STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525678	A. Building B. Wing	06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minocqua Health and Rehab	9969 Old Hwy 70 Rd Minocqua, WI 54548

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews, and record reviews, the facility did not consistently care for 3 out of 14 residents (R2, R18, R21) in a dignified manner, recognizing their individuality and promoting enhancement of his/her quality of life. - Resident (R)18 stated he laid in diarrhea in bed for over 1 hour 10 minutes before staff responded to his call light. - R21 stated she laid in a soiled brief for over two hours before staff were able to respond to her call light. - R2 expressed feelings of humiliation when having to wait greater than one hour in a brief that was soiled with bowel movement This is evidenced by: The facility policy and procedure for Dignity was reviewed. According to the policy statement, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy continues to state, the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth and demeaning practices and standards of care that compromise dignity are prohibited. Example 1: R18 has medical diagnoses that include, but are not limited to, Nondisplaced Fracture of the Greater Trochanter, Pressure Injury (PI) Left Heel-Stage III, Pressure Injury (PI) Right Buttock Unstageable with a wound vacuum, Morbid Obesity, Low Back Pain, Presence of Intrathecal pain pump, Major Depressive Disorder, Anxiety Disorder, Ataxia, Venous Insufficiency, Polyosteoarthritis, Presence of Left Artificial Hip Joint, Presence of Bilateral Artificial Knee Joint, and Anemia. According to the Minimum Data Set Assessment (MDS) completed for R18, which was an admission assessment dated [DATE], R18 has a Brief Interview of Mental Status (BIMS) score of 13/15, indicating slight areas of confusion but overall, cognitively intact. Other areas assessed include: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R18 requires extensive assistance of two staff to meet his most basic daily tasks of bed mobility, transfers, and toilet use. He is non-ambulatory related to a recent hip fracture and the inability to apply direct pressure on his right leg, as well as a Stage III PI to his left heel that was recently skin grafted, thus is transferred with the use of a mechanical lift. He requires extensive assistance of one staff to meet his most basic needs of dressing and personal hygiene, and is dependent on staff for bathing. This MDSA also assessed R18 as being occasionally incontinent of bladder function and always incontinent of bowel function. R18 has a history of depression and takes Bupropion (150 Milligrams daily), an antidepressant used to treat major depressive disorder and seasonal affective disorder. During the screening process of R18, on 06/08/21 at 11:03 AM, the Surveyor asked him if he receives care and his needs are met in a timely manner. R18 frowned and stated, There is a terrible, terrible staffing problem here. I am supposed to get the dressing on my foot (sticks out his left leg) every morning. Yesterday, they didn't come and they didn't come. Finally at 7:00 last night I asked 'when is my dressing going to get replaced?' The nurse on the evening shift finally did it. I have to direct all my own care or I wouldn't get taken care of the way I am supposed to. They don't either follow the orders the doctor has written, or they have no time to read them. Last night, I put on my call light a little after 7:00, after the nurse did my treatment. I had to go diarrhea. When I need to go, I need to go NOW. I tried to hold it, but finally it flowed like the Niagara falls out of me. That was after 1 hour and 10 minutes of waiting for someone to answer my call light. If you don't think that was embarrassing. Just terrible to s--- (expletive) your pants and have to lay in it until some young chickie comes and has to clean you up. Horrible! I am a grown man, and let me tell you, taking a dump in your pants is a most horrific feeling . right now, I am paying for the full load. I just wrote them out a check .the other day. I don't mind paying for it, but the expectation is that with that amount of money, I damn well better get better care than I am at this point. I will pay whatever is needed, but I expect better service than laying in s--- (expletive) for over an hour! Example 2: R21 has medical diagnoses that include but are not limited to Malignant Neoplasm of the Vulva and Thyroid Gland, Weakness, History of Falls, Functional Urinary Incontinence, and Urge incontinence. According to the most recent Minimum Data Set Assessment (MDSA) completed for R21, which was a Significant Change in Status assessment dated [DATE] related to R21 enrolling in Hospice Services, R21 requires extensive assistance of two staff to meet her most basic daily tasks of bed mobility, dressing, and toilet use. She requires extensive assistance of one staff to meet tasks such as transfers and personal hygiene. She is non-ambulatory and frequently incontinent of bowel and bladder function. The facility conducted a Brief Interview of Mental Status (BIMS), which scores the individual's cognitive function, and scored R21 as 9/15, indicating moderate impairment. The facility also conducted a PHQ-9 (Patient Health Questionnaire) which assesses each of the 9 DSM-IV (Diagnostic and Statistical Manual of Mental Disorder) criteria. R21 scored 8/27, which indicates mild depression. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the screening process on 6/8/21 at 10:27 AM, the Surveyor asked R21 if she receives care and her needs are met in a timely manner. R21 shook her head and stated, I feel they really need help badly. There are times I do have to wait upwards of two hours for help. Once I laid in my soiled diaper in bed for over two hours with my call light on. I soiled several times in that same incontinent product before someone came to help me. I think I would have been able to go on the toilet had someone come in when I put on my call light. Sometimes it is frustrating. That was very embarrassing for me, having to have young girls clean up a soiled diaper of an old lady. They are short staffed like everyone else in this country right now, people don't want to work . Sometimes the girls get short with us and say they can't help that they can't provide better service because they are short staffed, and will get grumpy. I just tell them, 'Well, I am not receiving the services I would want either' we're all in the same boat. I have to wait until they help me. They don't let me get out of my wheelchair by myself, but yet, they don't walk me in the hall either, so that I can get stronger. They don't have enough staff to do that, so I sit here, all day, just waiting. I guess I could put on my call light and ask for help, but I feel so bad for them. They just don't have the time . On 6/10/21 at 1:18 PM, the Surveyor interviewed Certified Nursing Assistant (CNA) P regarding general staffing and services provided to residents. CNA P stated she felt concerned because she is unable to provide residents with care they are deserving of. CNA P stated, It takes a long time sometimes to answer their call lights because we are short staffed and if we are in a room taking care of someone, we cannot leave to answer call lights. So sometimes it can be one-half to one hour, sometimes longer if there are several call lights going off at one time. I feel terrible for them (residents), they deserve better care. Some nurses will help out, but others won't. We don't have all people that work here help with call lights, which is frustrating when you see people just walk past them. CNA P was asked if she had noticed some decline in residents as a result of not being able to assist them timely. CNA P stated, Oh yes, there is an increase with incontinence because we can't get them to the bathroom in time, so they have to wait for us and end up going in their pants or in bed. I apologize to them, but I know it is embarrassing for some of the residents . I just wish we could give them better care but we are so strapped and can only do so much . 30570 Example #3: On 06/08/21 at 1:50 p.m. the surveyor spoke with R2. R2 indicated she is blind and bed ridden for the most part. R2 further expressed it takes staff a long time to respond to her call light. Usually greater than a half hour and greater than 1 hour is common. R2 expressed she puts on her light due when she needs to be changed. R2 further expressed it is humiliating to lay in bed full of (*X*X-expletive)- bowel movement for over an hour waiting for staff to answer her call light and change her. R2 indicated most staff change her when they get there but often has to wait for someone else after her light is answered. Often having to wait a long time to be cleaned up. Staff say they are too busy to respond to call lights because there is not enough help. R2 further indicated there are a lot of nurses but the facility need aides. Some nurses help, but not all. Some will not help out when you ask. Waiting over an hour full of (*X*X-expletive) bowel movement and you can't help yourself is humiliating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed R2's most recent Minimum data set completed 5/19/21 and noted the following: R2 understands, is understood, and is cognitively intact. R2 is always incontinent of bowel movement and is dependent on staff for personal hygiene. The surveyor reviewed R2's care plan and noted the following: Focus: ADL (Activities of Daily Living) deficit . Goal: Will have all ADL needs met by staff Toileting: incontinent of bowel, approximately change every 2 hours and prn (as needed). On 06/09/21 at 9:52 a.m. the surveyor spoke with Certified Nursing Assistant (CNA) M. CNA M expressed the facility is currently scheduling 3 nurse aides on am and pm shift for 4 floors and 50+ residents. CNA M further expressed it is impossible to respond to call lights timely when the CNA is pulled off one floor to assist on another floor. Often the CNA is absent from the floor for long period of time which causes long wait times for residents to have their needs met. The surveyor asked CNA M if residents are having to wait one hour or greater. CNA M responded she has heard residents complain that they have had to wait over an hour. 22548

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 30570 Based on observation, record review, and interview the facility did not provide the needed Activities of Daily Living (ADL) cares for 1 of 4 residents, (R2,) reviewed for cares. R2 does not receive a weekly bed bath as indicated in her plan of care. R2 is not provided the needed supplies and assistance by staff for brushing her teeth on a daily basis. This is evidenced by: On 06/08/21 at 1:34 pm the surveyor spoke with R2. R2 indicated she is supposed to get a full bed bath every Friday morning, but does not. R2 further expressed she gets a bed bath every couple of weeks. R2 further expressed she is unable to get supplies and complete the bed bath on her own. She is blind and bed ridden for the most part. R2 further expressed staff change her in the morning and evening but most often do not wash her up. The bed bath is needed each week to feel clean. On 06/09/21 at 10:07 am the surveyor spoke with Certified Nursing Assistant (CNA) M regarding R2's cares. CNA M indicated she is familiar with R2. CNA M expressed she completes R2's bed bath on Friday morning when she is assigned the 100 unit. CNA M further expressed CNAs are often unable to complete thorough cares; including bed baths due to being rushed to complete cares for too many residents. The facility is currently staffing 3 CNAs for 4 units of 50+ residents. Staff try their best but can not get everything done as thorough as it should for the residents. CNA M expressed she records the bed bath was done on R2's bed bath sheet in the computer and notifies the nurse when it is completed. 6/09/21 at 2:45 p.m. the surveyor requested and received R2's data for bed baths since 1/01/21. The data notes the following: Bathing weekly Friday AM and PRN (as needed)/bed bath: January 2021: 1/01/21, 1/26/21 (25 days from previous bed bath) and 1/29/21-noted 4/2= dependent on 1 staff for bed bath. February, 2021: 2/12/21 (15 days from previous bed bath) and 2/26/21 (14 days from previous bed bath)-noted as 4/2=dependent on 1 staff for bed bath March, 2021: 3/05/21, 3/12/21, 3/19/21, 3/26/21-noted as 0=Independent-no help or staff oversight at any time April, 2021: 4/2/21, 4/09/21, 4/16/21, 4/23/21 and 4/30/21 noted as 0=Independent or no staff help or oversight at any time May, 2021: 5/07/21, 5/14/21, 5/21/21 and 5/28/21: 4/2=dependent on one staff for bed bath June, 2021: 6/04/21: 0=Independent or no staff help or oversight at any time (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/09/21 at 2:45 p.m. the surveyor spoke with Registered Nurse (RN)/Minimum Data Set Coordinator K regarding R2's frequency of receiving a bed bath and bath documentation. RN K indicated prior to March, 2021, R2 was not scheduled on any specific day to receive a bed bath. The bed bath was a PRN (as needed). The facility scheduled R2 on Friday AMs in March. The facility could not tell when R2 was receiving a bed bath due to lack of documentation. Starting in March the data reflects a 0 which indicates R2 gave herself a bed bath with no help from staff. RN K further stated R2 is unable to give herself a bed bath and is dependent on staff as noted as a 4/2. The 0=data indicates no staff help and does not show R2 received a bed bath. On 6/08/21 at 1:34 p.m. R2 told the surveyor her teeth are not brushed by staff each day. R2 expressed she depends on staff to provide her with toothbrush with paste for her to brush teeth. Staff need to help her brush her teeth as she is blind and not sure she is doing a good job. Need staff to provide cup of water to rinse mouth and basin to spit. She can not get up on own to get supplies, can not fill a glass with water and can not do a thorough job brushing teeth. Further expressing she needs staff to help and has lost teeth in the past due to poor hygiene. R2 further expressed she is provided supplies and assisted with brushing her teeth about one time a month for the past year. R2 expressed her teeth feel grimy and she has resorted to cleaning her teeth by picking at them with her fingernails and wiping her teeth with a Kleenex. R2 further expressed she has had 4 teeth removed since living at the facility about a year ago due to poor oral hygiene. On 06/09/21 at 10:02 a.m. the surveyor again spoke with R2. R2 informed the surveyor she had been washed up in bed after breakfast, her gown and brief were changed and her hair was combed this morning. R2 expressed her teeth were not brushed again. R2 indicated she has 9 teeth remaining on the bottom and 3 teeth on top and does not want to loose any more teeth. Staff did not brush her teeth this morning and rarely do. R2 further indicated she will need to clean her teeth with fingernails and Kleenex which is not sufficient to get them clean. R2 again indicated she has had teeth extracted in the past because of poor care of her teeth and it was not done again today. During the conversation the surveyor noted a small basin on R2's bedside dresser containing a toothbrush which was visibly dry. On 06/09/21 at 10:07 am the surveyor spoke with Certified Nursing Assistant (CNA) M regarding R2's oral care. CNA M indicated she is familiar with R2. CNA M expressed R2 has some teeth. R2 needs staff to gather supplies, fill cup with water, and assist with brushing her teeth to do a thorough job. CNA M expressed she had completed R2's cares this morning with the exception of brushing her teeth. CNA M further expressed R2's teeth should be brushed 1x a shift. CNA M indicated resident toothbrushing is often one of the things the aides do not have time to do because of rushing with cares and lack of staffing. R2 is unable to gather her supplies as she can not get up on her own, she is unable to fill a glass of water on her own and is unable to thoroughly brush her teeth on her own. R2's most recent annual Minimum Data Set (MDS) completed on 5/19/21 notes: ~Understands, is understood and is cognitively intact. ~Does not reject cares, does not transfer from bed and requires extensive assistance of one staff for personal hygiene (including brushing teeth and washing self). Previous quarterly MDS noted on 2/17/21: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~Understands, is understood and is cognitively intact. ~Dependent on staff for transfer and personal hygiene (including brushing teeth and washing self). R2's Care plan notes: Focus: ADL (Activities of Daily Living) self-care deficit related to Diabetes Mellitus, glaucoma, blindness, foley catheter, depression, anxiety, weakness and impaired mobility, personal Goal: R2 will have all ADL's met by staff through review date. Date initiated: 1/18/21, revised on 6/04/21 with a target date of 9/04/21 Interventions: Bath Day: Extensive assist on Friday a.m. and prn Morning/bedtime cares: extensive assist of 1 for upper, dependent for lower and bed bath Oral Care: has own teeth, can brush own teeth with set up. The surveyor requested ADL documentation for R2 including oral care since 01/01/21. Review of the data shows no area for staff to record oral cares as completed. On 06/14/21 at 1:45 p.m. the surveyor spoke with Director of Nursing (DON) B regarding R2's care and staffing to meet resident needs. DON B expressed R2 is dependent on staff to meet her needs. She is alert and oriented. She can not complete her care on her own and she would expect staff to provide the needed care and assistance as outlined in R2's care plan. DON B further expressed the facility does not have enough staff to meet the needs of the residents, cares are rushed, things are missed, and short cuts are made due to current staffing levels.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22548 Based on observations, interviews, and record reviews, the facility failed to implement new approaches with changes in the care plans (CP) in attempts to prevent additional falls from occurring for 2 out of 5 residents (R) reviewed for falls (R11 and R33). The facility failed to do a root cause analysis of the falls, conduct a complete investigation of the falls, or do a risk assessment to identify potential for additional falls. - R33 had a fall in January 2021 after she attempted to transfer self onto the toilet. There was no investigation into the root cause of the fall and no care plan interventions implemented following this fall. R33 made another similar self transfer attempt onto the toilet in April 2021. R33 sustained a left hip fracture and T11-T12 vertebral (spine) fractures. R33 was hospitalized to treat the hip fracture and manage the pain associated with multiple fractures. R33 returned to the facility under Hospice services. R33's ADLs (activities of daily living) have declined and R33 experienced pain as a result of the fall. - R11 had a fall during evening hours. The facility did not determine a root cause analysis nor implement a new intervention after this fall. A few hours later R11 fell again and sent to the hospital where it was determined R11 had sustained multiple fractures. After returning to the facility R11 continued to experience falls during evening hours. The facility did not complete a root cause analysis of the falls, did not increase monitoring of R11 during the evening hours, nor implement new interventions. This is evidenced by: Example #1: R33 was admitted to the facility for long term care on 10/26/18 with the following, but not all inclusive, diagnoses: dementia, heart disease, stroke, depression, and kidney disease. R33 had an AHCPOA (activated health care power of attorney) effective April 2018. R33's AHCPOA was son and FM (Family Member)-F. The facility completed a quarterly MDS (Minimum Data Set) assessment for R33 on 02/02/21 with the following data noted: ~always able to make self understood and usually able to understand others. ~BIMS (brief interview for mental status) was an 8 out of 15 indicative of moderate cognitive deficits. ~able to locomote in room and outside of room with supervision. ~frequently incontinent of bladder and bowel. ~had no pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	~weight was 141#. The facility completed a significant change in status MDS assessment for R33 on 05/03/21 and noted the following declines: ~decline in ability to make self understood. ~decline in BIMS or cognitive function to 5 out of 15. ~change in bladder function. R33 had an indwelling catheter placed. ~decline in transfers. R33 was bedrest and did not transfer. ~decline in ability to locomote in room and outside of room. R33 was bedrest and did not locomote. ~decline in weight to 130#. ~reported frequent moderate pain that affected sleep and day to day activities. Review of the care plan titled .ADL self care . initiated 01/14/21 and last revised on 04/27/21 included fall interventions that read Fall Risk: bed in low position, anti rollback device on w/c (wheelchair), bilateral grab bars ., dycem under w/c seat, floor matt on side of bed, left side of bed against wall, call light in reach, pressure alarm to bed . Review of the care plan titled .risk for falls r/t (related to) confusion, incontinence, unaware of safety needs, decreased vision, Alzheimer's, diuretic (water pill) use, hx (history of) falls . initiated on 01/14/21 and last revised on 05/10/21 included interventions such as anticipate and meet needs, check on resident every 1-2 hours and provide repositioning, and review information on past falls and attempt to determine cause of falls, record root cause of falls, and remove potential causes. Review of R33's progress notes indicated on 01/04/21 at approximately 11:45 a.m., R33 was found on the bathroom floor. According to the nurses notes, R33 needed to go to the bathroom and had not put on call light. R33 did not sustain any injuries. The fall incident report noted R33 was confused, had impaired gait/balance, and memory. The incident report and progress notes did not indicate any changes to the care plan. Surveyor was unable to locate any change to the care plan or the identified root cause. On 01/04/21 at 3:32 p.m., the previous DON (Director of Nurses) documented in R33's progress notes that R33 was reaching for something on the floor which caused the fall to the floor. The facility gave R33 a reacher. The fall investigation did not include the last time a staff member provided care to R33 or did not include any investigation into the root cause of R33's fall. There was no information to support the previous DON's action to provide R33 with a reacher as that was not included in the investigation or identified as the root cause of the fall. The facility did not update the care plan to include the reacher. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R33's progress notes indicated on 04/11/21 at approximately 7:30 to 8:00 p.m. R33 was heard yelling for help by an adjacent resident (R16). R16 put on her call light to summon staff to help R33. RN-E, CNA-D, CNA-L, and RN-BB responded to R33's calls for help and found R33 laying on her left side with her head against the wall in the bathroom. R33 complained of pain in her left leg, left shoulder, and back with movement. R33 had a fall and sustained a left hip fracture, T11-T12 vertebral (spine) fractures, and was hospitalized to repair the left hip fracture and manage the pain associated with the multiple fractures. R33 was readmitted to the facility on [DATE] under Hospice services due to poor prognosis following the fall. Review of the fall incident report noted R33's fall factors were incontinence, impaired memory, and weakness. There was no investigation into the root cause of the fall. There were no staff interviews when R33 had last received staff assistance with cares. The facility completed an admission pain assessment on 04/20/21 and noted R33 had moderate pain as evidenced by her statements, moaning, and crying out in pain with movement. In addition, R33 was placed on bedrest and an indwelling foley catheter was placed due to pain with movement. On 06/09/21 and 06/10/21, Surveyor requested any information regarding R33's falls that would identify a thorough investigation into the root cause of the fall and any changes to the care plan. On 06/14/21 at 10:50 a.m., DON-B stated there was no additional information on R33's falls in January or April of 2021. DON-B stated the root causes of R33's falls were not identified and there were no changes to the care plan made following R33's falls in January and April 2021. DON-B stated there were no investigations of R33's falls documented. On 06/14/21 at 11:05 a.m., ADON (Assistant Director of Nurses)-CC approached Surveyor and stated there was no additional information to provide regarding R33's falls in January and April, 2021. ADON-CC stated there was no investigation, no root cause analysis, and no changes to the care plan following R33's falls. Surveyor requested a list of all staff working on 04/11/21 on the second shift and noted there was two RNs (Registered Nurses) and two CNAs (Certified Nursing Assistants) for a census of 51 residents. During the survey, all four staff working on 04/11/21 were interviewed regarding the events surrounding R33's fall. All four staff reported inability to meet R33's needs due to short staffing as the cause of R33's fall and injuries. CNA-L, RN-BB, RN-E, and CNA-D reported R33 had been sitting in wheelchair since prior to supper and was likely tired and wanted to use the toilet then go to bed. RN-BB, CNA-L, RN-E, and CNA-D stated R33 was inconsistent when asking staff for assistance with toilet use. RN-BB, CNA-L, RN-E, and CNA-D also stated R33 was usually in bed between 7:00 and 7:30 p.m. (continued on next page)

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Minocqua Health and Rehab	9969 Old Hwy 70 Rd Minocqua, WI 54548

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/09/21 at 3:00 p.m., Surveyor interviewed RN-E regarding R33's care needs and fall. RN-E confirmed she was on duty on 04/11/21 and assisted R33 following the fall. RN-E stated R33 had been sitting in the wheelchair for several hours and likely attempted to toilet self and fell . RN-E stated R33 was usually in bed around 7:00 p.m. RN-E stated usual staffing pattern for the second shift was 2 nurses and 2 CNAs (Certified Nursing Assistant) for an average census of 50 or more. RN-E stated all staff try to provide good care, but residents have to wait for call light response, help with toileting, and help getting ready for bed. RN-E stated all staff are frustrated because there isn't enough help and the facility continues to take new admissions. RN-E stated staff try hard to get the work done, but just can't when there are only 2 CNAs. RN-E stated showers, oral hygiene, toileting, and repositioning are not getting done because of not enough staff. On 06/9/21 at 7:15 p.m., Surveyor interviewed CNA-D who confirmed she worked on 04/11/21. CNA-D stated she had not provided any care for R33 since she arrived at the facility around 6:00 p.m. CNA-D stated there were only 2 CNAs on for the second shift on 04/11/21. CNA-D stated insufficient staffing was a factor in R33's fall because staff could not help her to the toilet after supper and R33 likely attempted to toilet self and fell . On 06/14/21 at 11:15 a.m., Surveyor interviewed CNA-L who confirmed he worked on 04/11/21. CNA-L stated R33 needed help with all ADL (activities of daily living) and was unsafe to transfer independently. CNA-L stated R33 had been up in the wheelchair since before supper and had likely wheeled self into the bathroom and attempted to toilet self and fell . CNA-L stated R33's usual bedtime routine was to use the toilet, wash up, brush her teeth, and settle into bed around 7:00 p.m. CNA-L stated the insufficient staffing was absolutely a factor in R33's fall. On 06/14/21 at 10:50 a.m. Surveyor interviewed DON (Director of Nurses)-B regarding the facility expectation following resident falls. DON-B stated the nurse at the time of the fall should conduct a thorough investigation of the cause of the fall. The investigation would include asking the resident what happened as well as interviewing the staff on duty. DON-B stated the nurse should attempt to determine the root cause of the fall and then implement appropriate care plan interventions based on the root cause. DON-B stated the IDT (interdisciplinary team) does meet to review the falls on the next business day and also to review the investigations completed at the time of the fall. The IDT looks for the root cause analysis identified. The IDT documents in the resident's progress notes that the fall was reviewed and reiterates the root cause as well as any changes to the care plan that were implemented. The IDT reviews the care plan and ensures that all changes were added and carried forward to be shared during the shift to shift report. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/14/21 at 4:00 p.m., Surveyor interviewed RN-BB via telephone regarding R33. RN-BB stated she was familiar with R33's care needs. RN-BB stated R33 required extensive to total staff assist for all ADL (Activities of Daily Living) needs. RN-BB stated R33 was able to make basic needs known and would sometimes use call light to ask for staff assistance, but was not consistent in the use of a call light. RN-BB stated R33 preferred to be assisted into bed before or near 7:00 p.m. RN-BB stated R33 had a fall on 04/11/21 when she attempted to toilet self. R33 was found in the bathroom on the floor. RN-BB stated she was called to assist RN-E, CNA-D, and CNA-L assess R33 following the fall. RN-BB stated R33 was unable to move without significant pain in her leg, back, and shoulder. RN-BB stated the contributing factors for R33's fall with injury and pain were R33's dementia and the lack of sufficient staffing in the building. RN-BB stated R33's fall was likely avoidable had staff assisted R33 with toileting and then into bed prior to 7:00 p.m. RN-BB stated R33 had likely been sitting in the wheelchair since before supper and was incontinent of urine and needing to be repositioned. RN-BB stated staff are unable to assist resident with repositioning and toileting needs timely. RN-BB stated the second shift was usually staffed with two nurses and one or two CNAs for an approximate census of 50 or more. RN-BB stated residents were not receiving adequate care with toileting, call light response, oral hygiene, skin care, and falls prevention because of the short staffing situation. On 06/09/21 at 8:30 p.m., Surveyor interviewed FM (Family Member)-F regarding the care of R33. FM-F stated R33 received marginal care at best and stated R33 has had several falls likely related to insufficient staffing. FM-F stated there was not enough staff to help R33 to the bathroom and due to R33's dementia, she does not know her transfer limits. 17661 Example #2: R11 has multiple medical diagnoses that include, but are not limited to Peripheral Vascular Disease (PVD), Spinal Stenosis of the Lumbar region, Major Depressive Disorder, Anxiety Disorder, Fibromyalgia, Osteoarthritis of the Knee and Right Wrist, Migraine Headaches, Cognitive Communication Deficit, History of Falls and Dementia. On 6/8/21 at 10:36 AM, the Surveyor conducted the screening process of R11 and noted a low bed with a concave mattress and a floor mat placed on the floor beside the right side of the bed with the left side of the bed against the window. R11 also had an alternating air mattress set at 15 with the firmness setting 5/8. The Surveyor completed a review of R11's Minimum Data Set Assessments (MDS's) and noted the following: 1. Quarterly MDS dated [DATE]: - Independent with bed mobility, transfers, ambulation both in her room and in the hall, locomotion on and off the unit, eating, toileting, personal hygiene and continent of bowel and bladder. - Supervision with no assistance from staff for dressing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Significant Change in Status MDS dated [DATE]: - Dependent on two staff for transfers - Dependent on one staff for bathing and locomotion on and off unit - Extensive assistance of two staff for bed mobility and toileting - Extensive assistance of one staff for dressing and personal hygiene - Indwelling urinary Foley catheter in place and always incontinent of bowel function - Non-ambulatory - Supervision of one staff for eating The following care plans (CP) were noted in R11's record: 1. CP plan: 1/16/20 start date: Last revised/reviewed 10/10/20: Problem: Resident is at risk for falls due to: psychotropic and opioid medications use, pain, spinal stenosis, fibromyalgia, low back pain, Osteoarthritis (OA), anxiety disorder Approaches: all dated 1/16/20 - 1:1 visit prn, assure comfort and dignity are maintained, invite family to care conferences. - Assure well light clutter free environment - Call light in reach in own room and bathroom, answer promptly, orient to to use and remind-especially at night - Comprehensive medication review by pharmacist, assess for polypharmacy and medications that increase the fall risk per policy and prn. - Increased staff supervision with intensity based on resident need. - Proper footwear with transfers and ambulation - Shoe rack in place. (R11) chooses to not declutter room. 2. CP dated 12/19/20: Initiated 3/1/21, revised on 5/25/21 (R11) is at risk for future falls r/t (related to) anxiety, depression, spinal stenosis, OA (Osteoarthritis), complaints of pain-migraines, antidepressant medication use, opioid medication use, antianxiety medication use, history of falls. History of a fractured humerus, right fibular, right foot, and dislocation of right shoulder joint, PVD (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/9/21 at 8:32 AM, the Surveyor interviewed Licensed Practical Nurse (LPN) DD regarding R11's decline in functional status. LPN DD stated R11 had two falls during the night shift hours. LPN DD did not know the details of R11's falls, indicating that she wasn't on duty at the time, but did state that R11 sustained several fractures with the falls and now requires a lot of care. On 6/10/21 at 2:37 PM, the Surveyor interviewed RN-K (Registered Nurse) regarding fall investigations. RN-K is also the facility Minimum Data Set (MDS) Coordinator. RN-K stated a complete fall investigation process is to always have a root cause analysis to determine what the resident was trying to do at the time of the fall and implement new interventions in hopes of preventing another fall from occurring. FALLS: Surveyor conducted interviews and record review with LPN CC on 6/14/21 at 1:54 PM. The following records were reviewed and discussed: Record Review: 3/1/21: 12:13 AM Incident Note . Resident was found sitting in the hallway at the doorway of the orange utility room. The nurse at the nurses' station did not hear any noises from the fall. She was sitting on her buttocks with her legs folded to the right. She denied hitting her head, she denied injuries although it was noted she had a red area on the top of her right knee. She was assisted back to her room. She was able to walk normal for self with her wheelchair . Doctor on call was notified and had no new orders. Power Of Attorney (POA) was notified . The fall occurred on 2/28/21 at 11:00 PM, as learned through review of Interdisciplinary Team Progress Notes; There was no root cause analysis. There were no new interventions put into place in attempts to prevent another fall and a fall risk assessment was not completed at the time of the fall. LPN CC stated (R11) sustained a bruise to her right knee. The next shift started and the nurse coming on duty completed a neurological assessment following the fall. The risk assessment report was dated 3/6/21, 5 days after the fall. LPN CC was asked what the process was following a resident fall. LPN-CC stated The nurse should have determined a root cause analysis and implemented a new intervention based on that root cause, in order to attempt to prevent another fall occurring. That is the standard. On 3/1/21 at 12:35 AM, it was noted R11 had worsening pain in the right arm. The doctor ordered R11 to be seen in the ER (emergency room .) However, there was no note corresponding to this order and no evidence that R11 was seen in the ER. 3/1/2021 5:32 AM: Incident Note . Resident was found on the floor near the doorway of her room. She was screaming in pain that her arm hurt. She denied pain elsewhere. She was on her left side on the floor with her right arm draped over her right hip/thigh. She said she couldn't move it. She had no shoes or socks on. Her skirt was in the bathroom. The wheel chair and walker were underneath where the TV hangs. Her POA was called and informed of injury . Report was called to the ER staff. Resident left with the EMTs (Emergency Medical Technicians) at 3:50 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Of concern with this fall is that the incident report indicates the fall occurred at 5:32 AM, R11 left in the ambulance to be evaluated after this fall at 3:50 AM. There was no root cause analysis for this fall. At 7:05 AM, the facility received a report from the hospital nurse stating that R11 sustained several fractures as a result of this fall, including a dislocated right shoulder, a fracture of the right proximal humerus and spinal Thoracic #2 compression fracture. R11 was transferred from the local hospital to Medical Center 1 hour and 48 minutes away. At 3:52 PM the facility did implement changes and updated R11's care plan to include:, - For no apparent acute injury, determine and address causative factors of the fall. (Initiated 3/1/21) - Keep the orange utility door closed- (Initiated 3/1/21) - Make frequent checks on her at NOC (night) due to her history of pacing at night or seeking out a nurse for a snack or due to complaints of a headache. (Initiated 3/1/21) - Offer/provide assist with toileting as needed or as resident allows to reduce risk of falls. Initiated (3/1/21) - Replenish supply of briefs every shift to decrease anxiety related to not having them available. (Initiated 3/1/21) R11 returned to facility on 3/4/21 at 1:00 PM. R11's POA decided on no surgical interventions. The following Medical Diagnoses were added to R11's diagnosis listing following this fall: - Nondisplaced Fracture of Lateral Malleolus of the Right Fibula (outer right ankle) - Displaced (moved out of its normal position) Fracture of the Greater Tuberosity of the Right Humerus (right shoulder) - Displaced Fracture of the Upper End of the Right Humerus (right shoulder) - Dislocation of the Tarsometatarsal Joint of the Right Foot (junction between the midfoot and the forefoot) - Wedge Compression Fracture of the Second Thoracic Vertebra On 3/5/21 the facility completed a Fall Risk Evaluation and scored R11 as 27, indicating At Risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3/5/2021 8:50 PM: Incident Note . Unwitnessed fall. Resident was noticed by writer as resident was sitting on the floor in the hall outside of her room. She said she got out of bed on the floor and scooted herself into the hall. CNA had just recently left resident room to let nurse know (R11) wanted to talk with the nurse. (R11) did not wait for nurse to go to her room . Resident had pulled out her catheter during incident. No blood noted. No injuries noted. Catheter reinserted after discussion with POA . PCP (Primary Care Provider) via fax and DON (Director of Nursing) also updated . Care plan updated with the following: - Resident has a bed alarm to alert staff to attempts to get up without assistance. (Initiated 3/6/21, Discontinued 3/29/21) - Encourage/remind to use call light to call for assistance, resident often refuses to use call light- (Initiated 3/8/21) When asked by Surveyor, LPN CC stated there was no fall investigation or Risk assessment completed at the time of the incident. On 3/9/21, the facility rearranged R11's room to place the bedside table closer to her as she could not reach her water with the alarming floor mat next to her bed. This note entered at 11:39 PM states that R11 . does not generally sleep through the whole night and that is her normal routine even when she was up and about. There was no record of increased monitoring of R11 during night hours. 3/11/2021 at 12:30 AM: Incident Note . Resident was found at approximately 12:30 AM laying supine on the floor in front of her bed. Resident was laying on her floor alarm that was not alarming. Batteries were switched out, floor mat was changed twice due to faulty alarms not sounding. When asked what resident was doing, stated that one (leg) is heavy and I am trying to make it lighter Resident was last checked on at 2345 (11:45 PM), resident was laying in bed. Resident denied having any new pain or discomfort. DON, POA, and MD was notified. Immediate intervention was finding a floor mat that works. The Surveyor asked LPN-CC what the alarm checking system is to ensure alarms are functioning properly. LPN-CC stated The staff are supposed to check that alarms are functioning properly each time they visit the room. There is no place to document that staff have checked the alarms with all cares, that I am aware of. There is no place on the MARs (Medication Administration Records) or TARs (Treatment Administration Records) for nursing to sign off, and no place for CNAs (Certified Nursing Assistants) to document that they checked the alarms with cares. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4/18/2021 at 3:34 AM: Incident Note . Resident found on floor of hallway in front of her doorway. Resident said she had spilled some water on the floor and was trying to get some help to clean it up. She said she scooted on her buttocks to the hallway where she was found by staff. Resident had pulled her catheter out when she crawled out of bed. Catheter was replaced once resident was assessed for injuries and placed back into bed. Resident was assisted off of floor with a hoyer. On call notified, primary updated via fax, POA notified. Vitals and neuros within normal limits. Will continue to monitor. Note: There was no new intervention with this fall. 5/31/2021 at 11:50 PM: Incident Note . Resident heard calling out for help. She was found sitting on the floor in the hallway outside of her room. She was upright with her legs curled underneath her. She stated she had fallen out of bed. She was unable to explain what she needed. She had pulled out her Foley and it was laying on the floor next to her bed with balloon inflated . She had a slipper on one foot and a gripper sock on the other foot . Denies any pain other than a headache . No injuries noted . There was no new intervention following this fall. The 'Immediate action taken' according to the Risk Assessment was Resident assisted off the floor with the hoyer lift and placed back into bed. Care plan update on 6/1/21 include: - Bed to be in low position during HS (Hour of Sleep) and NOC (night) shift. (Initiated 6/1/21) The facility did not conduct thorough fall investigations to include root cause analysis, falls risk assessments or implement new interventions. The facility did not increase monitoring of resident during evening hours despite knowing resident did not sleep all night and a majority of her falls occurred during that time, as indicated on the CP intervention dated 3/1/21

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 30570 Based on observation, record review, and interview the facility did not include actual hours worked by nursing staff on the daily staffing hours posting. This has the potential to affect all 54 residents. The daily staffing hours posting did not include actual hours worked by nursing staff when their hours differed from the noted shift hours. This is evidenced by: On 6/08/21 the surveyor noted the nurse staffing posting on a bulletin board across from the nurses station. The posting noted the following: Date: 6/08/21 Census: 54 Day shift 6 am to 2:00 pm RN (Registered Nurse) Total Number of staff: 2, Total hours worked: 16 LPN (Licensed Practical Nurse): 0, Total hours worked: 0 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 Other/Med. Tech/Nurse Grad.: 1, Total hours worked: 8 PM shift 2 pm to 10:00 pm RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 8 LPN (Licensed Practical Nurse): 1, Total hours worked: 4 (no actual hours noted) CNA (Certified Nursing Assistant): 4, Total hours worked: 22 (no actual hours noted) Other/Med. Tech/Nurse Grad.: 1, Total hours worked: 4 (no actual hours noted) Night shift 10 pm to 6 am RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 4 (no actual hours worked) LPN (Licensed Practical Nurse): 2, Total hours worked: 16 CNA (Certified Nursing Assistant): 2, Total hours worked: 16 Other/Med. Tech/Nurse Grad.: 0, Total hours worked: 0 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/09/21 the surveyor noted the nurse staffing posting on a bulletin board across from the nurses station. The posting noted the following: Date: 6/09/21 Census: 53 Day shift 5:45 am to 2:00 pm RN (Registered Nurse) Total Number of staff: 2, Total hours worked: 16 LPN (Licensed Practical Nurse): 1, Total hours worked: 8 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 Other/Med. Tech/Nurse Grad.: 0, Total hours worked: 0 PM shift 1:45-10:00 pm: RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 8? (no actual hours worked) LPN (Licensed Practical Nurse): 1, Total hours worked: 8 CNA (Certified Nursing Assistant): 3, Total hours worked: 16 Other: hospitality: 1, Total hours worked: 8 Night shift 9:45 pm to 6 am: RN (Registered Nurse) Total Number of staff: 0, Total hours worked: 0 LPN (Licensed Practical Nurse): 1, Total hours worked: 8 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 Other: 0, Total hours worked: 0 On 6/10/21 the surveyor noted the nurse staffing posting on a bulletin board across from the nurses station. The posting noted the following: Date: 6/10/21 Census: 53 Day shift 6 am to 2:00 pm RN (Registered Nurse) Total Number of staff: 3, Total hours worked: 24 LPN (Licensed Practical Nurse): 0, Total hours worked: 0 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Other/Med. Tech/Nurse Grad.: 0, Total hours worked: 0 PM shift 2 pm to 10:00 pm: RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 4 (no actual hours worked noted) LPN (Licensed Practical Nurse): 3, Total hours worked: 16 (no actual hours worked noted) CNA (Certified Nursing Assistant): 3, Total hours worked: 16 (no actual hours worked noted) Other: hospitality: 1, Total hours worked: 8 Night shift 9:45 pm to 6 am: RN (Registered Nurse) Total Number of staff: 0, Total hours worked: 0 LPN (Licensed Practical Nurse): 2, Total hours worked: 16 CNA (Certified Nursing Assistant): 2, Total hours worked: 16 Other: 0, Total hours worked: 0 On 6/10/21 the surveyor requested staff hours postings from 4/21/21 to present. The surveyor noted the postings much the same as posted on 6/08/21, 6/09/21 and 6/10/21. The postings did not note actual hours worked when staff hours were noted as less than 8 (a partial shift). The surveyor also noted inconsistencies with the hours of the actual am, pm, and night shift. On 6/10/21 at 9:18 a.m. the surveyor spoke with the Director of Nursing (DON)-B regarding the nurse staffing hours posting. DON-B indicated she is responsible for the daily nursing staff posting. DON-B verified the am shift as 6 am to 2 pm, the pm shift as 2 pm to 10 pm and the night shift as 10 pm to 6 am. DON-B indicated she was unaware the postings required actual staff hours when staff work hours other than the full shift. DON-B further indicated she was accurately trained when she took over the task and was not aware of the requirements.