were notified of the immediate jeopardy on 4/4/22 at 4:45 p.m. Per this regulation, the governing body is als responsible for the facility's Quality Assurance and Program Improvement (QAPI) plan. On 4/14/22 the facility had their first QAPI meeting. This was the first QAPI meeting conducted after 4/4/22 when the QAPI team met to discuss the IJ citations and plans of abatement. Neither the [NAME] President of Operations (VPO)-L nor Corporate RN BB were in attendance. On 4/14/22, Administrator A informed Surveyor that earlier this morning on 4/14/22, VPO- L and Corporate Consultant RN BB flew back to North Carolina, and they informed Administrator A there was an issue with the Management contract. Administrator A stated they VPO-L and Corporate Consultant RN BB indicated they would not be back in the building until the issue with the contract is clarified. As of 4/14/22 at the time of the exit of the partial extended survey, the Immediate Jeopardy was not removed. This is evidenced by: The Facility's Assessment reflects the following: Policy Review: Facility Assessment last revised October 2018 (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Policy statement: A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day- to- day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. Policy Interpretation and Implementation: 1.) Once a year, and as needed, a designated team conducts a facility- wide assessment to ensure that the resources available meet the specific needs of our residents. 2.) The team responsible for conducting, reviewing and updating the facility assessment includes the following: a. Administrator b. A representative of the governing body c. The medical director d. The director of nursing 3.) The facility assessment includes a detailed review of the resident population. This part of the assessment includes: a. resident census data from the previous 12 months b. resident capacity of the facility and its occupancy rate for the past 12 months c. factors that affect the overall acuity of the residents, such as the number and percentage of residents with: 1. Need for assistance with ADL's 2. Mobility impairments 3. Incontinence (bowel and bladder) 4. Cognitive or behavioral impairments 5. conditions or diseases that require specialized care (e.g. dialysis, ventilators, wound care) . 6.) The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps determine budget, staffing, training, equipment and supplies needed. It is separate from the Quality Assurance and Performance Improvement evaluation. The Facility Assessment Tool was last updated 1/24/2022 and reviewed with the Quality Assurance committee in January 2022. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility is licensed to provide care for 87 residents. The average daily census is 71 residents. Part 2: Services and Care that [NAME] of [NAME] Village offer based on resident's needs includes: activities of daily living, mobility and fall/ fall with injury prevention, bowel and bladder toileting programs, pressure injury prevention and care, manage the medical conditions and medication- related issues causing psychiatric, symptoms and behaviors, awareness of any limitations of administering mediations, assessment of pain, identification and containment of infections, prevention of infections, management of medical conditions, other special care needs such as Dialysis, hospice ostomy care, tracheotomy care and ventilator care, speech, physical and occupational therapy, nutrition services to address individualized dietary requirements, person- centered/ directed care, and psycho/ social /spiritual support. Part 3: Facility Resources needed to provide competent support and care for our resident population every day and during emergencies. Staff type: 1.1 [NAME] of [NAME] has the following staff members, other health care professionals, consultants, and medical practitioners to provide support and care for residents. This list includes but is not limited to: * Administration (i.e.- Administrator, staff development, environmental services, social services, admission. marketing, business office, finance, human resources, corporate compliance, corporate staff). * Nursing Services (i.e.- Director of nursing, Assistant Director of Nursing, RN, LPN, CNA, Medication Aide, MDS nurse, Wound/ Treatment nurse, Infection Control Coordinator) * Food and Nutrition Services (i.e. Director, cooks, support staff, registered dietician) * Therapy Services (i.e. TO, OTA, PT, PTA, RT, RT tech, speech language pathology) * Medical/ Physician Services (i.e. Medical Director, Attending Physician, Physician assistant, Nurse Practitioner) * Pharmacist * Behavioral and mental health providers * Support staff (i.e.- engineering, plant operations, information technologies, housekeeping, maintenance staff, laundry services) * Other (vocational services worker, clinical laboratory services worker, diagnostic x- ray services worker, blood services worker) psychiatric services and mental health providers. 3.2) Staffing plan: (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	* Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/ or post traumatic stress disorder, and implementing nonpharmacological interventions. The following concerns show that the governing body and the facility did not have the capacity to meet the needs of, and to competently care for, their residents during day- to -day operations, based on the facility assessment: 1. The Governing body and the facility did not ensure 70 residents residing in the facility were free from neglect when the facility did not ensure sufficient staff were deployed to care for residents. This resulted in a finding of immediate jeopardy and substandard quality of care. (Cross Reference F600) 2. The Governing body and the facility did not promote a quality of life by providing 70 residents with the necessary cares and services for residents to maintain their highest practicable level of physical, mental, and psychosocial well-being. Residents stated that they felt scared and felt neglected and felt as if no one would help them because there was no staff. The governing body did not ensure and the facility did not provide an adequate level of staff to provide cares and services to residents of the facility for an extended period of time. This left residents to go without showers/baths, daily personal hygiene, repositioning in the bed and chairs, proper treatment and assessments of pressure ulcers, prevention of falls and medications administered per physician orders and within required timeframes. The facility continued to admit new residents to the facility knowing that they were facing daily staffing shortages and providing necessary cares and services to the current residents proved to be incomplete. This pervasive disregard for residents' quality of life created a finding of Immediate Jeopardy and Substandard Quality of Care. (Cross Reference F675) 3. The Governing body and the facility did not provide sufficient staffing to meet the needs of 70 residents living in the facility. The survey team entered the building on 3/28/22 at 8:00 a.m. Staff interview was conducted, and it was confirmed that there was only 1 Registered Nurse and 5 Certified Nursing Assistants to care for 70 residents. Facility staff stated that the morning medication pass would not be completed and the only Registered Nurse had to stay on the Vent unit, leaving the other 4 units without a licensed nurse. A review of the facility staff schedules for the month of March 2022 showed that the facility was often understaffed causing staff to work on more than one unit and at times working without the assistance of another staff member on their assigned unit. Because there was inadequate staff, residents were left in their rooms and in bed, did not receive showers/ baths, did not receive assistance with daily hygiene, residents were not provided with enough supervision to prevent falls, residents who were at risk for skin breakdown were not turned and repositioned, medications were not administered timely, and treatments were not always provided. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The failure to provide adequate staffing created a finding of Immediate Jeopardy. (Cross reference F725) 4. The Governing body and the facility did not ensure 10 residents who are dependent of staff for activities of daily living received weekly skin checks and showers/baths and assistance with personal hygiene. The governing body was aware of the staffing shortages and should have anticipated that all care needs could not be met without sufficient staff. The facility did not have accurate documentation/information to show R10, R5, R11, R8, R3, R7, R2, R4, R13, R14 received showers consistent with R's care plans, in addition skin checks were not always completed as per facility policy for R3, R7, R2, R4, R13, R14. R10 is not receiving weekly showers in accordance with R10's plan of care. R10 was observed on 3/28/22 at 9:20 AM, 12:20 PM, and 2:45 PM and again on 3/29/22 at 7:45 AM and appeared very disheveled with dry, flaky skin and excessive facial hair. R11 was observed in bed on 3/28/22 at 12:39 PM .R11's hair was very disheveled and appeared to be greasy as if not washed in some time. R11 is to have a shower at least weekly however no indication of a set day for the shower. The facility was unable to provide any evidence that R11 had been provided a shower for the months of February and March 2022. R4 was observed on 3/29/22 at 8:10 AM lying in the bed on her back with lips cracked and no moisture noted on dry mucous membranes and long beard hairs on chin. R4 stated liking to have her chin shaved and telling the nurses if they see anything on the face to take it off. Surveyor noted R4 had only one documented shower on 3/9/22 in the last 30 days. (Refer to F677) 5. The Governing body and the facility did not ensure 4 residents (R4, R10, R5, R18) received appropriate treatment and services to prevent/ heal pressure ulcers. On 3/29/22, at 6:53 AM, Surveyor interviewed Director of Nursing (DON)-B who stated that for Pressure Injuries I just document what I see, not Wound Certification so no staging. DON-B stated nurses don't measure, only describe, where, what, approximate size but no measurements but stated an RN could stage. DON-B has not seen MD-N notes for over 2 weeks regarding his assessments, measurements, and treatments. DON-B stated she is trying to get access to his corporate notes. On 3/29/22, at 12:54 PM, Surveyor interviewed DON-B who stated the facility doesn't do their own separate staging and measurements, only MD-N stages and measures wounds. DON-B stated she was doing a little bit of everything and has not seen the Wound Physician notes for 2 weeks therefore unable to address any questions. On 2/14/22, R4 developed three unstageable pressure injuries. These combined into one unstageable wound that is now 56 times larger in area than when first identified (2.02 sq. cm. vs. 160 sq. cm). In addition, during 2 different wound care observations, R4 had developed two additional ischial wounds that were not addressed by the facility. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R10 acquired an unstageable pressure injury while residing at the facility and was hospitalized , requiring intravenous antibiotic treatment for the infected pressure injury. R5 acquired a stage 4 pressure injury while residing at the facility and was hospitalized , requiring antibiotic treatment for the infected pressure injury. R18's pressure ulcer to the coccyx was not compressively assessed upon her original admission on 3/1/22 and then upon readmission on 3/22/22 and 3/23/22. R18 did not have a plan of care addressing the pressure ulcer with interventions put into place to aide in the healing of the pressure ulcer. The facility was unable to determine if the treatment they were applying daily to R18's coccyx was effective because they had no means to know if the area was healing or not. Repositioning of residents at risk for skin breakdown could not always occur. On 3/30/22, at 7:00 AM, Surveyor interviewed LPN-P who stated she was the only nurse in the facility when the PM nurse who stayed to help night shift left around 4:00-5:00 AM. LPN-P stated there were only 2 CNAs overnight in the facility so not all care was possible because repositioning requires 2 people. The governing body should have been aware that DON- B was on the schedule to work on the Ventilator Unit, often working 2 shifts a day. With DON- B working on the floor, she was unable to keep up with other tasks that were assigned to her such as being a part of the Wound Team. DON- B stated that she did not feel comfortable with the entire assessment of pressure injuries and the governing body did not ensure, per the facility assessment, they could provide sufficient wound care. This resulted in Immediate Jeopardy and Substandard Quality of Care. (Cross Reference F686) 6. The Governing body and the facility did not ensure 2 residents (R16 and R3) were provided with care in supervision to prevent accidents, resulting in serious injuries. The governing body should have been aware that the lack of sufficient staff, often leaving a unit with only 1 CNA or no CNAs and a shared nurse to provide assessment, would not be able to provide supervision to those residents who were at high risk for falls. This resulted in Immediate Jeopardy and Substandard Quality of Care. R16 has had 12 falls since admission on 2/18/22 to 4/3/22. The fall on 3/27/22 (which was the second fall that day) resulted in stitches above the right eyebrow. The fall on 3/26/22 resulted in staples to the back of the head. The fall on 4/2/22 resulted in a re-opening of the staples. The fall on 4/3/22 led to a laceration on the resident's face that required steri-strips. After review of nursing schedules with each of R16's falls, it is noted that based on census and 15 total Residents residing on the same unit as R16, there was an inadequate number of staff to provide supervision to R16 in order to prevent R16 from frequent falling. On 3/20/22 R3 had a fall with injury and a fall assessment with a thorough root cause analysis, and Neuro checks was not completed. (Cross Reference F689) (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7. The Governing body and the facility did not ensure 2 residents (R16 & R9) who experienced significant weight loss received dietician and physician recommendations based on a comprehensive assessment. The Governing Body should have been aware that not all staff had access to the resident medical records in Point Click Care. The Dietician did not have access to vital information that should have been accessible on each resident so she could conduct a thorough assessment of the residents' nutritional needs. This resulted in Immediate Jeopardy and Substandard Quality of Care. On 3/31/22, R16's weight was obtained. RD-D documents R16's weight has declined to 72.6 pounds, an 18. 6% weight loss since admission. RD-D describes the weight as severely underweight and life-threatening. RD-D contacted the Nursing Home Administrator and recommended R16 be transferred to the hospital STAT. R16 was sent to the emergency room (ER) and returned to the facility on [DATE]. R9 experienced a significant weight loss of 35.4 pounds (29.8%) from 11/15/21 to 1/31/22 without any compressive assessment or dietary intervention. (Cross Reference F692) 8. The Governing body and the facility did not ensure 12 residents received their morning and noon medications on 3/28/22 when the facility only had 1 nurse in the building and could not complete the medication pass. Of the 12 residents, 6 residents experienced a significant medication error by not being administered their insulin, tube feeding or IV antibiotic. The Governing Body should have been aware the lack of sufficient staff, including nurse, would lead to a delay or even omission of the administration of medications for the residents. Upon entrance to the facility on [DATE], there was only 1 nurse on the schedule for 70 residents. Administration was aware and was not able to rectify the situation. During the first shift on 3/28/22, the facility had only 1 Registered Nurse (RN) on duty with a census of 70 residents. Due to staffing shortages, the 3/28/22 morning and noon medications were not administered to the following residents (R8, R11, R18, R2, R4, R13, R14, R10, R3, R7, R16, and R17). The facility did not follow physician orders to administer medications within the required timeframe. The facility did not ensure that 7 (R2, R4, R13, R14, R10, R11, R18) of 8 residents reviewed were free from significant medication errors. (Cross Reference F755 and F760) On 3/30/22 at 3:30 p.m., Surveyor interviewed Administrator - A regarding the staffing shortage that the facility is experiencing. Administrator - A provides a weekly orientation to new staff and has found that for whatever reason staff don't stay on as employees after orientation. Administrator- A acknowledged that there are many open positions for nursing and certified nursing assistant staff and that Corporate level staff are aware. Administrator- A stated that she reports weekly to VPO L where the facility is at with staffing levels. Administrator- A confirmed that DON- B is wishing to step-down and just work on the Vent Unit and this will leave an opening for a Director of Nursing as well as there is an opening for a MDS Nurse. Administrator - A stated that the facility has a contract with 3 different staffing agencies, and often this can be challenge because the staffing agencies are short on staff. Administrator- A stated that the Corporation was going to send a Regional Nurse to assist, but the nurse fell ill and was unable to travel. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/31/22 at 12:10 p.m., Surveyor interviewed Administrator- A regarding the facility's admission during the month of February and March 2022. Administrator- A provided Surveyor with a report that showed the facility accepted 47 new admissions during February and March 2022. Administrator- A stated that she was aware of the staffing shortages and would report this to the Corporation weekly. Administrator- A states she was told the facility should continue to take new admissions during this time. The Failure to ensure the governing body implemented policies and procedures related to the management and operation of the facility contributed to multiple care issues identified during this survey and created a finding of immediate jeopardy. As of 4/14/22, the facility continued to have ongoing staffing issues with obtaining and retaining CNAs and licensed nursing staff. According to Administrator A, the facility owes staffing agencies money which limits their ability to get staff. According to the facility's Immediate jeopardy removal plan approved on 4/7/22, the Governing body composed of the Corporate MDS nurse-RN, Nurse Consultant RN, Human Resource Director, and [NAME] President of Operations will monitor the facility daily for proper follow up for 4 weeks, then weekly for 4 months, and monthly thereafter in the areas identified but no limited to implementation of the clinical team, abuse, neglect, misappropriation, staffing, quality of care, wound care, falls, and weight loss. The governing body will review the outcome of the monthly QAPI to ensure the areas of the plans of correction are implemented, monitored, and maintained. The results of daily walking rounds, wound care, staffing to meet the acuity of residents, falls, assessment/interventions, comprehensive assessments, care plans, weight loss will be reviewed by the governing body for further follow up and recommendation. The VPO will review the outcome of these audits with the facility and corporate QAPI committee monthly for 6 months. The VPO will further review with the Medical Director the status of and outcomes of the audits monthly for further follow up and recommendations. Additionally, Corporate RN BB is part of the facility's IJ removal plan to assist with the stability, training and to ensure clinical systems are reinstituted, monitored and maintained until the facility shows compliance as determined by the Regional Nurse Consultant and Corporate team. Corporate RN BB is also part of the Monitoring, Audit, and QAPI plan. This plan was not followed as evidenced by: On 4/11/22 from 9:00 PM to 10:00 PM there was only 2 CNAs and 2 nurses for the facility. According to Administrator A, on 4/11/22 Scheduler I informed Administrator A, VPO-L and RN-BB of concerns about the 4/11/22 PM staffing shortage. Administrator A stated they were piecemealing the evening shift with staff and they could not get anyone else. VPO-L and Corporate RN BB were in the building and aware of the staffing shortage. Administrator A stated VPO L and Corporate RN BB are both RNs. Administrator A stated neither VPO L nor RN BB went to assist with Resident care. Administrator A stated VPO L and Corporate RN BB left the building at 9:00 PM. Administrator A stated although she is not a nurse she went to the units to help out where she could. On 4/14/22 the facility had their QAPI meeting. This was the first meeting conducted after 4/4/22 when the QAPI team met to discuss the IJ citations and plans of abatement. Neither VPO-L or Corporate RN BB were in attendance. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/14/22, Administrator A informed Surveyor that earlier this morning on 4/14/22, VPO- L and Corporate Consultant RN BB flew back to North Carolina, and that they informed Administrator A there was an issue with the Management contract. Administrator A stated they VPO-L and Corporate Consultant RN BB indicated they would not be back in the building until the issue with the contract is clarified. The Failure to ensure the Governing body implemented policies and procedures related to the management and operation of the facility contributed to multiple care issues identified during this survey and created a finding of Immediate Jeopardy. As of 4/14/22 at the time of the partial extended survey exit the facility had not removed the immediate jeopardy.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. 42037 Based on record review and interview the facility did not test 6 (Staff Member-B, Staff Member-E, Staff Member-F, Staff Member-G, Staff Member-H) with medical and non-medical exemptions for COVID-19 in accordance with the facility's policy and procedure based off of county positivity rates. Staff Member-D was not tested in accordance with the facility's policy and procedure based off of county positivity rates and was not granted a medical or non-medical exemption. This had the potential to affect all 56 residents in the facility. Findings include: On 6/6/22, Surveyor reviewed the County positivity rates from April 2022 to June 2022. Surveyor noted that from 4/21 - 6/1/22, the county positivity rate was noted to be at High activity. Surveyor reviewed the Facility's Testing Policy dated 8/28/20. The Facility's Policy and Procedure indicates when the county positivity rate is noted as High that facility staff should be tested for COVID-19 twice weekly. On 6/6/22 at 10:58 AM Surveyor interviewed IP (Infection Prevention) Nurse- C. Surveyor asked when facility staff gets tested for COVID-19. IP Nurse-C stated staff who have exemptions are tested on ce weekly. IP Nurse-C told Surveyor they had just recently started working at the facility in May and is not sure how often the facility was conducting staff testing previous to their hire date. On 6/6/22 at 11:35 PM Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked when facility staff get tested for COVID-19. DON-B stated staff who have exemptions are tested on ce weekly. DON-B added that the facility had recently had a COVID-19 outbreak in which they were testing all staff, including staff members with medical and non-medical exemptions and residents twice weekly. Surveyor asked how staff is made aware of the county positivity rates. DON-B responded they are in contact with the health department and work under their guidance. Surveyor reviewed the facility's employee testing logs. Surveyor noted Staff Member-B, Staff member-E, Staff Member-F, Staff Member-G and Staff Member-H were receiving once weekly testing from 4/21/22 to 6/1/22. During this time period, Staff Member-D, who was hired 2/2/22 and is not fully vaccinated, did not receive testing until 5/17/22. Staff member - D tested positive on 5/17/22. On 6/6/22 at 12:35 PM, Surveyor shared concerns with NHA (Nursing Home Administrator)-A related to facility not following their policy and procedure related to testing per county positivity rates which would have included twice weekly testing for employees from 4/21 to 6/1/22. No additional information was provided by facility at this time.

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F 0888 Level of Harm - Actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 22692 Based on record review and interview, the facility did not ensure all staff were fully vaccinated for COVID-19. The facility's current staff vaccination rate is 95.5% and is not at 100%. Findings include: On 3/31/22, the facility's policy titled Employee Inoculation COVID-19 Pandemic dated 11/8/21 was reviewed and read: All employees must be inoculated unless specifically exempted. On 3/31/22, Surveyor reviewed the NHSN (National Health Safety Network)'s most recent data for the facility dated 3/20/22. On 3/20/22, the facility's percentage of fully vaccinated staff for COVID-19 was noted at 90. 2%. On 3/31/22, Surveyor was provided with facility's current staff vaccination rates as of 3/31/22. On 3/31/22, the facility's percentage of fully vaccinated staff for COVID-19 was noted at 95.5%. As of 3/31/22, the facility currently has a total of 90 staff members, including direct facility hires and contracted employees. As of 3/31/22, 86 of 90 staff members were fully vaccinated and 4 of the 90 staff members were partially vaccinated without exemption or delay. The staff members who were not fully vaccinated were Staff-CC, Staff-DD, Staff-EE, and Staff-FF. On 3/31/22 at 3:00 PM NHA (Nursing Home Administrator)-A was interviewed and indicated she was aware that 4 staff members who should be fully vaccinated were not, and arrangements had been made to get them fully vaccinated soon but could not provide a date when that was going to be. NHA-A indicated that it was the staffs' responsibility before she was made aware that not everyone was fully vaccinated but now the facility is arranging to get this done. No residents were found to have been Covid positive in the last 4 weeks. The above finding was shared with Administrator-A on 3/31/22 at 3:00 PM, Additional information was requested. None was provided.