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	05/10/2022

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

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945 Based on observation, interview, and record review, the facility failed to assess the safety risks and prevent the use of restraints for 1 of 1 resident reviewed for restraints (R2). *R2 has a right and left enabler bar on R2's bed. The facility did not assess the enabler bar as a restraint with the use of an air mattress. There is no assessment to determine if the intervention of placing a pillow on left side of R2 under the draw sheet to prevent resident from sliding/crawling out of bed is a restraint. This is evidenced by: R2 was admitted to the facility on [DATE]. Her Power of Attorney (POA) is activated. Her diagnoses include: Dementia with Lewy Body, Parkinson's Disease, history of falling, cognitive communication deficit, and hallucinations. R2's Minimum Data Set (MDS) assessment dated [DATE] indicates Brief Interview for Mental Status (BIMS) is 8 (moderate cognitive impairment). MDS functional status with bed mobility states resident requires extensive assist with 2+ physical assist and uses a wheelchair for mobility. R2 receives Citalopram 20 mg by mouth every evening, and Seroquel 50 mg by mouth at bedtime. Care Plan: Date initiated: 02/26/21 ADL: Baseline Care Plan Self Care deficit related to Parkinson's, Dementia, Type II Diabetes Mellitus, Morbid Obesity, Depression, and Chronic Kidney Disease. Interventions: Date initiated: 02/26/21 Bari-Bed, lip mattress Repositioning: Assist of 1. Reposition approximately every 2 hours and prn (as needed). Right/Left enabler bars for bed mobility and transferring. Ensure proper positioning to promote comfort. Care Plan: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date initiated: 03/02/21. Revision: 11/30/21 The resident has had actual falls related to hallucinations, antipsychotic med use, dementia, type2 diabetes, depression, antidepressant med use, morbid obesity, postural kyphosis, cognitive impairment, weakness, repeated falls, and diuretic med use. Interventions: Date initiated: 09/29/21 Place pillows on left side of resident under draw sheet to prevent resident from sliding/crawling out of bed. R2's enabler bars were ordered 12/14/21. Facility did not perform an assessment to determine if the bars are a restraint. No individualized assessment was located in the medical record to determine if the enabler bars and pillow were restraining R2's movements. On 05/02/22 at 2:03 p.m., Surveyor interviewed Director of Nursing (DON) B. DON B was asked if facility had assessed the enabler bars and pillow to determine if they were a restraint. DON B stated the facility hasn't had enough staff. DON B stated that assessing for a restraint had not been done.

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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 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** 30570 Based on interview and record review, the facility did not report 2 of 2 potential misconduct incidents involving R8 and R2 to the State's Office of Caregiver Quality (OCQ) via the State's Misconduct Incident Reporting (MIR) system immediately upon learning of the incidents. Example #1: R8 eloped from the facility through a door that was not alarmed on 04/26/22 at 9:00 p.m. Although the facility administration learned of the elopement incident on 04/26/22 at 9:26 p.m., they did not report the incident to OCQ until Surveyor inquired about the reporting. The immediate reporting did not occur until 05/02/22 at 1:37 p.m. Example #2: R2 was found 05/01/22 between 6:00 a.m. and 6:30 a.m. wedged between R2's bed and the wall. R2's face was noticed to be swollen. R2 sustained right and left temporal bruising and bruising on right shoulder. R2 was hospitalized for overnight observation. R2 was diagnosed at hospital with a urinary tract infection. R2's diagnoses of Lewy Body Dementia, hallucinations, need for assistance with bed mobility, and history of falls, puts R2 at a higher risk of harm and increased need for supervision. Findings include: Example #1: On 04/27/22 at 9:30 a.m., Nursing Home Administrator (NHA)-A informed Surveyor of incident of R8 eloping from the facility on 04/26/22 at 9:00 p.m. NHA-A indicated he had just learned of the incident. On 04/27/22 at 2:25 p.m., Surveyor spoke with Director of Nursing (DON)-B regarding R8's elopement incident. DON-B indicated she had learned of R8's elopement on 04/26/22 at 9:26 pm. RN-O had called her and reported the incident. RN-O expressed R8 had eloped through a door at the end of the 400 wing. The door alarm was not armed. DON-B indicated she did not instruct RN-O to begin an investigation as the root cause of the elopement was known, R8 had gone out a door that's alarm was not activated. DON-B further expressed she did not instruct RN-O to check the other alarmed doors in the facility or to start staff education on the alarm system as she herself was not familiar with the system. DON-B further expressed she did not call NHA-A and report the incident. On 04/27/22 at 6:28 p.m., Surveyor requested information regarding the facility investigation into R8's elopement incident. The NHA-A provided Surveyor with a form titled, Minocqua Health and Rehab Elopement Response. It noted: (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Root cause analysis completed regarding 04/26/22 elopement. Root cause was the control panel button for alarm was in a position/silencing alarm. A lack of staff knowledge and education about the door alarm function, and lack of supervision of a known high risk elopement resident were the reasons for the elopement. Both of these meet the definition of not meeting the needs and services of R8. Door alarm control panel education has been initiated. The information showed no reporting of the incident to OCQ via the MIR system. On 05/02/22 at 8:30 a.m., Surveyor asked DON-B for evidence of reporting R8's elopement incident to OCQ via the MIR system. DON-B expressed she does not have reporting rights in the system, NHA-A would not be reporting to work on 05/02/22, and the incident has not yet been reported to her knowledge. On 05/02/22 at 1:37 p.m., DON-B informed Surveyor she now has access to the MIR system. R8's elopement incident was just reported to OCQ via the MIR system. DON-B confirmed this was the facility's first reporting of R8's elopement incident. DON-B showed Surveyor the Misconduct Incident Report that had been submitted. On 05/03/22 at 11:23 a.m., Surveyor spoke with NHA-A via the phone. NHA-A indicated he is responsible for reporting potential misconduct incidents to the OCQ via the MIR system. NHA-A indicated he did not immediately learn of the incident as he was not called on 04/26/22 after the incident. NHA-A expressed he first learned of the incident on 04/27/22 at approximately 9:30 a.m. He reported the incident to Surveyors in the building but did not report the incident to OCQ via the MIR system but should have immediately upon learning of the incident and/or no greater than 24 hours. Surveyor requested and reviewed the facility policy titled, Abuse and Neglect Prevention, which is dated 12/01/2015. The policy in part states: Purpose: To establish guidelines that prevent, identifies and report resident abuse and neglect. Reporting: Once the facility administration becomes aware of any alleged violations, the home must report immediately to the designated state agency. CMS (Center of Medicare and Medicaid Services) indicates the term immediately means as soon as possible, but no more than 24 hours after the alleged incident is discovered. 41945 Example 2: The facility policy dated 12/01/15 with no revision dates and titled, Abuse and Neglect Prevention documents under the Policy section, The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. It is the policy of the facility, to ensure that each resident is treated with dignity and care, free from abuse and neglect and to take swift and immediate action to investigate alleged resident abuse and neglect. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy states under the Identification section, It is the responsibility of the Administrator and Nursing Services to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse/neglect and to determine the direction of the investigation. The policy states under Investigation, The Administrator and/or the Director of Nursing Services are responsible for initiation of the investigation immediately upon notification of alleged event or findings. The policy states under the Reporting section, Once the facility administration becomes aware of alleged violations, the home must report immediately to the designated state agency. CMS indicates that the term immediately means as soon as possible, but no more than 24-hours after the alleged incident is discovered. R2 was admitted to the facility on [DATE]. Her POA is activated. Her diagnoses include: Dementia with Lewy Body, Parkinson's Disease, Type II Diabetes Mellitus, history of falling, cognitive communication deficit, and hallucinations. MDS dated [DATE] indicates BIMS is 8 (moderate cognitive impairment). MDS functional status with bed mobility states resident requires extensive assist with 2+ physical assist and uses a wheelchair for mobility. R2 receives Citalopram 20 mg by mouth every evening, and Seroquel 50 mg by mouth at bedtime. HHS (U.S. Department of Health and Human Services) website provides information on Lewy Body Dementia, and includes the following common symptoms: problems judging distance or depth, visual hallucinations, and movement changes. (https:www.alzheimers.gov/alzheimers-dementia/lewy-body-dementia). R2's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Mental Interview for Mental Status with a score of 2, which means severe cognitive impairment. The MDS documents R2 requires extensive assist with 2+ person physical assist for bed mobility, requires extensive assist with 1+ person physical assist for transfer, dressing, toilet use, and personal hygiene. R2's Care Plan dated 11/30/21 reads: *Cognition: alert and oriented to person and place often forgetful, varies with time of day and level of fatigue *The resident has had actual falls related to hallucinations, cognitive impairment, weakness, and repeated falls. Interventions include place pillows on left under draw sheet to prevent resident from sliding/crawling out of bed. *Bed mobility: Extensive assist of 1. Reposition every two hours. Right and left enabler bars. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's nursing progress note dated 05/01/22 at 10:08 p.m., states: Note Text: When shift started writer and CNA observed resident rolled towards wall in bed. Both writer and CNA repositioned resident and noticed her face was extremely puffy. We did a set of vitals signs that were within normal, and resident was very restless. Writer observed bruising to residents right top of hand with a skin tear or laceration. Resident's arms were swollen. Resident's head was elevated and was monitored. Elevated Resident's head of bed and gave resident some fluids with medications. Towards the afternoon resident's swelling did go down some and DON was notified. All vital signs were within normal limits, but resident had increasing pain. Writer then noticed two different bumps on each side of the residents forehead by the temple region. Resident also had a hematoma on the right shoulder blade posterior to the spinal cord. DON was notified of all resident's injuries and injuries were reported to POA [[NAME].] Resident was seen at the ER and diagnosed with a UTI and is being kept over night for observation. This was communicated with [[NAME]] RN at [Marshfield Minocqua] emergency department. Will continue to monitor resident's status. Resident was very scared and timid when cares were performed. Resident was difficult to [NAME], at the ER resident notified POA that she had been struck but didn't say by what or who. Writer will report change in condition to primary and will follow up with POA, DON and administrator. On 04/28/22, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if facility had reported R2's incident and if an investigation had been done to determine the cause of the swelling and bruising on R2. DON B stated the NHA A (Nursing Home Administrator) was supposed to have reported it immediately, but didn't, and no investigation had been started.

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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 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** 30570 Based on interview and record review, the facility did not immediately and thoroughly investigate 2 of 2 potential misconduct incidents involving or report the results of the investigation to the State's Office of Caregiver Quality (OCQ) via the State's Misconduct Incident Reporting (MIR) system within 5 days. R8 eloped from the facility through a door that was not alarmed on 04/26/22 at 9:00 p.m. The facility learned R8 had eloped from a door that was not alarmed as it should have been, allowing R8 to elope. The facility did not investigate how the door was left unarmed from the alarm system. The facility did not conduct staff interviews in an attempt to determine how the door was left unarmed from the alarm system. The facility did not report a thorough investigation of the incident to OCQ via the Misconduct Incident Reporting (MIR) system. R2's diagnoses of Lewy Body Dementia, hallucinations, need for assistance with bed mobility, and history of falls, puts R2 at a higher risk of harm and increased need for supervision. R2 was found 05/01/22 between 6:00 a.m. and 6:30 a.m. wedged between R2's bed and the wall. R2's face was noticed to be swollen. R2 sustained right and left temporal bruising and bruising on right shoulder. R2 was hospitalized for overnight observation. Findings include: Example #1: On 04/27/22 at 9:30 a.m., Nursing Home Administrator (NHA)-A informed Surveyor of incident of R8 eloping from the facility on 04/26/22 at 9:00 p.m. NHA-A indicated he had just learned of the incident. On 04/27/22 at 2:25 p.m., Surveyor spoke with Director of Nursing (DON)-B regarding R8's elopement incident. DON-B indicated she had learned of R8's elopement on 04/26/22 at 9:26 pm. RN-O had called her and reported the incident. RN-O expressed R8 had eloped through a door at the end of the 400 wing. The door alarm was not armed. DON-B indicated she did not instruct RN-O to begin an investigation as the root cause of the elopement was known, R8 had gone out a door that's alarm was not activated. DON-B further expressed she did not instruct RN-O to check the other alarmed doors in the facility or to start staff education on the alarm system as she herself was not familiar with the system. DON-B further expressed she did not call NHA-A and report the incident. On 04/27/22 at 6:28 p.m., Surveyor requested information regarding the facility investigation into R8's elopement incident. The NHA-A provided Surveyor with a form titled, Minocqua Health and Rehab Elopement Response. It noted: Root cause analysis completed regarding 04/26/22 elopement. Root cause was the control panel button for alarm was in a position/silencing alarm. A lack of education was the reason the button being pushed in due to the button needing to be pressed twice to return to active status. Door alarm control panel education has been initiated. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The information showed no staff interviews in attempts to determine who may have left the door unarmed from alarming and did not report a thorough investigation of the incident to OCQ via the MIR system. On 05/02/22 at 8:30 a.m., Surveyor asked DON-B for evidence of investigation of R8's elopement incident and reporting of the investigation to OCQ via the MIR system. DON-B expressed she did not investigate the incident as the facility determined the door at the end of the hallway on 400 wing alarm system was not armed. DON-B further expressed she did not report any information to the MIR system as she does not have rights in the system. DON-B further expressed NHA-A is responsible for investigating and reporting incidents. NHA-A would not be reporting to work on 05/02/22 and the incident has not yet been investigated or reported to her knowledge. On 05/02/22 at 1:37 p.m., DON-B informed Surveyor she now has access to the MIR system. R8's elopement incident was just reported to OCQ via the MIR system. DON-B confirmed this was the facility's first reporting of R8's elopement incident. DON-B showed Surveyor the Misconduct Incident Report that had been submitted. The report showed R8 eloped outside, and the alarm panel was disarmed but showed no staff interviews in an attempt to determine how or when the door alarm system was disarmed and not reset or any other potential misconduct. On 05/03/22 at 11:23 a.m., Surveyor spoke with NHA-A via the phone. NHA-A indicated he is responsible for investigating and reporting potential misconduct incidents to the OCQ via the MIR system. NHA-A indicated he did not immediately learn of the incident as he was not called on 04/26/22 after the incident. NHA-A expressed he first learned of the incident on 04/27/22 at approximately 9:30 a.m. He did not obtain staff statements as part of an investigation as he did not believe there was any staff misconduct from R8's progress notes he had reviewed. NHA-A expressed he did not obtain staff statements in attempts to determine how and when the door alarm was disarmed and not reset, or if lack of supervision of R8 was a root cause. NHA-A expressed he should have obtained staff statements, conducted a more thorough investigation, and reported the results to OCQ via the MIR system. Surveyor requested and reviewed the facility policy titled, Abuse and Neglect Prevention, which is dated 12/01/2015. The policy in part states: Purpose: To establish guidelines that prevent, identifies and report resident abuse and neglect. ~After the facility submits an immediate report of alleged violation, the facility must conduct a thorough investigation: prevent any other incidents from occurring during the investigation and report the results of the investigation to the states agency within 5 working days or as designated by law. 41945 Example #2: The facility policy dated 12/01/15 with no revision dates and titled, Abuse and Neglect Prevention, documents under the Policy section, The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. It is the policy of the facility, to ensure that each resident is treated with dignity and care, free from abuse and neglect and to take swift and immediate action to investigate alleged resident abuse and neglect. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy states under the Identification section, It is the responsibility of the Administrator and Nursing Services to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse/neglect and to determine the direction of the investigation. The policy states under Investigation, The Administrator and/or the Director of Nursing Services are responsible for initiation of the investigation immediately upon notification of alleged event or findings. Facility will document investigation findings, including witness statements, corrective actions, and conclusions in administrative file. Facility will be responsible to notify the resident, resident's legal representative or interested family member of any investigational findings and facility outcomes as allowable within privacy standards. The policy states, Once the facility administration becomes aware of alleged violations, the home must report immediately to the designated state agency. CMS indicates that the term immediately means as soon as possible, but no more than 24-hours after the alleged incident is discovered. R2 was admitted to the facility on [DATE]. Her POA is activated. Her diagnoses include: Dementia with Lewy Body, Parkinson's Disease, Type II Diabetes Mellitus, history of falling, cognitive communication deficit, and hallucinations. MDS dated [DATE] indicates BIMS is 8 (moderate cognitive impairment). MDS functional status with bed mobility states resident requires extensive assist with 2+ physical assist and uses a wheelchair for mobility. R2 receives Citalopram 20 mg by mouth every evening, and Seroquel 50 mg by mouth at bedtime. HHS (US Department of Health and Human Services) website provides information on Lewy Body Dementia, and includes the following common symptoms: problems judging distance or depth, visual hallucinations, and movement changes. (https:www.alzheimers.gov/alzheimers-dementia/lewy-body-dementia). R2's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Mental Interview for Mental Status with a score of 2, which means severe cognitive impairment. The MDS documents R2 requires extensive assist with 2+ person physical assist for bed mobility, requires extensive assist with 1+ person physical assist for transfer, dressing, toilet use, and personal hygiene. R2's Care Plan dated 11/30/21 reads: *Cognition: alert and oriented to person and place often forgetful, varies with time of day and level of fatigue *The resident has had actual falls related to hallucinations, cognitive impairment, weakness, and repeated falls. Interventions include place pillows on left under draw sheet to prevent resident from sliding/crawling out of bed. *Bed mobility: Extensive assist of 1. Reposition every two hours. Right and left enabler bars. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's nursing progress note dated 05/01/22 at 10:08 p.m., states: Note Text: When shift started writer and CNA observed resident rolled towards wall in bed. Both writer and CNA repositioned resident and noticed her face was extremely puffy. We did a set of vitals signs that were within normal, and resident was very restless. Writer observed bruising to residents right top of hand with a skin tear or laceration. Resident's arms were swollen. Resident's head was elevated and was monitored. Elevated Resident's head of bed and gave resident some fluids with medications. Towards the afternoon resident's swelling did go down some and DON was notified. All vital signs were within normal limits, but resident had increasing pain. Writer then noticed two different bumps on each side of the residents forehead by the temple region. Resident also had a hematoma on the right shoulder blade posterior to the spinal cord. DON was notified of all resident's injuries and injuries were reported to POA [[NAME].] Resident was seen at the ER and diagnosed with a UTI and is being kept over night for observation. This was communicated with [[NAME]] RN at [Marshfield Minocqua] emergency department. Will continue to monitor resident's status. Resident was very scared and timid when cares were performed. Resident was difficult to [NAME], at the ER resident notified POA that she had been struck but didn't say by what or who. Writer will report change in condition to primary and will follow up with POA, DON and administrator. On 04/28/22, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if facility had reported R2's incident and if an investigation had been done. DON B stated the NHA A (Nursing Home Administrator) was supposed to have reported it immediately, but didn't, and no investigation had been started.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on record review and interview, the facility did not complete Minimum Data Set Assessments (MDSA) for 5 of 7 residents reviewed (R1, R11, R12, R15, and R3.) - R1 was admitted to the facility following an extensive hospitalization (nearly 4 months) for wound care. As of the completion of the investigation on 4/28/22, there has not been an MDSA completed for R1. - R11's most recent MDS was completed 1/05/2022. R11's next MDSA was an annual assessment due no later than April 07, 2022. R11's MDS is 26 days overdue. - R12's most recent MDS was completed 12/20/21. R12's next MDS assessment was due no later than March 22, 2022. R12's MDS is 42 days overdue. - R15's most recent MDS was completed 12/29/21. R15's next MDS assessment was an annual assessment due no later than 03/31//22 R15's MDS is 33 days overdue. - R3 was admitted to the facility 04/08/22. As of the completion of the investigation on 04/28/22, there has not been and MDSA completed for R3. This is evidenced by: According to Chapter 2 of the RAI (Resident Assessment Instrument), an admission MDSA must be completed within 14 calendar days after an individual is admitted to the facility. Chapter 2, page 2-21 goes on to further state, . Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being . On 4/27/22 at 12:28 PM, Surveyor interviewed RN C (Registered Nurse) regarding MDSA's. RN C was the former MDSA Coordinator. RN C stated that she stepped down from the position 4/8/22 and to date, there isn't any staff completing MDSAs. At 12:45 PM, Surveyor interviewed DON B (Director of Nursing) who is rather new to the position. DON B verified RN-C's interview and stated, No one is currently doing MDSAs, as of 4/8/22. We have recently hired someone to do them, but she has not started to work yet. I have mentioned this to Corporate and like I said, she won't start until next week . When asked the importance of an MDSA, DON stated, It's important because it drives the resident's care. Example 1: (continued on next page)

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	525678	A. Building B. Wing	05/10/2022

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/22, R1 was admitted to the facility with medical diagnoses that include but are not limited to Paraplegia because of a Motor Vehicle Accident in 1981 in which he sustained a Cervical-Spine fracture, Chronic Obstructive Pulmonary Disease, Chronic Normocytic Anemia, Peripheral Vascular Disease, History of Methicillin-Resistant Staphylococcus Aureus Infection, History of Renal Failure, and Chronic Anticoagulant therapy. There were multiple wounds noted on R1 upon admission, including Stage IV wounds on his back. Observations conducted indicate he is dependent on staff to meet his most basic Activities of Daily Living (bathing, dressing, personal hygiene, toileting) and eating if a utensil is needed. He is able to feed himself finger foods. R1 also is in need of pain control regarding his wounds and cannot sit upright in a chair at this time. He is nonambulatory and on consistent bed rest. As of the completion of the investigation (04/28/22) the facility had not yet started the MDSA process for R1. This is a concern as all care and services stem from this assessment, including the care planning process and additional assessments, if needed, including pain, sleep, behaviors, and skin/wound. 30570 Example 2: Surveyor reviewed R11's record and noted his most recent MDS was a quarterly MDS completed on 1/05/22. R11 was due to have an annual MDS completed no later than 4/07/22. R11's MDS was noted as 26 days overdue. Example 3: R12's most recent MDS was a significant change in status MDS completed 12/20/21. R12 was due to have a quarterly MDS completed no later than 3/22/22. R12's MDS was 42 days overdue. Example 4: R15's most recent MDS was a quarterly MDS completed on 12/29/21. R15 was due to have an annual MDS completed no later than 3/31/22. R15's MDS was 33 days overdue. Centers of Medicare and Medicaid (CMS) RAI version 3.0 manual states quarterly assessment is a non-comprehensive assessment that must be completed at least every 92 days following the previous assessment of any type Assessment Reference Dates (ARD) must be within 92 days of the previous assessment (quarterly .annual). 41945 Example 5: (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease with late onset, Dementia with behavioral disturbances, and depression. Assessments conducted indicate he is dependent on staff to meet basic ADLs (dressing, bathing, personal hygiene, and toileting). R3 is a high fall risk. R3 was an elopement risk while at home and is at risk for elopement at facility. R3's MDS on entry dated 04/08/22 is incomplete. This MDS is 12 days overdue as of 04/27/22. R3's admission MDS dated [DATE] is incomplete. This MDS is 6 days overdue as of 04/27/22. Facility has not completed an MDSA on R3 since admission and it is a concern for the health and welfare of R3 with the lack of needed assessments for overall care and services.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on record review and interview, the facility did not develop/revise a Care Plan (CP) for 2 residents reviewed (R1, R3). - R1 was admitted to the facility following an extensive hospitalization (nearly 4 months) for wound care. As of this writing (5/3/22), there has not been a comprehensive CP developed for R1. - R3 was admitted to the facility on [DATE] with a history of elopement while at home, and a Fall Risk Assessment completed on admission indicated R3 was at a high risk for falls. R3 sustained a fall on 04/15/22 and was sent to the emergency room for evaluation. A care plan for fall risk was not completed until 04/21/22, and a care plan for elopement/wandering was not completed until 04/27/22. This is evidenced by: Example 1: R1 was hospitalized [DATE] from an assisted living related to generalized weakness. While in the hospital they discovered multiple Stage IV Pressure Injuries on his back, Severe Anemia with a Hemoglobin level of 4. 6 (Normal for a [AGE] year-old male is 14-17) and purulent drainage of the Suprapubic catheter. On 4/4/22, he was admitted to the facility with medical diagnoses that include but are not limited to, Paraplegia because of a Motor Vehicle Accident in 1981 in which he sustained a Cervical-Spine fracture, Chronic Obstructive Pulmonary Disease, Chronic Normocytic Anemia, Peripheral Vascular Disease, History of Methicillin-Resistant Staphylococcus Aureus Infection, History of Renal Failure, and Chronic Anticoagulant therapy. Further documentation revealed that R1 also has conditions such as Diabetes Mellitus Type II, Failure to Thrive, Congestive Heart Failure, Insomnia, Fall Risk, and a History of Seizures. There were multiple wounds noted on R1 upon admission, including Stage IV wounds on his back. Observations conducted indicate he is dependent on staff to meet his most basic Activities of Daily Living (bathing, dressing, personal hygiene, toileting) and eating if a utensil is needed. He is able to feed himself finger foods. R1 also is in need of pain control regarding his wounds and cannot sit upright in a chair at this time. He is nonambulatory and on consistent bed rest. As of this writing (5/3/22), there was no comprehensive CP developed to direct staff in R1's care and needs. In reviewing what the facility does have completed, there was an initial Activities of Daily Living for the Certified Nursing Assistant staff to follow, a Psychosocial CP and a Nutritional Risk CP completed, but in critical areas such as wound care, sleep, pain management, and behavioral/anxiety, there is no staff direction on how to maintain or achieve R1's highest practicable well-being. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2: R3 was admitted to the facility on [DATE]. R3 has diagnoses of, in part, .Alzheimer's disease with late onset, Dementia in other diseases classified elsewhere with behavioral disturbance, and Depression . R3's medical record documents R3 was an elopement risk while at home. R3 medications include, in part: .Sertraline HCl Tablet 50mg-Give 2 tablets by mouth in the morning . Facility completed an Elopement Risk Evaluation on 04/08/22. R3's score was 1. A score of 1 or greater indicates at risk for elopement. R3 did not have a care plan for elopement risk between 04/08/22 and 04/27/22 to direct staff with interventions on wandering/elopement behaviors. A Fall Risk Assessment was completed on 04/08/22 which indicated a score of 14. A score of 10 or greater means the resident is at high risk for falls. On 04/27/22, Surveyor reviewed R3's medical record. On 04/15/22, R3 had a fall in R3's room. Documentation states R3's head was sticking out of the door. R3 was laying on the floor on R3's right side. R3 denied hitting head. R3 was dressed appropriately and was walking without the wheeled walker. A chair in R3's room was slid out indicating R3 may have tripped on it. R3's wife arrived to the facility and wanted R3 evaluated at the emergency room . R3 was sent to the emergency room , physician updated. On 04/15/22, R3 returned to the facility. R3 had a hand contusion, right rib pain, and right wrist sprain. Facility did not receive any new orders. Facility did not develop a care plan for risk for falls until 04/21/22. Facility did not complete a Fall Risk Assessment after the fall, nor an incident report with root cause analysis and interventions. Facility did not have a care plan for risk of falls between 04/08/22 and 04/21/22 to direct staff with interventions on preventing falls. On 4/27/22 at 12:45 PM, Surveyor interviewed DON B (Director of Nursing) regarding the CP process. DON B stated, To be honest, I don't know who does them. I am now trying to get caught up on evaluating the CPs for accuracy.

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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. 17661 Based on observations, staff and resident interviews, and record reviews, the facility did not provide the necessary services to maintain grooming and personal hygiene for 1 of 4 residents reviewed (R1). - R1 is unable to take a shower either on a shower chair or bathing trolley. Interview with R1 indicated that he does not receive daily bathing related to staff shortages. This is evidenced by: Example 1: On 4/4/22, R1 was admitted to the facility with medical diagnoses that include, but are not limited to, Paraplegia because of a Motor Vehicle Accident in 1981 in which he sustained a Cervical-Spine fracture and Peripheral Vascular Disease Observations indicated that R1 requires staff assistance to meet his most basic daily tasks of bathing, personal hygiene, dressing, and toileting. He is on bed rest, as he is unable to sit upright in a chair. He has a Suprapubic catheter and is continent of bowel function, but because of functional disabilities, will notify staff of need, in which they place a pad under his buttocks and he will move his bowels while in bed. He is unable to sit on a bedpan or a toilet. R1 was noted to be alert and oriented and remains his own decision-maker. On 4/27/22 at 10:21 AM, Surveyor interviewed R1 regarding the care he receives. R1 was asked if he was receiving showers. He stated that he does not get showers, that it isn't easy for him to shower. He prefers bed bathing, and further stated, I do want to get washed up every day, but that doesn't happen. Most times they give me a washcloth to wash my face and that's it. The staffing is so short here, they don't have time to spend with me. I wonder how they take care of those that can't say anything . Like I said, it's rare I get washed up like it should be . I flat out don't get the care I need . A record review was conducted on R1 and Surveyor noted the facility did not complete a Minimum Data Set Assessment for R1 to identify his functional abilities. There also was no Care Plan for Activities of Daily Living. These are 10 days overdue. There was a CNA (Certified Nursing Assistant) Care Card available for review, which had many areas left blank, such as bathing needs, oral hygiene needs, and personal hygiene needs. The CNA Care Card did indicate that R1 is transferred with the Hoyer lift and requires assistance of one staff for bed mobility and dressing. Surveyor then reviewed the CNA Care Tracker. According to this document, located in the Electronic Medical Record, staff were to document showers given to R1. The Care Tracker indicated that R1 received a shower on 4/11/22 and 4/25/22 by CNA G. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/02/22 at 8:35 a.m., Surveyor spoke with CNA G (Certified Nursing Assistant) regarding R1's shower schedule. CNA G reported she is familiar with R1. CNA G indicated she has never given R1 a shower since he was admitted to the facility. R1 reports he is unable to sit in a shower chair. CNA G further indicated she does not believe the facility has ever tried a table bath for showering R1. R1 requires a Gurney when leaving the facility for the wound clinic. Surveyor asked CNA G about documentation of R1 having a shower on 2 occasions as initialed by her on R1's shower documentation. CNA G expressed she has given R1 a full bed bath on 2 occasions which was documented under the shower documentation in the ADL (Activities of Daily Living) tracker as she was told to document a shower even though it was a bed bath. There was no documentation for a full body bath/shower for 4/18/22, indicating it was not completed.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, interview, and record review, the facility did not ensure that a resident (R) identified as at risk for impaired skin integrity received necessary care and treatment in accordance with professional standards of practice for 1 of 7 residents reviewed for skin integrity (R19). The facility did not promptly identify R19's skin impairment, resulting in non-pressure related wounds. This is evidenced by: R19 admitted to the facility on [DATE]. Diagnoses include: Type 2 Diabetes Mellitus, history of non-healing lower extremity ulcer, below the knee amputation, Chronic Kidney Disease Stage 4, weakness, and cognitive communication deficit. Minimum Data Set (MDS) completed 1/12/2022: Brief Interview for Mental Status (BIMS) 15, indicated R19 had intact cognitive response. Braden score for assessing pressure injury risk, 10, indicated high risk. MDS showed R19 as having no pressure injuries. Care Plan: dated 1/31/2021 and revised 2/6/2022. Included area for potential to develop pressure injury. No current focus area, or interventions for actual pressure injury or skin integrity. Skin assessment dated [DATE] indicated no skin issues. Orders: Shower day every Monday, complete skin assessment. No documentation on treatment record or progress notes for 4/18/2022 and 4/25/2022. Reviewed the following progress notes: 3/6/2022 Late Entry: Note Text: Resident had Incontinence Associated Dermatitis (IAD) to right buttock. 3 area: superior 0.5 cm X 0.3 cm mid: 0.3 cm X 0.3 cm and inferior 0.4 cm X 0.4 cm. Area excoriated. No drainage. Surrounding area pink. No signs and symptoms (s/s) of infection. Denies pain to area. Resident has IAD area to left gluteal fold. 0.3 cm X 0.3 cm. Area excoriated. No drainage. Surrounding area pink. No s/s of infection. Denies pain to area. Updated on call Nurse Practitioner (NP), new orders obtained for cream every shift and as needed. Power of Attorney (POA) updated. Will continue to monitor. 3/17/2022 Note in paper chart: NP received note from Skilled Nursing Facility (SNF) staff that resident's excoriation to right and left buttock are healed. 4/9/2022 Note Text: Quarterly nutrition note: Height: 68 Weight: 227.5# Weight is stable within 3.7# range when compared to 30, 90, and approximately 180 days ago. No significant changes in weight. BMI: 34.6 and within obese class I category. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Skin: Per 3/6/22 skin note: IAD to right buttock and left gluteal fold. No noted pressure areas. Diet: Diabetic/Regular Texture/Thin Consistency Meal intakes are excellent: 76-100%. Nutritional intake is adequate for needs and to support healing progress of skin. R19 eats independently and is tolerating diet without chewing or swallowing problems. Nutritional status is stable currently. Current diabetic diet is appropriate secondary to diabetes diagnosis. Will continue to monitor weight, nutritional intake, tolerance of diet, and will provide medical nutrition therapy as necessary. 5/2/2022 at 8:20 AM, interview with R19, reported that R19's butt is sore, and does not have a dressing. R19 stated that R19 has had skin concerns before; R19 had some difficulty recalling details of skin concerns. R19 was able to state that R19 had an amputation of her right lower extremity. R19 has bilateral enabler bars and uses these to help reposition self. 10:24 AM, observed peri-care of R19, provided by Registered Nurse (RN C) and Certified Nursing Assistant (CNA L). Observed 3 excoriated areas to R19's buttocks. RN C described areas as excoriated, scabbed, dry. RN C reported that she was not aware of these areas and R19 has no treatment orders. Observed RN C measure areas and reported: superior area: 1.5 cm X 2.0 cm, area dry and excoriated, no drainage. Inferior area: 0.8 cm X 0.6 cm. Area dry scabbed, no drainage. Inner area: 1.9 cm X 0.4 cm, area dry and excoriated, no drainage. 5/2/2022 at 2:36 PM, record review of progress note: Note Text: resident has excoriated area to right buttock. Superior area: 1.5 cm X 2.0 cm. Area dry and excoriated. No drainage. Surrounding area pink and blanchable. No s/s of pain. Inferior area: 0.8 cm X 0.6 cm. Area dry scabbed. No drainage. Surrounding area pink and blanchable. No signs of pain. Inner area: 1.8 cm X 0.4 cm. Area dry and excoriated. No drainage noted. Surrounding area pink and blanchable. No s/s of pain. Updated NP on areas, new orders obtained per wound nurse recommendations. Resident and POA update on new orders. Will continue to monitor. New orders reviewed: -Cleanse excoriated area to right inner buttock with soap and water, pat dry. Apply Calazinc every shift and as needed. Discontinue when healed. -Cleanse inferior excoriated area to right buttock with soap and water, pat dry. Apply Calazinc every shift and as needed. Discontinue when healed. -Cleanse superior excoriated area to right buttock with soap and water, pat dry. Apply Calazinc every shift and as needed. Discontinue when healed. 5/2/2022 at 3:42 PM, Surveyor requested comprehensive care plan, Activities of Daily Living (ADL) care plan, and shower log for April from DON B. DON B provided documentation for 4/25 of shower completed by CNA D; shower sheet indicates no skin issues on this date. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	DON B reported that if a resident refuses a shower the protocol is that CNA will update DON B, DON B to reapproach resident, if resident continues to refuse, CNA to chart in resident record. Surveyor asked if CNAs could document in progress notes and DON B stated that the policy should be changed that nurses will document resident refusal in progress notes. Reviewed care plan interventions for potential for pressure injury: -Follow facility policies and protocols for the prevention/treatment of skin breakdown. -Monitor/document/report any changes in skin status. -Repositioning: See ADL care plan. -Toileting: See ADL care plan. Reviewed ADL care plan: -Reposition every 2 hours. -Toileting: Hoyer lift. Offer bed pan. 5/2/2022 at 3:47 PM, Surveyor conducted an interview with Social Services Director (SSD K). She reports that she works as a CNA sometimes. SSD K reported that if staff find skin concerns during cares or showers, they are to update the RN working. 5/2/2022 at 4:16 PM, Surveyor conducted an interview with CNA D who reported that the facility protocol regarding observation of resident skin concerns, is to update the nurse working. The nurse should observe the resident's skin at time of update. CNA D stated that if the nurse is busy and unable to observe, the nurse will often instruct staff to apply barrier cream. CNA D confirmed that she observed a skin concern to R19's bottom last week but could not determine the date. Last week's dates would have included dates 4/24/2022-4/30/2022. CNA D stated that she reported R19's skin concerns to Licensed Practical Nurse (LPN F). LPN F did not observe R19's skin and directed CNA D to apply barrier cream. Surveyor was unable to obtain interview with LPN F. There is no documentation in R19's record to confirm that a skin assessment was completed after CNA D reported R19's skin concerns. R19's incontinence associated dermatitis skin breakdown had increased in size due to the lack of assessment and interventions to promote skin integrity for R19.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31088 Based on observations, staff and resident interviews, and record reviews, the facility did not provide care consistent with professional standards to prevent Pressure Injuries (PI) for 6 of 7 residents reviewed for PIs (R7, R1, R16, R17, R6, and R4). 1. R7 did not have his skin assessed for the risk for the development of PIs upon admission and the facility did not implement a Care Plan (CP) to direct staff in the care and interventions to assist in the prevention and healing of PIs. As a result, R7 developed 6 unstageable PIs. 2. R1 was admitted with 8 wounds of various stages to his legs, feet, and back. Upon hospital discharge, he had two Stage IV PIs to his back (shoulder and spine). The facility did not complete an initial comprehensive assessment of these wounds, nor were there weekly wound assessments. 3. R16 was admitted on [DATE]. R16 required two+ persons physical assistance with bed mobility and transfers. The facility did not complete a skin assessment upon admission and did not coordinate care with the wound clinic to monitor pressure injuries for promotion of healing. R16's wounds were not assessed and reassessed weekly. The facility's failure to comprehensively assess wounds, it's failure to develop a care plan to direct staff on care and treatment to promote healing and prevent new PIs from developing, and it's failure to perform treatments to the wounds as ordered by the Physician created a finding of immediate jeopardy that began on 3/29/2022. Surveyor notified Nursing Home Administrator (NHA) and Director of Nursing (DON) of the immediate jeopardy on 5/2/22 at 2:36 PM. The immediate jeopardy was removed on 5/4/2022. However, the deficient practice continues at a scope/severity of G (harm/isolated) as the facility continues to implement its action plan and as evidenced by the following. 4. R17's skin integrity was not comprehensively assessed upon admission and weekly skin assessments were not conducted. Also, the facility did not develop a CP for R17 to direct staff in the care and interventions to assist in prevention and healing of PIs for each resident. As a result, R17 developed 3 new Stage II PIs. 5. R6 developed an unstageable pressure injury on right heel. No routine skin assessments of heel were performed by facility as per current professional standards of practice. 6. R4 had areas of skin breakdown on ankle and toes; areas were not routinely assessed in a manner consistent with current professional standards of practice. This is evidenced by: According to Prevention and Treatment of Pressure Ulcers and Injuries Quick Reference Guide, NPIAP (National Pressure Injury Advisory Panel) 2019, EPUAP (European Pressure Ulcer Advisory Panel), and PPPIA (Pan Pacific Pressure Injury Alliance), 2014, the following information should be evaluated for each individual with a PI (Note this is not all-inclusive): - Assess the pressure injury initially and reassess it at least weekly; (continued on next page)

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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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- With each dressing change .assess and accurately document physical characteristics such as correct anatomical location, category/stage, size, tissue type(s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization. According to the NPIAP/EPUAP, Weekly assessments (of a pressure injury) provide an opportunity for the health care professional to detect early complications and the need for changes in the treatment plan. Without critical aspects of a comprehensive wound assessment, the professionals involved with a resident's treatment and care plans, cannot accurately determine if the wound is healing or worsening. Without this important information, the professional cannot order a more appropriate treatment plan in order to assist the wound to progress to the healing phase. The facility's policy and procedure for Pressure Ulcers, which was a canned policy written by Med-Pass 2001 with their revision date of 2009, directs staff to initially complete a comprehensive skin assessment then to proceed to complete an MDS (Minimum Data Set) Assessment to determine risk factors, medications, comorbidities, or potential behaviors, such as refusing certain care or treatments. Staff are then directed to develop an individualized care plan. Additional directives instruct nursing to complete comprehensive skin assessments on a weekly basis or more frequently if indicated. Example 1: R7 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) documents R7 has no pressure injuries but is at risk to develop pressure injuries. The MDS documents R7 has a pressure relieving device for his bed and chair. R7 has a Brief Interview for Mental Status score of 13, meaning he is alert and oriented and able to answer most questions accurately. R7 needs extensive assistance with assist of two persons for transfers, bed mobility, and personal hygiene. R7 is always incontinent of urine and frequently incontinent of bowel. The medical record contains no admission skin assessment or skin care plan. The nurses' notes contain in part: 3/29/22 Resident admitted to facility on 3/29/22. admitted to hospital on 3/22 for Acute kidney injure, acute encephalopathy, aspiration pneumonia and hypokalemia. Episodes of confusion .Incontinent wears brief. Does have a pressure ulcer to buttocks, dressing on for protection . The admission note does not identify a location for a pressure injury, size or stage. Dietary Note 3/31/2022 19:46 Nutrition/Dietary Note Text: Initial RD Nutrition Risk Assessment: Calorie Goal: 2400/d (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Fluid Goal: 2300 ml/d minimum Protein Goal: 140 g/d (1.5 g/kg due to skin impairment). Skin: Open areas on buttocks- spots of blistering. Resident has history of pressure areas to buttocks. Care plans Potential for nutritional problems .Interventions: Provide and serve supplements as ordered: 1 oz additional dietary protein at meals and 1 scoop protein powder tid 3/31/22. Activities of Daily Living Care Plan: Repositioning: Assist of one Transfers: ext assist of 2 sit to stand. The skin assessments that were completed since R7's admission contain the following information. 4/21/22 Skin Only Evaluation: Does resident have skin issues? Yes, IAD (Incontinence associated dermatitis, admitted with). No other information is on this assessment related to wound bed, size, wound exudate, peri wound condition, wound color, or tissue condition. 4/22/22 Skin Only Evaluation: Does resident have current skin issues? No Education provided: Resident aware of diagnosis and plan of care: yes. Treatment Administration Record (TAR) Moisture Barrier Ointment BID (Twice daily) as indicated to keep irritants or moisture from skin surface. This is signed out by licensed nursing staff twice a day, except for 8 entries that are left blank. On 04/27/22 at 9:40 a.m., Surveyor interviewed R7 to ask if he had any skin issues. R7 stated he had a problem on his bottom, and it hurt really bad lately. Surveyor observed his bed and noted a regular mattress on the bed. Surveyor examined the wheelchair cushion that had an approximate 1.5 inch cushion in it. Surveyor asked if R7 gets care done to this area. R7 said, Sometimes they do. I can't say how often, but not every day. Surveyor asked if R7 had been educated about staying off of his bottom to make it feel better. R7 said, No. On 4/27/22 at 3:15 p.m., Surveyor asked Director of Nursing (DON) B what treatments R7 had to his pressure injury, as DON B had identified R7 on the pressure injury list. DON B said, I don't know. Surveyor reviewed the TAR with the DON B and noted that barrier cream was the only skin treatment identified. DON B said, Maybe it's healed. Surveyor asked if staff could assist R7 with lying down so Surveyor could see the status of the skin. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/27/22 at 3:35 p.m., RN C assisted R7 with turning onto his side and pulled down his brief for Surveyor to observe the area. Surveyor noted 5 open areas. Each of these areas contained slough, had regular borders with observable depth on the approximate 2 cm x 1 cm area on the left lower buttock. This wound is located in an area that would get direct pressure when R7 is seated in his wheelchair. R7 had yellow slough apparent on the coccyx. Surveyor asked RN C to separate the buttocks for better visibility. RN C separated the buttock cheeks. Surveyor observed a large amount of yellow slough, with the base of the pressure injury partially visible. Surveyor asked RN C what these areas were. RN C stated that the areas didn't look like this before. The area on the coccyx was not present before. Surveyor asked RN C how she would stage these areas. RN C stated they are unstageable. On 4/27/22 at 3:45 p.m., Surveyor went to DON B and shared concerns with the findings of R7's skin integrity. Surveyor asked if R7 had a pressure reducing mattress or special cushion. DON B stated, No, I will get a roho cushion and a better mattress on the bed right now. Surveyor asked to review the CNA care card for R7. DON B pulled up the information on the computer and noted that it was blank other than R7's transfer status. Surveyor asked how R7 had no wound care treatments or assessments. DON B indicated that because she has no MDS nurse the care plans don't get done. DON B went on to say, I can honestly tell you I haven't seen his pressure injuries. I have no idea what is there. On 4/27/22 at 5:15 p.m., Surveyor interviewed CNA D, asking if R7 has had skin issues. CNA D indicated that R7 was admitted with a pink dressing on his bottom. One day when transferring R7, it came off. The CNA said she told the nurses and they told CNA D to apply barrier cream. Surveyor asked if any other dressings had been applied. CNA D stated, No, nothing else. Surveyor asked if R7 would ever refuse to lie down or lay on his side. CNA D indicated that R7 is very pleasant and does not refuse to do things. On 4/27/22 at 6:30 p.m., Surveyor interviewed CNA E and asked if R7 refused to lie down or reposition. CNA E stated that R7 is always agreeable. Surveyor asked if R7 had any special instructions for offloading his bottom. CNA E was not aware of anything. On 4/27/22 at 7:45 p.m., Surveyor asked for the assessment of R7's pressure injuries during the observation at 3:45 p.m DON B brought Surveyor the nurse's note that contained the following: 4/27/2022 17:43 Skin/Wound Note (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note Text: Resident has unstageable pressure ulcer to left buttock X 4. Inner: 0.8 cm X 2.4 cm. Bed wound mixed slough-50% and granulated with epithelial islands-50%. Scant serous drainage. No odor. Wound edges raised. Surrounding area blanchable. No s/s of pain with palpation. Outer: 0.3 cm X 1.0 cm. Bed wound mixed slough-50% and granulated with epithelial islands-50%. Scant serous drainage. No odor. Wound edges raised. Surrounding area blanchable. No s/s of pain with palpation. Mid: 0.2 cm X 0.2 cm. Bed wound mixed slough-50% and granulated with epithelial islands-50%. Scant serous drainage. No odor. Wound edges raised. Surrounding area blanchable. No s/s of pain with palpation. Inferior: 1.3 cm X 2.1 cm. Bed wound mixed slough-50% and granulated with epithelial islands-50%. Scant serous drainage. No odor. Wound edges raised. Surrounding area blanchable. No s/s of pain with palpation. Resident has unstageable pressure ulcer to coccyx. 3.0 cm X 1.8 cm. Bed wound mixed slough in center of wound-50% and granulated with epithelial islands-50% to surrounding. Scant serous drainage. No odor. Wound edges raised. Surrounding area blanchable. No s/s of pain with palpation. Right buttock has unstageable pressure ulcer. 0. 2 cm X 3.0 cm. Bed wound mixed slough-50% and granulated with epithelial islands-50%. Scant serous drainage. No odor. Wound edges raised. Surrounding area blanchable. No s/s of pain with palpation. Resident c/o pain to left areas when in room assessing. Writer went into room to dress wounds and resident stated that wound felt much better now that writer put stuff on them. Writer did not put anything on wounds at this time. Resident rate pain 0 on 0-10 scale at that time. Updated NP [name] of areas, gave new orders per writer recommendations. Updated RD of areas. SP mattress. Resident encouraged to lay in bed throughout day. SP cushion will be applied to w/c when charged. Resident aware of new orders. Will continue to monitor. 17661 Example 2: On 4/4/22, R1 was admitted to the facility with medical diagnoses that include, but are not limited to, Paraplegia because of a Motor Vehicle Accident in 1981 in which he sustained a Cervical-Spine fracture, Chronic Obstructive Pulmonary Disease, Chronic Normocytic Anemia, Peripheral Vascular Disease, History of Renal Failure, and Chronic Anticoagulant therapy. Further documentation revealed that R1 also has conditions such as Diabetes Mellitus Type II, Failure to Thrive, and Congestive Heart Failure. Initial medical record review revealed that as of 4/28/22, the facility did not initiate a Minimum Data Set Assessment (MDSA) or a CP for R1. This is 10 days overdue. There was a CNA (Certified Nursing Assistant) Care Card available for review. Bathing needs, oral hygiene needs, and personal hygiene needs were blank. The CNA Care Card did indicate that R1 is transferred with the Hoyer lift and requires assistance of one staff for bed mobility and dressing. The Care Card directs CNA staff to float R1's heels and to wear a blue boot on the right foot. DON B completed initial wound care on R1's admitted [DATE]. The documentation indicated the size and location of the wounds and the treatment performed. This included: 1. Underside of right shin: 9.0 centimeters (cm) Length (L) x 4.5 (cm) Width (W) reddened area 2. Middle back: 4.5 cm L x 2 cm W with an open area measuring 0.5 cm x 0.5 cm. 3. Lower back: 2 cm L x 3.0 cm W- Stage II (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Right Shoulder: 7 cm L x 3 cm W- stage IV 5. Left Shoulder: 1.0 cm L x 1.0 cm W- currently superficial 6. Right Heel: 4.0 cm L x 3.0 cm W, oblong in shape- stage IV 7. Right Buttock: 0.5 cm L 1.0 cm W- Stage IV 8. Right Buttock: 4.0 cm L x 3.0 cm W with an open area that measured 0.5 cm L x 1.0 cm W Per documentation, Allevyn was applied to all the wounds. Surveyor observations indicated that R1 requires staff assistance to meet his most basic daily tasks of bathing, personal hygiene, dressing, and toileting. He is on bed rest as he is unable to sit upright in a chair. He is nonambulatory and requires transfers with the use of a Hoyer mechanical lift. He has a Suprapubic catheter and is continent of bowel function, but because of functional disabilities, will notify staff of need, in which they place a pad under his buttocks and he will move his bowels while in bed. He is unable to sit on a bedpan or on a toilet. He is able to feed himself finger foods, but if utensils are required for the meal he requires staff assistance. R1 was noted to be alert and oriented and remains his own decision-maker. On 4/27/22 at 10:21 AM, Surveyor interviewed R1. During the interview, R1 expressed concerns regarding his wounds stating, .I have 6 major wounds, on my butt, my back, my shoulders and my heel. I do not get the treatments sometimes for 4 or 5 days. God, they smell so bad . My right shoulder smells of rotting flesh .the nurses are charting that I've been getting the treatments every day, but I'm actually lucky if they are done twice a week. Or they will chart that I refused. I've never refused a treatment . Surveyor reviewed the documentation of treatments performed for R1 and noted a treatment was signed out on admission day (4/4/22) but no treatments were documented on 4/5, 4/6 or 4/7/22. There was then an entry on the Treatment Administration Record (TAR) on 4/8/22 of details for wound care for each wound to be completed each morning. These were then signed out 4/8/22 - 4/11/22. On 4/12/22, the treatment time was changed to Hour of Sleep, and they were signed out daily with the exception of 4/17 in which the nurse documented that resident was asleep and wound dressings were not conducted. Surveyor was unable to obtain affirmation from nursing staff of missing any scheduled treatments. The treatment orders as written on 4/8/22 were: 1. Left Shoulder: Cleanse with wound cleanser and pat dry. Cover each wound bed with Aquacel AG (silver), then cover all with an island dressing. Change daily and as needed. 2. Right Shoulder: Cleanse with wound cleanser and pat dry. Cover wound bed with damp/moist 4 x 4 gauze in Dakins Solution then cover with and ABD pad and secure with tape. Change daily and as needed. Note: an ABD pad is an abdominal pad that is used for large wounds or for wounds requiring high absorbency because of large amounts of drainage. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Midline Lower Back: Cleanse with Dakins Solution, Cover with Aquacel AG then adhesive foam. Change daily and as needed 4. Right Buttock: Cleanse with soap and water and pat dry. Apply Calazinc twice daily and as needed 5. Left Buttock: Cleanse with soap and water and pat dry. Apply Calazinc twice daily and as needed 6. Left Gluteal Fold: Cleanse with soap and water and pat dry. Apply Calazinc twice daily and as needed 7. Right Ankle: Cleanse wound with Dakins Solution and cover with Aquacel AG. Cover with an ABD pad and wrap lightly with Kerlix. Secure with tape. Change daily and as needed. 8. Right Heel: There is no treatment listed for this area even though it was present according to the initial wound care DON B completed on admission. During the interview with DON B on 4/27/22 at 12:45 PM, DON B indicated that R1's wounds were assessed on admission, as she herself completed it. Also, DON B stated the lower back wound was very deep, and she admitted she should have staged it as a Stage IV as it was deep and covered with slough. She also indicated the right shoulder wound had visible bone. She could not recall if she started a CP for R1's wounds, and upon checking in the Electronic Medical Record (EMR), noted that there was no CP for R1. Upon further interview, DON B stated, To be honest, I do not know who does the CPs. We currently do not have anyone doing MDSAs (Minimum Data Set Assessments) and are behind on those as well. R1's wounds have not been evaluated since he was admitted by either a trained wound nurse or a physician. Surveyor then reviewed the documentation DON B entered into the NPNs for R1's admitted [DATE]. According to the documentation, there were 8 wounds identified. Of concern is the documentation was not a comprehensive assessment as it did not include a full description of each wound's characteristics, such as the presence of eschar or slough, infection, drainage amount and type, the presence or absence of granulation, tunneling/undermining, staging of each wound, or the appearance of the surrounding tissue of each wound as well as wound bed. Wound Care Observation: On 4/27/22 at 6:25 PM, Surveyor observed LPN F (Licensed Practical Nurse) complete wound care for R1. After preparing her supplies, LPN F washed her hands and donned gloves. She then proceeded with wound care, as follows: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Right Heel: LPN F removed an eggcrate foam pad that was fastened with Velcro over the top of the right foot. The old dressing contained a bloody to yellowish drainage and the wound measured approximately 6.0 Centimeters (cm) length x 7.0 cm width. This wound appeared to be a Stage II as depth could not be measured related to the nearness to the surface the wound bed was. LPN F cleansed the wound with Sterile Saline by pouring the liquid over the wound. There was no wiping or patting the wound dry afterwards. She then proceeded to cover the wound bed with Derma/Col AG and a foam dressing, covered with Kerlix. This technique of not wiping the wound with a solution prevents the removal of potential bacteria, which can create a burden on the wound healing process as bacteria compete for the oxygen and nutrients in a wound. The foam pad that was being used on R1's foot was not a pressure floating or redistribution boot. The pad did not allow for floating of the heel and there was no floating Heels-Up device on the bed, allowing the heel to rest directly on the bed mattress, creating additional pressure to the heel. Note: There were no treatment orders written for the right heel to compare accuracy of observation. The wound has increased in size from 4/4/22 and also was originally staged as a Stage IV. b. Right Shoulder: The old dressing contained large amounts of a light lime green drainage. The wound measured approximately 6.5 cm length x 3.0 cm width. There was no odor from the wound. The wound was filled with what can only be described as a pale pink pigmented cluster of grapes indicating hypergranulation to the wound. There was a presence of slough from 7 O'clock to 10 O'clock inside the wound bed and approximately 0.5 centimeters (cm) from the edge into the wound. This wound was an Unstageable wound as one could not visualize the depth of the wound with the cluster of tissue on the surface. LPN F poured Sterile Saline over the wound and did not wipe or pat the wound dry. LPN F applied a Derma/Col Ag dressing over this as well. Note: The treatment order for this wound was to cleanse with wound cleanser and pat dry. Cover wound bed with damp/moist 4 x 4 gauze in Dakins Solution then cover with and ABD pad and secure with tape. This was not completed as ordered. The wound did decrease in size, however DON B noted that she could see bone on 4/4/22 and there is an addition of hypergranulation currently, which was not present on 4/4. Hypergranulation prevents epithelialization (new, healthy cell growth) and the healing process may be halted. The wound generally will not heal when there is hypergranulation tissue because it will be difficult for epithelial tissue to migrate across the surface of the wound. c. Left Shoulder: The old dressing contained a moderate amount of bloody drainage and the wound measured approximately 1.0 cm in diameter. This was a Stage II wound. LPN F poured Sterile Saline over the wound and did not wipe or pat it dry prior to applying a Derma/Col Ag dressing covered with a foam dressing. Note: The treatment orders for this wound were to cleanse with wound cleanser and pat dry. Cover each wound bed with Aquacel AG (silver), then cover all with an island dressing. This was not completed as ordered. Also, this wound remained the same with no changes from 4/4/22. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The foam boot used for the heel was a simple eggcrate bootie fastened with Velcro over the top of the foot. It was not a heel-floating boot. - There was no Heel floating observed during the length of the survey (4/26 - 4/28). - Treatment observed was not completed as ordered On 4/27/22 at 12:45 PM, Surveyor interviewed DON B (Director of Nursing) regarding the expectations of wound assessments. DON B stated the expectation of all residents is that upon admission, the admitting nurse completes a full body assessment, including an assessment of all wounds and documents the assessment in the Nursing Progress Notes (NPNs). All other residents, the expectation is that nursing complete weekly assessments of all wounds. DON B also stated a CP should be developed to assist staff in following interventions to promote healing of the wounds and to prevent additional wounds from developing. On 4/28/22 at 10:01 AM, DON B was interviewed regarding wound assessment and documentation. DON B stated, I really don't have much experience with wound care and we do not have a wound nurse since (Registered Nurse C) transitioned into a floor nurse on 4/8/22. There is no one else on staff trained to do wound care. When asked if there were issues related to not having properly trained individuals for wound care, DON B stated, Well yes, there really isn't the knowledge to correctly assess wounds. This is a problem because there would be, but isn't any consistency. I really need to work on this . 44863 Example #3: R16 was admitted to the facility on [DATE]. Diagnoses include, chronic kidney disease stage 3, kidney stone post lithotripsy, chronic pain, skin impairments, pressure areas. Discharge summary from hospital dated 4/6/2022 indicated R16 needs ongoing wound care. Summary indicated resident has multiple chronic wounds, dating back to 2017. Multiple skilled nursing facility and hospital admissions. Most recent hospital stay approximately 88 days. The admission Minimum Data Set (MDS) dated [DATE] indicated R16 had a Brief Interview for Mental Status (BIMS) score of 15. Skin Condition indicated R16 had one or more unhealed pressure ulcers/injuries. Current number of unhealed pressure injuries at each stage is not completed. The medical record contains no skin assessments. Nursing note dated 4/8/2022: -Wounds to bilateral lower extremities. Change daily. Cleanse with wound cleanser. Apply collage dressing, silver foam wrap, and Unna boot compression with cast padding and compression wrap in the morning. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Bilateral lower extremities cannot be measured entire lower legs are open areas scattered throughout. Skin not intact to wound beds, peri areas have skin sloughing off due to maceration, moderate mixture of discharges present (purulent, serosanguineous). -Right knee laceration measuring 3.5cm in length. scab intact and no drainage or signs of infection. -Left thigh cluster of four open areas 2cm X 2cm, 1.5cm x 1cm, 4cm x 1.5cm, 2cm x 1.5cm all wound beds present with epithelial tissue, bloody drainage present. -Left low back closed area tissue is red measures 4cm X 0.50cm, protective bandage applied. -Right shoulder wound measures 3cm x 1.5cm bloody drainage present, wound bed present with epithelial tissue, no signs of infection. -Mid back two open wounds close in proximity measure 0.75 x 0.50, 0.25 x 0.25 both with epithelial tissue present, no drainage, no signs of infection. -Right buttock area measures 17cm x 9cm x 6cm. Wound bed red with scant blood drainage. No signs of infection, resident stated area was painful to touch. Dietary note dated 4/9/2022: Ht: 67 Weight: 253# No noted significant changes in weight in past 180 days. BMI: 39.6 and within obese class II category. Calculation weight: 174# (adjusted due to obesity). Calorie Goal: 2580/d Fluid Goal: 2000 mL/d Protein Goal: 120 g/d minimum (1.5 g/kg- increased needs to support healing progress of wounds). Skin: 5 pressure ulcers to back and upper thighs. Bilateral wounds on shins. Diet: Regular/Regular Texture/Thin Consistency Meal intakes are excellent: 76-100%. Recommend 2 oz additional protein at meals, 1 scoop protein powder tid added to food or drink, and Arginaid bid to support healing progress of wounds. Cook confirmed that resident is receiving this. Care Plan dated 4/6/2022 with revision date of 4/9/2022 and target date of 7/5/2022: Baseline care plan: Interventions: skin monitoring, pressure relief mattress, cushion in wheelchair, float heels on wedge pillow, repositioning assist of two, transfers with hoyer lift assist of two. Dietary interventions include 2 ounces additional protein at meals, Arginaid twice daily, 1 scoop protein powder three times daily. (continued on next page)

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	525678	A. Building B. Wing	05/10/2022

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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A care plan for skin integrity or pressure injuries was not located. Treatment Record April 2022: All treatment orders contained start date of 4/12/2022 and discontinued date of 4/29/2022: -Cleanse bilateral lower extremity wounds with cleanser, pat dry, cover with petroleum gauze, cover with meplix superabsorbent or non-adhesive foam. Wrap with Kerlix, wrap with ACE wrap. Change daily and PRN. -Cleanse intergluteal cleft with soap and water, pat dry. Paint open area no-string skin prep. Let dry. Every day shifts. -Cleanse left hip wound with wound cleanser. Pat dry. Cover with non-adherent pad/telfa. Secure with tape. Change daily and PRN. -Cleanse left knee with abrasion with wound cleanser. Pat dry. Cover with non-adherent pad/telfa. Secure with tape. Change daily and PRN. -Cleanse left lower back and right side of mid back abrasion with wound cleanser. Pat dry. Apply skin protectant ointment daily and PRN. -Cleanse right buttock denuded area and left buttock excoriation with soap and water. Pat dry. Paint open area with no-string skin prep. Let dry. -Cleanse right hip wounds with wound cleanser. Pat dry. Cover with ABD pad. Secure with tape. Change daily and PRN. -Cleanse right upper shoulder area with wound cleanser. Pat dry. Cover with telfa. Change daily and PRN. Orders: -Arginaid-1 packet BID -Braden scale on admission and weekly for 4 weeks. Documented on 4/13/2022 and 4/27/2022. No documentation on 4/20/2022. -Nurse to do full skin inspection on shower day, every Tuesday for shower. Documented 4/12/2022, 4/19/22. Not documented on 4/26/2022. 5/2/2022 at 6:52 AM, Surveyor requested face sheet, care plan, MDS assessment, skin assessment, and treatment record for R16. DON B stated that she knows R16 does not have a completed MDS. Surveyor requested to observe R16's wounds. DON B reported that Surveyor would not be able to observe R16 wounds as he went to wou [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** 30570 Based on observation, interview and record review the facility failed to ensure 6 of 20 sample residents (R8, R11, R12, R14, R3, and R15) were provided appropriate supervision and interventions to prevent elopement/unsafe wandering from occurring. The facility did not have a system in place to activate or monitor the door alarm system to prevent residents from exiting the building unsupervised. R8 eloped from the facility on 04/26/22. R8 was found outside at approximately 9:00 p.m. R8 was found down a ravine with his wheelchair tipped over and R8 laying on the ground. R8 had been wandering throughout the building earlier, exhibiting exit seeking behavior and staff did not increase supervision. Facility staff lacked knowledge on how to operate the door alarm system and did not know one of the exit doors was not alarmed. The facility's failure to provide supervision on for a resident at risk for elopement, the failure to have a working knowledge of the door alarm system, and the failure to ensure the alarm system was operational created a finding of Immediate Jeopardy (IJ) that began on 4/26/22. Surveyor notified the Nursing Home Administrator (NHA) A of the IJ finding on 04/28/22 at 3:30 PM. The IJ was removed on 05/02/22, however the deficient practice continues at a scope/severity level E (potential for more than minimal harm/pattern) as the facility continues to implement its removal plan and as evidenced by the following. The facility did not provide appropriate supervision and put interventions in place to prevent elopement/unsafe wandering from occurring for R11, R12, R3, R14, and R15, who are also at risk for elopement from the facility. This practice places R11, R12, R3, R14, and R15 at risk for elopement as demonstrated by R8. Findings Include: The facility policy entitled, Prevention of Elopement dated 11/01/2016 with a review date of 11/2017 states: Purpose: To prevent a safe environment by assessing residents' risk factors and implementing a plan of care to prevent accidents related to wandering behavior or elopement. Elopement is defined as leaving the facility or supervised environment without accompaniment or knowledge of the staff prior to their scheduled discharge. To prevent elopements, appropriately assess resident risk factors, observe resident patterns, communicate with family/responsible party, identify the significance of risk factors and implement prevention interventions. Residents identified as risk for wandering/elopement: ~A wandering/elopement risk book will be kept at the nurses' station and contain a photograph and identifying information about each resident for each resident identified at risk for wandering/elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~Signs such as Stop or Do not enter may be posted at each exit door as a possible deterrent to cognitively impaired residents. Door Alarm Drills: ~Staff will be educated on proper identification, risk factors and interventions for residents at risk for wandering/elopement behavior. ~The facility shall develop a schedule of conducting unannounced elopement drills at least quarterly and more frequently based on resident population at risk. ~Additional training and education will be provided in response to the door alarm drill as necessary. Example #1: Surveyor reviewed R8's record and noted the following: R8 was admitted [DATE] with diagnoses that include, traumatic subarachnoid hemorrhage, dementia with behavioral disturbance, repeated falls, anxiety, and difficulty walking. R8's Elopement risk assessment dated [DATE] notes R8 is at risk for elopement. Risk factors include resident has verbally expressed desire to go home, packed belongings to go home or stayed near an exit door, resident wanders, wanders aimlessly, and is confused. R8's physician orders included: 1/15/22: Order: check wander guard each shift for proper function. R8's Treatment Administration Record (TAR) was reviewed from 1/15/22 through 4/27/22. The TAR for monitoring Wander guard function each shift shows no check was completed on 26 occasions. R8's Admission MDS dated [DATE] notes: ~ Sometimes understands, is sometimes understood and has moderately impaired cognition. ~ Displays: other behavioral symptoms, does not wander. (Of note: this information is not consistent with R8's Elopement Risk assessment dated [DATE]). ~ Requires extensive asst of 2 staff for transfer and bed mobility, does not walk. ~ Has a fall history and balance is not steady. R8's record contained no care plan to prevent accidents from unsafe wandering or elopement, identifying risk factors and directing staff of R8's prevention interventions. R8's care card, which is used by staff to direct his care, does not identify R8 is at risk for elopement. The care card did not contain prevention interventions for R8's unsafe wandering/elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R8's picture is in the elopement risk book at nurses' station, however there is no identifying information for R8 as outlined in the facility policy. R8's care plan indicates resident at high risk for falls with a clip alarm, room close to nurses' station, appropriate footwear, and bedside alarm identified as interventions. Surveyor reviewed R8's progress notes with the following noted: 3/25/22: 11:25 am (Social Services) Continuing to exit seek all morning, stating he needs to go outside and read meters. Resident leaving activities, 1:1's and writers office, all attempts of redirection unsuccessful. 3/30/22: (Social Services) 2:23 pm Continues to exit seek all morning/afternoon. Setting off door alarms at ends of hallways. 4/04/22: 4:04 pm (Social Services) Resident exit seeking all day setting off door alarms in each hallway, interventions of 1:1, ice cream and activities not effective 4/26/22: Incident: which was noted 4/27/22 at 2:00 a.m. Resident was outside of facility, resident got outside of facility and fell outside of building by green hall door at approximately 9:00 p.m. Found lying on his back, in the ravine, wheelchair was upside down. Resident assessed with noted abrasions to face and bruising to left upper cheek by his eye. PCP (Personal Care Provider) notified and sent to ER for evaluation. EMS arrived at approx. 9:15 pm. Transferred via [NAME] to local hospital. POA (Power of Attorney) and DON (Director of Nursing) notified. CT and other tests negative. Returned at 12:15 am. Transferred to bed. No pain voiced at this time. *The note does not indicate the door alarm was not armed, all doors were checked to ensure the alarm was armed, or immediate education was provided to staff regarding the door alarm system. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/27/22 at 4:57 p.m., Surveyor spoke with RN O via phone about R8's elopement/fall incident. RN O indicated she had given R8 medications somewhere between 8-8:30 p.m. on 4/26/22. At approximately 9:00 p.m. Certified Nursing Assistant (CNA) Q went looking for R8 to put him to bed. R8 was not at nurse's station. CNA Q and CNA E started an internal search going room to room on each hall and checking other areas in the building such as therapy and the dining room. R8 was not located. RN O went out the front door that was not locked and heard both R8's clip alarm and him yelling. RN O located R8 down a grassy sloped area off the end of the 400 wing. R8's wheelchair was tipped over and he was flat on his back. R8 was assessed and found to have facial abrasions and a goose egg that was bruised with abrasion below his eye on his cheek. 911 was called and R8 was transferred to the ER. Report from hospital were all tests and CT scan were negative. R8 was returned to the facility and again assessed before lying down. R8 reported no pain. RN O indicated the root cause of R8's elopement and fall was the door alarm at the end of 400 wing was not set. RN O also reported lack of sufficient staffing to properly supervise residents at risk for elopement. RN O indicated there were 2 certified nursing assistants in the building, along with RN O at the time of the incident. RN O reported it is not possible for staff to care for all the residents and try to keep residents from leaving the building with current staffing levels. RN O further reported it is not uncommon for the facility to have 1 nurse and 1 CNA in the building from 6:00 p.m. to 10:00 p.m., which she reports is not sufficient to care for the residents and supervise residents. RN O expressed she informed DON B of incident and was not directed to check all alarmed doors or to start immediate staff education. RN O indicated she was not aware the door alarm needs to be first turned off then the alarm button pushed again to reset the alarm. RN O reported she is still not clear on the functions of the door alarms and how to properly work the alarm system. RN O reports a daily check of resident wander guard should be done each shift to ensure they are functioning. RN O indicated there is a device on the medication cart to check the wander guard systems on the doors armed with the wander guard system to ensure they are functioning properly. RN O reported the front door is not checked at night to ensure it is locked. The alarm doors are not checked to ensure proper function. Alarms cannot be heard in resident rooms or up the hall until at the nurse's station. Surveyor checked the outside temperature via Weather.com and noted the outside temperature at 9:00 p.m. on 4/26/22 as 26 degrees Fahrenheit. On 4/27/22 at 5:30 p.m., Surveyor visualized area outside 400 wing's exit door. Surveyor noted a cement pad just outside the door with an adjacent sidewalk. A grassy sloped area was just past the sidewalk. Surveyor noted the grassy sloped area to be 10 steps from the sidewalk. A ravine area was at the bottom of the grass slope, just before some wetlands. A highway is just past the wetland area. R8 was noted to be found at bottom of slope in ravine area. The location is 84 paced steps from front entrance which RN O exited when she heard R8's alarm and him yelling. Surveyor observed R8 throughout 4/27/22 wandering about facility, at times down hallways near exit doors. The doors at the end of the hallways did not have signs to deter residents that are cognitively impaired from going outside as outlined in the facility policy. On 4/27/22 at 1:53 p.m., Surveyor and Maintenance Director (MD) M spoke regarding the facility's door alarm system, conducting checks of doors on alarm or any facility drills that have occurred in the facility as outlined in the facility policy. MD M has been on staff approximately one month. MD M does not conduct formal audits or drills of the door alarm system and is not aware of any auditing system. MD M indicated he does an informal walk through maybe one time a week and checks the doors to ensure the alarms are armed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/27/22 at 1:55 p.m., Surveyor and MD M conducted a walk through and observed the facility exits. The facility has doors at the end of each of the 4 hallways that are on an alarm system, which alerts at the panel across from the nurse's station. The doors at the end of the hallways do not have a wander guard monitoring system in place. The facility front door is not alarmed and not locked. It has a set of double doors that are on the wander guard system just prior to the lobby at the front door entrance. The facility is checking the doors daily with a device that is maintained in the medication cart. There are two exits to the left side of the building. One is employee entrance and one is for deliveries. Both have a set of double doors on wander guard system prior to the exits. Both are not locked. The delivery door is on the alarm system but is not armed. MD M indicated the delivery door should not be armed due to the frequency of the noise it creates. The staff entrance door is not locked or tied to the alarm system. The door previously had a keypad for staff to open the door without alarm. The keypad at the door had wiring issues and the pad was not replaced. The door is not locked or on alarm system. There is a door off the dining room that leads to a resident fenced area. The door does not have wander guard system. The door is on the alarm system. The doors on the alarm system were checked as follows: Doors at the end of the hallway were checked for alarm system. All alerted at panel at nurse's station. The alarm was heard by peer Surveyor at nurse's station. Surveyor with MD M could not hear the alarm sounding when at end of hall or coming up the hallway until approaching the nurse's station. The doorway from the dining room was opened and no sound was heard at the alarm system by peer Surveyor. MD M and Surveyor repeated opening of the door and holding it open for a short period. Again, the alarm was not heard at the alarm panel. Surveyor and MD M reported to the alarm panel and noted the door was not armed. MD M armed the door, indicating it should be armed to alert staff of the door being opened and resident going to patio. Residents could have exited this door on 4/27/22 and an alarm would not have sounded. On 4/27/22 at 2:20 pm, NHA-A indicated he learned of R8's elopement incident at approximately 9:30 am 4/27/22. He was not called when the incident occurred thus, he did not direct staff to check all alarmed doors or to start immediate staff education. On 4/27/22 at 2:25 pm, Surveyor spoke with DON B who was called by Registered Nurse (RN) O on 4/26/22 at 9:26 p.m. RN O reported R8's elopement incident and assessment as well as R8's transfer to ER. DON B indicated she asked RN O how R8 got out of the building. RN O told DON B the root cause of the elopement/fall was the door at the end of the 400 hall alarm was not set. DON B indicated she did not direct RN O to check all doors on the alarm system or to start immediate staff education related to the alarm system. DON B expressed she is not familiar with the system and was not aware staff need to turn off the alarm by pushing the corresponding button to the door and push the button again to rearm the alarm. Surveyor requested investigation information the facility has completed thus far. Surveyor requested staff education that had been completed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/27/22 at 2:40 p.m., NHA A informed Surveyor all doors on alarm system are now set, just learning now about the door alarm system and the need to first disarm the alarm by pushing button and push button again to rearm the alarm system. On 4/27/22 at 2:57 pm, Surveyor reviewed a staff education note left at nurses' desk by DON B. It read: No One is to turn off the door alarms for any reason. If there is a problem with them, please alert maintenance, administrator or DON. It contains DON B's signature and 2 other staff. **Education does not address the alarm process for rearming alarms. On 4/27/22 at 3:11 pm, Surveyor spoke with CNA P about door alarm system. CNA P indicated the doors at the end of the halls are on alarm system. Staff can tell which door has been opened by sound and corresponding light at alarm panel. CNA P indicated the button should be turned off when it is safe. CNA P was not aware she needed to push the button again to rearm the alarm. CNA P worked since 10:00 am today. On 4/27/22 at 5:29 p.m., Surveyor attempted to call CNA Q who first noted R8 was missing. CNA Q was not working on 4/27 and her phone was not working. On 4/27/22 at 6:10 p.m., Surveyor spoke with CNA E. CNA E has worked at facility over one year with previous employment for over [AGE] years. CNA E expressed he also works as a medication technician at the facility. CNA E reported R8 could not be found, and an internal search of building areas was initiated. R8 could not be located. RN O went out front door and heard R8 and his alarm. R8 was found down a grass sloped area off 400 wing. R8 was damp from wet grass, shivering, and had abrasions to nose/face. R8 was provided blankets. R8 was assessed and 911 was called, R8 was transferred to ER. CNA E found the front door unlocked and the button on the alarm system was not pushed in or armed for the 400 wing door. CNA E reported he needed to help answer resident call lights, put people to bed, and help the nurse with medications when he returned inside. Further expressing he did not recheck other doors and reported he did not believe anyone checked the doors. CNA E also expressed he was not provided education on the door alarm system. On 4/27/22 at 6:28 p.m., NHA A provided Surveyor with a form titled, Minocqua Health and Rehab Elopement Response it noted: Root cause analysis completed regarding 4/26/22 elopement. Root cause was the control panel button for alarm was in a position/silencing alarm. A lack of education was the reason the button being pushed in due to the button needing to be pressed twice to return to active status. Door alarm control panel education has been initiated. New elopement assessment was completed for resident that eloped; care plan updated. DON verified all residents identified as elopement risk have elopement interventions in their care plans. Education regarding elopement book and elopement prevention. Maintenance Director verified all wander guard's door alarm sensors are functioning properly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Maintenance Director verified all wander guard pendants are functioning properly. Maintenance Director verified all door alarms are functioning properly. Surveyor requested and reviewed Staff Education completed to this point and noted pm staff working 4/27/22 had not yet been educated. Requested pm education be provided and a plan for night staff before survey team would exit. On 4/27/22 at 7:44 p.m., Surveyor received and reviewed education provided to pm staff with context discussed. Context now includes process for rearming alarm. The facility's failure to provide supervision of a resident at risk for elopement, the failure to have a working knowledge of the door alarm system, and the failure to ensure the alarm system was operational created a reasonable likelihood for serious harm to occur, thus creating a finding of Immediate Jeopardy (IJ) that began on 4/26/22 The IJ was removed on 05/02/2 when the facility completed the following: Wandering and elopement assessments completed; Door alarm panels audited each shift to ensure activated; Visual cues in form of stop signs posted at all exit doors; Care plans updated for all residents assessed to be at risk; Education and training provided to all staff on activating and alarming all doors; Education on wandering and elopement policies and procedures for all staff. The deficient practice continues at a scope/severity level E based on the following examples: Example #2: Surveyor requested and received a list of residents at risk for elopement from DON B. The list contained R3, R11, R12, R14, and R15, in addition to R8. Surveyor reviewed records for residents at risk for elopement and noted the following: R3 was admitted [DATE] with diagnoses that include, dementia with behavioral disturbance, and hemiplegia and hemiparesis following a cerebral infarction. R3's Admission MDS dated [DATE] is not complete and is in progress. The MDS notes R3 is cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the facility identified R3 as an elopement risk, the facility did not complete a care plan to direct staff in his elopement risk factors or elopement prevention interventions. R3's care card did not inform staff of R3's risk of elopement. R3's picture was on the facility resident elopement risk book at the nurse's station; however, the book contained no identifying information for R3 as directed in the facility policy. Example #3: R11 was admitted [DATE] with diagnoses that include, dementia with behavioral disturbance, repeated falls, history of traumatic brain injury, and muscle weakness. R11's most recent quarterly MDS dated [DATE] notes: ~Severe cognitive impairment with inattention and disorganized thinking ~Does not wander ~Requires extensive assistance of one staff for bed mobility and transfer ~Has balance concerns and is not steady and has experienced falls with no injury R11's Elopement Risk assessment dated [DATE] notes: ~History of elopement ~History of attempting to leave facility without informing staff ~Wanders aimlessly or non-goal directed ~Wandering likely to affect safety and well-being of self and others ~Wandering likely to affect privacy of others R11's care plan notes: Focus: Elopement: potential for injury attempts to leave the facility without supervision related to behavioral and psychological symptoms of dementia, impaired judgement, Alzheimer's disease. Goal: Will not leave the facility without supervision throughout review date: Date Initiated: 1/14/21, revised on 5/20/21. Target date: 7/27/21. Interventions: Alarm mat at end of 300 hall, check wander guard bracelet per facility protocol, elopement assessment on admission, quarterly, readmission, significant change in status, and as needed . There is no evidence an elopement risk assessment was completed from 8/27/21 to time of R8's elopement as directed in R11's plan of care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R11's picture was in the wander risk book at the nurse's station. The picture did not resemble R11. The picture did not show R11 with a beard as he currently has grown out. There was no identifying information in the book for R11. Example #4: R12 admitted [DATE] with diagnoses that include, dementia without behavioral disturbance, cognitive communication deficit, muscle weakness, difficulty walking, and repeated falls. R12's most recent significant change in status MDS dated [DATE] notes: ~Usually understands, usually understood and is severely cognitively impaired ~Requires extensive assistance of two staff for bed mobility and transfer and does not walk R12's Elopement Risk evaluation dated 4/13/22 notes: ~History of elopement ~History of attempting to leave facility without informing staff ~Verbally expressed the desire to go home, packed belongings to go home or stayed near and exit door ~Resident wanders ~Wanders aimlessly or non-goal directed ~Wandering likely to affect privacy of others R12's care plan indicated: Focus: Resident is an elopement risk/wanderer related to dementia and cognitive impairment, poor safety awareness, wandering . Goal: Resident safety will be maintained through review date. Date initiated: 3/14/21, Revised on: 4/27/21, target date: 7/27/21. Interventions: Check function of wand guard daily, replace every 3 months and as needed, document wandering behavior and attempted diversional interventions, elopement assessment quarterly and as needed with safety and behavioral concerns . R12's care card indicates she has a wander guard. R12's picture is in the book at the nurses station. It does not contain identifying information. Example #5: (continued on next page)

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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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R14 was admitted [DATE] with diagnoses that included, mild cognitive impairment, repeated falls, difficulty walking, cognitive communication deficit, and muscle weakness. R14's most recent annual MDS dated [DATE] notes: ~Understood, understands and has moderately impaired cognition ~Does not wander ~Requires extensive staff assistance of one for bed mobility and transfer R14's Elopement Risk Evaluation dated 2/11/22 notes: ~Resident wanders ~Wanders aimlessly or non-goal directed ~Wandering likely to affect privacy of others R14's Care plan notes: Focus: Resident is an elopement risk related to impaired safety awareness, tried leaving the facility unattended, confusion Goal: Resident will not leave the facility unattended, Resident safety will be maintained. Date Initiated: 4/19/21, Revised on: 11/19/21, target date: 2/24/22 Interventions: Check function of wander guard daily and replace every 3 months and as needed. Document wandering behavior, elopement assessment quarterly and as needed .like to go on patio, sign in and out and do frequent checks . R14's Care card indicates he has a wander guard. R14's picture was in the book at the nurse's station but contained no identifying information Example #6: R15 was admitted [DATE] with diagnoses that include dementia, altered mental status, and weakness. R15's most recent quarterly MDS dated [DATE] notes: ~Understood, usually understands and has moderately impaired cognition ~Does not wander ~Independent in bed mobility, transfer and walking R15's Elopement Risk Evaluation dated 4/06/22 notes: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~History of attempting to leave facility without informing staff ~Verbally expressed the desire to go home, packed belongings to go home or stayed near and exit door ~Resident wanders ~Wanders aimlessly or non-goal directed ~Wandering behavior likely to affect the safety and well-being of self/others ~Wandering likely to affect privacy of others R15's care plan indicates: Focus: Potential for elopement related to attempts to leave the facility without supervision and verbalizing the need/want to leave Goal: Resident will not leave the facility without supervision through next review date. Date Initiated: 1/15/21, Revised on: 1/10/22, target date: 1/20/22 Interventions: Check wand guard per facility protocol, elopement assessment on admission/readmission, quarterly and as needed . R15's care card indicates she has a wander guard. R15's picture was in the book at the nurse's station but did not contain any identifying information. R3, R11, R12, R14, and R15 were at risk for elopement out the 400 wing door due to no alarm being set as demonstrated by R8 on 04/26/22.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41874 Based on interview and record review, the facility did not ensure 1 of 4 residents (R5) reviewed maintained acceptable parameters of nutritional status and health. R5's meal intakes were not consistently recorded and weight was not obtained since 5/15/2021. This is evidenced by: R5 was admitted to facility on 7/9/2015 and has diagnoses that include, Chronic Diastolic Heart Failure, Type 2 Diabetes Mellitus, Major Depressive Disorder, Hypothyroidism, Hyperlipidemia, and Legal Blindness. R5's most recent Minimum Data Set (MDS) assessment, dated 2/16/2022, indicated R5 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R5 was cognitively intact. R5 required extensive assistance with support of 1-person physical assist for eating. Height: 63 inches. Weight: 154 pounds. Weight loss or gain: Not Assessed. No nutritional assessments were found in R5's medical record over the past year. R5's Physician Orders included: Monthly weight one time a day starting on the 15th and ending on the 15th every month for monitoring. Start Date: 2/15/2021. Most recent weight recorded for R5 was 154 pounds on 5/15/21; no weights recorded since. R5's Care Plan dated 1/18/2021, read: Focus: The resident has potential for nutritional problem ., multiple interventions were listed, which included in part: .Provide, serve diet as ordered. Monitor intake and record q (every) meal .Weights per facility protocol. Resident declines being weighed . Surveyor requested to review past 6 months of R5's meal intakes. Director of Nursing (DON) B stated she could only retrieve the past 30 days (4/3/2022 through 5/2/2022) of meal intakes: 4/4/2022 8:28 PM: 0-25% 4/7/2022 8:28 PM: 0-25% 4/8/2022 7:30 AM: 26-50% 4/8/2022 11:30 AM: 26-50% 4/10/2022 7:30 AM: 26-50% 4/10/2022 11:30 AM: 0-25% 4/11/2022 7:30 AM: 76-100% (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/11/2022 11:30 AM: 0-25% 4/11/2022 4:30 PM: 0-25% 4/12/2022 4:30 PM: 0-25% 4/17/2022 4:30 PM: 76-100% 4/18/2022 8:37 PM: 0-25% 4/21/2022 9:23 AM: 0-25% 4/21/2022 4:30 PM: 0-25% 4/22/2022 4:30 PM: 0-25% 4/23/2022 4:30 PM: 26-50% 4/24/2022 7:30 AM: 26-50% 4/24/2022 11:30 AM: 26-50% 4/25/2022 4:30 PM: 26-50% 4/26/2022 4:30 PM: 26-50% 4/29/2022 1:54 PM: 0-25% No intakes are recorded for 15 of the past 30 days (4/3/22, 4/5/22, 4/6/22, 4/9/22, 4/13/22, 4/14/22, 4/15/22, 4/16/22, 4/19/22, 4/20/22, 4/27/22, 4/28/22, 4/30/22, 5/1/22, 5/2/22). On 4/28/2022, Surveyor interviewed R5. Have you lost weight recently? yes. Does that concern you at all? Yes, a little. R5 stated she would love to get weighed, but the machine doesn't work. R5 stated she wished they would get it fixed because it's been many months since she was last weighed; at that time, she weighed 154 lbs. Do staff help you with every meal? I have to yell my head off and then they do. Have there been any meals that you have missed because no one was available to help you? Last Monday they forgot to feed me breakfast; a girl didn't come to help me until 10am, and sometimes I don't get lunch until 1pm, and that's only after yelling. R5 was unable to tell Surveyor what time she would have preferred to eat her meals. On 5/2/2022 at 12:15 PM, Surveyor interviewed DON B. Surveyor asked if the facility had a working scale. DON B stated the scale was in working order and has always been as far as she knows. DON B stated R5 refuses to be weighed. Surveyor expressed concern with no weights being obtained when R5 had a Physician's order for monthly weights and asked if R5's refusals were documented in the medical record. R5's Care Plan dated 1/18/2021 reads, resident declines being weighed; no additional documentation is found indicating resident's continued refusal of being weighed. Surveyor informs DON B of interview in which R5 expressed desire to be weighed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews, and record reviews, the facility did not ensure pain management was achieved for 2 of 5 residents reviewed for pain (R1, R9). R1 had severe pain related to extensive wounds. There was no pain assessment or Care Plan (CP) to direct staff on managing R1's pain. R9 was admitted with chronic pain, and has no pain assessment or interventions in place for his pain. This is evidenced by: Example 1: On 4/4/22, R1 was admitted to the facility with medical diagnoses that include, but are not limited to, Paraplegia because of a Motor Vehicle Accident in 1981 in which he sustained a Cervical-Spine fracture and Peripheral Vascular Disease. Further documentation revealed that R1 also has conditions such as Diabetes Mellitus Type II and Failure to Thrive. There were multiple wounds (8) noted on R1 upon admission, including Stage IV wounds on his back. According to documentation upon admission (4/4/22), R1 had wounds located on his right heel, right ankle, two on his back along the spine, left and right buttocks, left shoulder, and right shoulder. Observations conducted by Surveyor indicate he is dependent on staff to meet his most basic Activities of Daily Living (bathing, dressing, personal hygiene, and toileting.) As of 4/28/22, the facility had not initiated a Minimum Data Set Assessment for R1, which assesses basic areas of pain. There also was no pain assessment completed for R1. As of this writing (5/3/22), there was no comprehensive CP developed to direct staff in R1's care and needs. On 4/27/22 at 10:21 AM, Surveyor interviewed R1 regarding his pain. R1 stated that he had concerns that a doctor, who he has never seen, has been adjusting his pain medication. He stated, I have been here nearly a month . I have never seen her . My medications have been changed and she hasn't even evaluated me . she just changes them without even coming to talk to me about them . R1 further stated that he had been prescribed liquid Morphine while in the hospital and that controlled his pain, stating, I only asked for it when I really needed it. It was discontinued the first day I was here. They said I was dependent on it. Again, they didn't talk to me about it. They gave me a tablet that was supposed to be faster acting, it's sufficient for bed rest but doesn't always take the pain away. It lessens it . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was asked further regarding his pain control and responded, I do have pain control when I am in bed, when they give it, but it's getting them (staff) to respond to my light when I need medication. The other day, I put on my light at 5:00 PM to ask for pain medication. It took staff 1 hour to respond to come in and turn it off. They said 'I don't have time now' and left. This was at 6:00. So I waited and put it on again and waited until 7:30 PM when someone came in and said they told a nurse. They turned it off and left. I put it back on. I still wasn't given anything for the pain. Finally I called my sister. She called here and the nurse told her that she wasn't told that I needed pain medication. The pain was excruciating by that time. What kind of place is this? . The medication they give me lessens the pain, it doesn't take it away but they don't come in and check to ask me if it helped . On 4/27/22 at 6:25 PM, Surveyor observed LPN F (Licensed Practical Nurse) complete wound care for R1. During the care of the right heel Pressure Injury, R1 frequently grimaced and jumped with pain. LPN F questioned R1 regarding the pain and he replied that the heel wound is always very painful but is more so at this time and he prompted LPN F to continue with the treatment. Surveyor then reviewed the Medication Administration Record (MAR) for R1 and noted the last pain medication given was Morphine Sulfate 15 MG administered at 2:40 PM. Although R1 was not able to be given Morphine prior to this dressing change, another medication for pain control prior to the treatment could have been administered. This observation also shows that the Morphine 15 MG does not control R1's pain for the 6 hours it is ordered for (see below). Surveyor reviewed R1's pain regimen. According to the physician orders, R1 has the following for pain control: - Acetaminophen 500 Milligrams (MG), two tablets every 6 hours as needed (4/4/22) - Morphine Sulfate Solution 10 MG/0.5 Milliliters (ml), give 4 MG as needed for pain control (4/4/22) - Morphine Sulfate tablet, 15 MG, give 1 tablet every 6 hours as needed - Tramadol 100 MG, give 1 tablet every four hours as needed. He also was prescribed Baclofen 5 MG one tablet three times daily (4/4/22). Baclofen acts on the spinal cord nerves and decreases the number and severity of muscle spasms caused by spinal cord conditions. It also relieves pain and improves muscle movement. In reviewing the MAR for the time period of 4/4/22 - 4/27/22, the following was noted: 1. The Liquid Morphine was discontinued on 4/13/22. Prior to it's removal from R1's medication regimen, the liquid Morphine was administered 12 times for pain ratings of 3-7/10. All were listed as being effective with the exception of one dose, administered on 4/13 at 9:18 AM. The pain rating following this administration was listed as 2/10. 2. Acetaminophen was administered 6 times out of 96 times available (every 6 hours x 24 days) for pain ratings of 3-7/10. All were documented as being effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Morphine Tablet 15 MG was administered 61 times of 96 available. All were listed as being effective with the exception of 4/5/22 and 4/16/22. There was no pain rating for any of these 61 entries. In comparing the Nursing Progress Notes on the dates each dose of the Morphine was administered, Surveyor noted there were no pain ratings listed there as well. On the dates the medication was ineffective there were no entries on a follow-up pain rating or what non-pharmaceutical interventions were attempted to assist R1 with his pain. 4. Tramadol was administered 13 times out of 144 time slots available. (every four hours as needed x 24 days) for pain ratings 3-8/10. All but one dose administered was listed as being effective. Also of concern, there were no notes documented on what other non-pharmaceutical interventions were attempted, such as massage, repositioning, warm or cold compresses, soft music, or other diversional approaches that may have been effective to lessen or treat R1's pain. 31088 Example 2: R9 was admitted to the facility on [DATE], with diagnoses in part: Osteoarthritis of both hips, neuropathy, and chronic pain. R9 does not have an Minimum Data Set completed. R9 has a care plan for nutrition and activities, there are no other care plans or baseline care plan in the medical record. There is no baseline information to address R9's pain. The physician orders in part: Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for Neuropathy 4/22/22. On 4/27/22, Surveyor was in the hallway and could hear R9 moaning and saying, My feet, they hurt. Surveyor reviewed the medical record for any pain assessments. A comprehensive pain assessment had not been completed for R9 on admission when pain was his primary concern. Surveyor reviewed the Medication Administration Record and noted that pain was to be assessed every shift for R9. The pain levels were not documented five times in the 5 days since R9's admission. On 4/27/22 at 1:30 p.m., Surveyor interviewed R9 asking about his pain. R9 expressed that he has terrible neuropathy. R9 described it as pins and needles feeling with a heavy pressure in his feet. Surveyor asked about pain medication. R9 stated he is to have Gabapentin, but has not received it yet today. Surveyor asked if they assess his pain level by asking him on a scale of 1-10 how bad the pain is. R9 said they never ask him about his pain. Surveyor asked if the facility has tried any non pharmacological interventions for pain. R9 said, No. Surveyor asked how badly the pain is affecting R9. R9 stated that if he gets his medicine it calms down and he is alright with the pain level after the medicine is given. Surveyor reviewed the Medication Administration Records and noted all doses had been signed out as ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/27/22 at 2:00 p.m., Surveyor interviewed DON B about R9's history. DON B indicated R9 had a history of pain issues and abuse of medications. Surveyor asked about assessing R9's pain as he had been heard moaning and described intense pain at times. DON B said she would check into it. Surveyor asked if there were any interventions implemented to address R9's pain other than the Gabapentin. DON B acknowledged there was no pain assessment or care plan to address R9's pain.

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945 Based on interview, observation, and record review, the facility failed to assess the safety risks of using an air mattress in combination with the enabler bars attached to each side of the bed, and failed to assess whether the bed rail was still needed for 3 of 3 residents (R) utilizing bed rails with an air mattress (R2, R7, R10). Failure to assess the residents for the risk of entrapment with the use of the assist bars and the air mattress resulted in R2 becoming entrapped between the mattress, enabler bar, and the wall. This created a finding of immediate jeopardy that began on 05/01/22. Surveyor notified the facility of the finding of immediate jeopardy on 05/05/22 at 4:40 p.m. The immediate jeopardy was removed on 05/05/22. This is evidenced by: Manufacturer's instructions for the Air Advance Bariatric Mattress include, but are not limited to, the following information under the heading of Warning: -Failure to comply with all directions and warning may result in injury or death; use only as directed. -This product is not suitable for all individuals. Other devices may be required. -This product is designed to assist in the prevention and treatment of pressure ulcers and may require other equipment. This may include, but is not limited to: *Bedrails for repositioning and fall prevention *Resident monitoring devices for elopement prevention *Other devices as specified by the caregiver -This device is only a tool to assist with pressure reduction as part of an overall care plan. Failure to comply with all instructions, warning, and precautions or using the product for a purpose other than the recommended use could result in bodily injury or death. -This product is not designed to replace good caregiving practices including, but not limited to: *Direct patient and resident supervision *Adequate care plans and training for staff personnel for entrapment and fall prevention *Inspection and testing before use (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Manufacturer's instruction also NOTE: Selection of an appropriate bed system to use with the product and proper maintenance and use of the product. Manufacturer's instructions state under Preventative Maintenance: It is important to periodically test the Panacea Air Advance control unit to verify the proper functionality. Lack of regular maintenance can result in poor or reduced resident support. Manufacturer's instructions state the mattress is also available with optional 3 inch raised side perimeters to further help minimize resident falls. (R2 had the lipped edges on the mattress.) Manufacturer's instructions state the mattress has a low-pressure alarm, which sounds indicating loss of air pressure. Manufacturer's instructions did not specify compatible side rails or bed frames to be used with the mattress. Example 1: R2 was admitted to the facility on [DATE]. Power of Attorney (POA) is activated. R2's diagnoses include: Dementia with Lewy Body, Parkinson's Disease, history of falling, cognitive communication deficit, and hallucinations. R2's Minimum Data Set (MDS) assessment dated [DATE] indicates Brief Interview for Mental Status (BIMS) is 8 (moderate cognitive impairment). MDS functional status with bed mobility states resident requires extensive assist with 2+ physical assist and uses a wheelchair for mobility. R2 receives Citalopram 20 mg by mouth every evening, and Seroquel 50 mg by mouth at bedtime. Care Plan: Date initiated: 02/26/21 ADL: Baseline Care Plan Self Care deficit related to Parkinson's, Dementia, Type II Diabetes Mellitus, Morbid Obesity, Depression, and Chronic Kidney Disease. Goal: Date initiated 02/26/21, Revision: 11/29/21, Target Date: 05/17/22 In the next 3 months will actively participate in ADLs (activities of daily living) through next review. Interventions: Date initiated: 02/26/21 Bari-Bed, lip mattress Repositioning: Assist of 1. Reposition approximately every 2 hours and prn (as needed). Right/Left enabler bars for bed mobility and transferring. Ensure proper positioning to promote comfort R2 has no order for the Air Advance Bariatric Mattress. Care Plan states the date initiated was 02/26/21. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's enabler bars were ordered 12/14/21. Facility did not perform a side rail assessment. Only Physical Therapy (PT) order is dated 11/25/20 for PT evaluation and treatment for wheelchair management/mobility and positioning. Facility did not assess the risk of entrapment for the use of the air mattress with the enabler bars when the enabler bars were placed on the bed. No individualized assessment for the risk of entrapment, including evaluating possible areas of entrapment, or measuring and testing by an assessment team, could be located within R2's medical record. On 05/01/22, Surveyor observed R2's bed/mattress but could not assess. R2's mattress was deflated and turned in the off position due to hospitalization of R2. R2's medical record progress note documented an entry on 05/01/22 at 10:08 p.m. by Licensed Practical Nurse (LPN) F stated: When the shift started LPN F and CNA P observed R2 rolled towards wall in bed. and CNA P repositioned R2 and noticed R2's face was extremely puffy. The note states they did a set of vital signs that were within normal limits and R2 was very restless. LPN F observed bruising to R2's right top of hand with a skin tear or laceration. R2's arms were swollen. R2's head was elevated and was monitored. R2's head of bed was elevated and R2 received fluids with medications. Towards the afternoon, R2's swelling in the face decreased and Director of Nursing (DON) B was notified. Note states all vital signs were within normal limits, but R2 had increasing pain. LPN F then noticed two different bumps on each side of R2's forehead by the temple region. R2 also had a hematoma on the right shoulder blade posterior to the spinal cord. DON B was notified of all R2 injuries and injuries were reported to POA (Power of Attorney. Note states R2 was seen at the ER (emergency room) and diagnosed with a UTI (urinary tract infection) and was being kept overnight for observation. The note states this communication was through an RN at Marshfield Minocqua emergency department. Further documentation states the facility will continue to monitor R2's status. R2 was very scared and timid when cares were performed. R2 was difficult to console. Documentation states at the ER, R2 notified POA that R2 had been struck but didn't say by what or who. LPN F documented that the information would be reported to primary physician and LPN F would follow up with POA, DON B and NHA (Nursing Home Administrator) A. On 05/03/22, Surveyor reviewed the emergency room /Hospital Documentation 05/01/22 H & P time stamp 6:42 PM Marshfield Medical Center-Minocqua. Document stated R2 was brought in for pain control. R2 was unable to provide any history due to neurocognitive dementia with Parkinson's Disease. Physician documented he spoke with R2's daughter and the nursing home staff who stated R2 was found wedged between the bed and the wall at the nursing home. Documentation stated trauma work-up was unremarkable with a head CT and CT of the spine and x-ray of the chest. CK was slightly elevated at 200. UA was done that showed pyuria. Physician documented he asked if anything was wrong or if R2 was in pain and R2 stated she felt weird. Physician documented that R2 was able to, interact with him despite the observation in the ER. Documentation stated R2 was intelligible in the ER. Documentation in the H & P stated R2 had a UTI, which was uncomplicated due to no fever and no leukocytosis. R2 was started empirically on Unasyn (antibiotic). Documentation stated R2 would be on observation overnight and discharged back to nursing home tomorrow (05/02/22). (continued on next page)

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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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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/03/22, Surveyor reviewed R2's pending discharge information from Marshfield Medical Center-Minocqua. Documentation stated R2 was kept for observation because of concern about worsening mental status having been discovered stuck between the bed and the wall. Was found to have a UTI. Observed overnight. No evidence of rhabdomyolysis. R2 did have bruising on both arms. On 05/02/22 at 1:12 p.m., Surveyor interviewed Certified Nursing Assistant CNA Q. CNA Q was asked the incident that occurred with R2. CNA Q stated on the night shift of 04/30/22 into 05/01/22, R2 slept well. CNA Q stated she last checked R2 at 3:30 AM and R2 was sleeping well. CNA Q stated she burped (let the gas out of) R2's colostomy and let R2 sleep. No problems at that time were noticed. On 05/02/22 2:30 p.m., Surveyor interviewed LPN F. LPN F was asked about the incident that occurred with R2. LPN F stated that on 05/01/22 between 6-6:30AM, R2 was found face down on the bed wedged between the bed and the wall. LPN F was asked if R2's body was involved with the bed rail. LPN F stated R2's forehead was leaning on the bed rail. LPN F stated the side rail probably prevented the resident from falling further as she was pressed up against the rail. LPN F stated she and a CNA P repositioned R2 and R2's face was swollen, vital signs were normal, bed was locked, call light was within reach. LPN P stated that the air mattress on the bed was not working properly. Box at end of bed was beeping. LPN P stated she did call MD M and MD M came to the facility, but she wound up changing out the pump on the mattress. LPN P stated R2 was monitored throughout the day. LPN P stated the swelling did start to go down on R2's face and it was noticed she had two lumps on her head. LPN P was asked where the lumps were. LPN P stated on the top of R2's forehead as LPN P is pointing to the top of her own forehead. LPN P stated R2 also had a laceration on her right hand and a bruise on her right shoulder. LPN P was asked if physician, family, or administration were called regarding incident. LPN P stated the nurse practitioner was faxed an SBAR (Situation, Background, Assessment, Recommendation) form, the POA, DON B, and NHA A were notified by phone. LPN F couldn't state what time notifications were made. LPN P stated R2 started to have pain and so she thought she should be evaluated, and R2 was sent to the ER shortly after the PM shift started at 3:00 p. m. On 05/02/22 at 1:20 p.m., Surveyor interviewed CNA P. CNA P was asked about the incident that occurred with R2. CNA P stated she came on shift at 6:00 AM on 05/01/22. At 6:30 AM, LPN F called her down to R2's room. R2's bed was against the wall and R2 was wedged between the bed and the wall. R2 was laying on her stomach/face. R2's face was swollen, and R2 had red spots on her head. CNA P stated the LPN F and herself repositioned R2 and elevated the head of the bed. CNA P stated R2 did not make any sound or move much at all during the day. CNA P stated she was in the room multiple times throughout the day. CNA P stated when the PM (afternoon) shift started, she and CNA D went into R2's room to change R2 (perform incontinence cares). The swelling did start to go down on the R2's face and when that happened, it was noticed the red spots on the head (sides of head) were raised. CNA P stated LPN F was notified to come down to R2's room. CNA P stated R2 had her arms clenched across her chest and was in pain. LPN F decided to send R2 to the ER due to the pain. CNA P was asked what time that was? CNA P stated she was not sure exactly, but it was between 3-3:30 p.m. CNA P added that R2's hand was very red and puffy but could not state which hand. CNA P was asked if R2's bed rail was involved with how R2 was positioned when found. CNA P stated she thought R2 was positioned below from where the bed rail was. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/02/22 at 1:10 p.m., Surveyor interviewed RN O. RN O was asked about the incident that occurred with R2. RN O stated she came on shift on 05/01/22 at 6:00 PM and received report from previous shift nurse, LPN F. The report included that R2 was found face down in bed and R2's face was swollen at 6 AM. R2 was monitored during the day. RN O stated she was told it was possible anaphylaxis. Report given stated swelling went down throughout the day, but it was decided to send R2 out to the ER because of increased pain. RN O stated this was not until 3:00 p.m. RN O stated the aides told her that R2 had bruising and wasn't acting like herself. RN O stated the LPN F did not mention any bruising/hematoma. RN O stated R2's daughter, who is R2's POA, came to the facility at 5:00 PM and was asking questions. RN O stated she did not have much information to give her because she herself wasn't given very much information. On 05/02/22 at 10:20 a.m., Surveyor interviewed Registered Nurse (RN) C. RN C was asked about the incident that occurred with R2. RN C stated this morning, 05/02/22, RN C received report from the night nurse (RN R) that R2 was admitted to the hospital with a diagnosis of a UTI. RN C stated the only thing reported was R2 had swelling of the face and mouth and RN R stated something about bruising. RN C stated there was no report of a fall. RN C stated she asked if there was a fall because R2 is known to tip out of chair when she hallucinates. On 05/02/22 at 1:53 p.m., Surveyor interviewed Maintenance Director (MD) M. MD M was asked if any issues were noted with R2's mattress or if MD M received any notification of any issues. MD M stated, No. MD M was asked what process is in place to ensure the mattresses are working properly. MD M stated if the alarm sounds on the mattress, then there is an issue. MD M was asked about the facility process for side rail checks/placement. MD M stated he just made an inventory list of all the beds with air mattresses and side rails. There is no current process for side rail safety inspections. No specific system for checking mattresses or side rails provided by MD M. On 05/02/22 at 2:03 p.m., Surveyor interviewed DON B. DON B was asked what the facility plan is for prevention of any further incidents with R2 upon return to facility. DON B stated the mattress was fixed, there will be a body pillow put between the bed and the wall, R2 will be placed on more frequent monitoring, and R2 already has a mat on the floor at the bedside. DON B stated that all residents are to be assessed for bed rails and mattresses prior to placement. DON B was asked what time she was notified of the incident with R2. DON B stated she was notified at approximately 11:00 a.m. on 05/01/22. Mattress not working properly with air pressure not accurate, which led to cause of entrapment of R2 between mattress and the wall. It is unknown how long the mattress alarm was had been beeping or how much earlier that staff should have been aware that the mattress had malfunctioned. The failure to have a system in place to ensure bed rails, air mattress and bed frames are compatible, and the failure to have a process to ensure that bed rails are installed correctly and inspected regularly created a reasonable likelihood for serious harm, which created a finding of Immediate Jeopardy. The facility removed the jeopardy on 5/5/22 when it had completed the following: All residents were assessed for use of side rails. Provided education and training to Maintenance Director and Director of Nursing and all direct care staff on entrapment guidelines. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Maintenance Director measured the 7 zones identified by the Food and Drug Administration Entrapment Guidelines to ensure all zones were within the standard parameters for all residents with bed rails. Entrapment and bed rail assessments completed for residents with bed rails. Implemented inspection schedule for bed rails. The deficient practice continues at a scope/severity level of D based on the following examples for R7 and R10: -The facility does not have a process to ensure bed rails, mattress, and bed frames are compatible. The facility does not have a process to ensure that bed rails are installed correctly and inspected regularly. 44863 Example #2: R7 was admitted to the facility on [DATE]. Diagnoses: Impaired Mobility, Paraplegia following spinal cord injury, pressure injury of back; Stage 4, pressure injury of skin of multiple topographic sites. The admission Minimum Data Set (MDS) dated [DATE] documented the following: -Brief Interview for Mental Status score of 15, indicting cognitively intact response. -Pressure injuries Stage 2 and Stage 4. Pressure relieving device for bed and chair. -Bed rails are not used. -Extensive assistance with assist of two persons for bed mobility. Total dependence with two persons for transfers. Extensive assist of two persons for ADLs. -Indwelling catheter and always incontinent of bowel. Physician Orders, dated 4/4/22: -Enabler bars to aid in mobility and repositioning. -Physical, Occupation and Speech therapy evaluation and treatment as indicated. Care Plan dated 4/6/22: -Did not include any information regarding the use of bed rails. -Did not include therapy services. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Did not include adaptive equipment. 5/3/22 at 8:14 AM, Surveyor observed R1 sleeping in his bed, lying on his back. R1 was sleeping on an air mattress and had bilateral enabler bars attached to his bed. Surveyor reviewed R1's record and was unable to locate a bed rail assessment or consent to the use of bed rails. 5/3/22 at 11:35 AM, Surveyor observed R1 sleeping in his bed, rolled partially to his left side. 5/3/22 at 12:10 PM, Surveyor conducted an interview with R1. R1 reported that he was told at admission that he would be getting an air mattress for his bed. R1 stated that it took a week or two to get his mattress. R1 confirmed that he requires assistance with bed mobility but uses the bilateral enabler bars to independently reposition himself as much as he can. Surveyor asked R1 if facility staff provided him any education on the risks of entrapment related to the air mattress and the enabler bars, R1 reported that he did not think so. Surveyor asked if R1 signed a consent indicating that he was aware of the risks, and R1 reported that he did not think so. Surveyor asked R1 if he or the facility had tried any other methods to assist with repositioning besides the enabler bars, and R1 reported no other methods. R1 stated, I'm not worried about getting stuck, it would be hard to do. Surveyor observed that R1's air mattress was working properly. The air mattress fit tightly against the enabler bars. Enabler bars were secured to the bed. 5/3/22 at 12:14 PM, interview with Certified Nursing Assistants (CNAs) G and L. CNAs G and L reported that any resident that may need an air mattress or bed rails is referred to the Director of Nursing (DON B). If an air mattress or bed rails are not working properly a referral is made to the facility maintenance department. 5/3/22 at 12:22 PM, DON B reported that facility procedure for bed rails is that all new admissions are assessed by therapy department to determine a resident's transfer status. Nursing is then responsible to enter a progress note indicating the use of bed rails. DON B confirmed that consents for bed rails have not been completed. Therapy department did not have documentation of assessments indicating a resident's need for bed rails. 5/3/22 at 1:05 PM, Surveyor requested manufacturer's instructions for R1's bed, mattress, and enabler bars. Interview with Maintenance Director M. Maintenance Director M confirmed that he was not aware of the resource identified by the Food and Drug Administration, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. Reviewed manufacturer's instructions regarding R1's mattress, which reads in part, .This product may require other equipment. This includes bed rails for repositioning. Instructions did not reference compatible bed frames and bed rails. Reviewed manufacturer's instructions for bed frame model number SC900DLX, Invacare Continuing Care, Inc., regarding the use of bed rails, which indicated the model number for assist rails, IHRAILAE-DLX. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/3/22 at 2:59 PM, Maintenance Director M showed Surveyor the enabler bar the facility uses. Enabler bar is tall and narrow and widens at the bottom. Maintenance Director M had referenced the Invacare website to determine if this was the correct model bed rail to be used with bed frame model. He confirmed that he was unable to match the model number of the bed rail the facility is currently using to the Invacare online catalog and is unable to determine if current bed rail is compatible with bed frame. Example #3: R10 was admitted to the facility on [DATE]. Diagnoses: Type 2 Diabetes Mellitus with Chronic Kidney Disease with dependence on renal dialysis. The admission Minimum Data Set (MDS) dated [DATE] documented the following: -Brief Interview for Mental Status score of 14, indicting cognitively intact response. -No pressure injuries, at risk for developing pressure injuries. -Bed rails are not used. -Extensive assistance with assist of two persons for bed mobility and transfers. Extensive assist of two persons for ADLs. -Frequently incontinent of urine and always incontinent of bowel. Physician Orders, dated 1/27/22: -Enabler bars to aid in mobility and repositioning. -Physical, Occupation and Speech therapy evaluation and treatment as indicated. Care Plan dated 1/28/22: -Bilateral enabler bars for bed mobility and repositioning. 5/3/22 at 8:14 AM, Surveyor observed R10 sleeping in her bed, lying on her back. R10 has air mattress and left side enabler bar. Surveyor reviewed R10's record and noted enabler bar assessment completed on 1/27/22. Indicated for transfers and bed mobility related to weakness. Assessment does not indicate if R10 was assessed for safety using enabler bar. Surveyor observed that R10's air mattress was working properly. The air mattress fit tightly against the enabler bar. Enabler bar was secured to the bed. Right side of bed against wall. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/3/22 at 12:14 PM, interview with Certified Nursing Assistants (CNAs) G and L. CNAs G and L reported that any resident that may need an air mattress or bed rails is referred to the Director of Nursing (DON B). If an air mattress or bed rails are not working properly a referral is made to the facility maintenance department. 5/3/22 at 12:22 PM, DON B reported that facility procedure for bed rails is that all new admissions are assessed by therapy department to determine a resident's transfer status. Nursing is then responsible to enter a progress note indicating the use of bed rails. DON B confirmed that consents for bed rails have not been completed. Therapy department did not have documentation of assessments indicating a resident's need for bed rails. 5/3/22 at 1:05 PM, Surveyor requested manufacturer's instructions for R10's bed, mattress, and enabler bars. Interview with Maintenance Director M. Maintenance Director M confirmed that he was not aware of the resource identified by the Food and Drug Administration, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. Reviewed manufacturer's instructions regarding R10's mattress, which reads in part, .This product may require other equipment. This includes bed rails for repositioning. Instructions did not reference compatible bed frames and bed rails. Reviewed manufacturer's instructions for bed frame model number SC900DLX, Invacare Continuing Care, Inc., regarding the use of bed rails, which indicated the model number for assist rails, IHRAILAE-DLX. 5/3/22 at 2:59 PM, Maintenance Director M showed Surveyor the enabler bar the facility uses. Enabler bar is tall and narrow and widens at the bottom. Maintenance Director M had referenced the Invacare website to determine if this was the correct model bed rail to be used with bed frame model. He confirmed that he was unable to match the model number of the bed rail the facility is currently using to the Invacare online catalog and is unable to determine if current bed rail is compatible with bed frame.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 41874 Based on interviews and record review, the facility did not ensure the Physician reviewed the resident's total program of care, including medications and treatments; and wrote, signed, and dated progress notes at each visit. This occurred for 2 of 5 Residents (R4 and R5) Facility could not provide evidence that R4 or R5 had been seen by a Physician within the past six months. This is evidenced by: Example 1: R4 admitted to facility on 8/7/2020 and has diagnoses that include Hyperlipidemia, Hypertension, Major Depressive Disorder, and History of Malignant Neoplasm of Cervix. The most recent Physician Progress Note found in R4's medical record was dated 7/20/2021. On 4/28/2022, Surveyor requested to see notes from R4's Physician visits in the past 6 months. On 4/28/2022 at 1:39 PM, Director of Nursing (DON) B stated there were no Physician notes in the system for R4 within the past 6 months. Example 2: R5 admitted to facility on 7/9/2015 and has diagnoses that include History of Urinary Tract Infections, Hypertensive Heart Disease with Heart Failure, Type 2 Diabetes Mellitus, Major Depressive Disorder, Hyperthyroidism, Hyperlipidemia, Glaucoma, Chronic Pain, Retention of Urine, and Functional Quadriplegia. The most recent Physician Progress Note found in R5's medical record was dated 8/10/2021. On 5/2/2022, Surveyor requested to see notes from R5's Physician visits in the past 6 months. On 5/2/2022 at 12:15 PM, DON B informed Surveyor no Physician visit notes were located for R5 within the past 6 months. On 5/2/2022 at 12:15 PM, Surveyor asked for clarification regarding how often the Physician visited the facility. DON B stated the Nurse Practitioner visited the facility twice weekly and the Physician visited monthly. DON B stated the provider would write a progress note using the eFax system and it would then be printed out and placed in the resident's chart. DON B stated there was a backlog of progress notes to be printed because the facility was currently without a medical records staff person. DON B stated she would look for progress notes for R4 and R5; no further documentation was provided.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 41874 Based on interviews and record review, the facility did not ensure residents were seen by a Physician at least every 60 days. This occurred for 2 of 5 Residents (R4 and R5) Facility could not provide evidence that R4 or R5 had been seen by a Physician or a Non-Physician Practitioner (a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)) within the past six months. This is evidenced by: Example 1: R4 admitted to facility on 8/7/2020 and has diagnoses that include Hyperlipidemia, Hypertension, Major Depressive Disorder, and History of Malignant Neoplasm of Cervix. The most recent Physician Progress Note found in R4's medical record was dated 7/20/2021. On 4/28/2022, Surveyor requested to see notes from R4's Physician visits in the past 6 months. On 4/28/2022 at 1:39 PM, Director of Nursing (DON) B stated there were no Physician notes in the system for R4 within the past 6 months. Example 2: R5 admitted to facility on 7/9/2015 and has diagnoses that include, History of Urinary Tract Infections, Hypertensive Heart Disease with Heart Failure, Type 2 Diabetes Mellitus, Major Depressive Disorder, Hyperthyroidism, Hyperlipidemia, Glaucoma, Chronic Pain, Retention of Urine, and Functional Quadriplegia. The most recent Physician Progress Note found in R5's medical record was dated 8/10/2021. On 5/2/2022, Surveyor requested to see notes from R5's Physician visits in the past 6 months. On 5/2/2022 at 12:15 PM, DON B informed Surveyor no Physician visit notes were located for R5 within the past 6 months. On 5/2/2022 at 12:15 PM, Surveyor asked for clarification regarding how often the Physician visited the facility. DON B stated the Nurse Practitioner visited the facility twice weekly and the Physician visited monthly. DON B stated the provider would write a progress note using the eFax system and it would then be printed out and placed in the resident's chart. DON B stated there was a backlog of progress notes to be printed because the facility was currently without a medical records staff person. DON B stated she would look for progress notes for R4 and R5; no further documentation was provided that would evidence R4 or R5 had been seen by a provider.

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F 0725 Level of Harm - Minimal harm or potential for actual harm 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. 17661 Based on record review, observations, and interviews, the facility did not provide sufficient staffing to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being. This has the potential to affect all 41 residents. As a result of insufficient staffing, the residents went without Minimum Data Set Assessments, lack of care plans to direct care, no pressure injury and non pressure wound assessments and timely treatment, lack of assistance of daily living care, long wait times for assistance, insufficient staffing to supervise high risk elopement residents, and inadequate staffing to keep the resident's rooms clean. This is evidenced by: MDS Assessments The facility did not complete Minimum Data Set Assessments (MDSA) for 5 of 7 residents reviewed (R1, R11, R12, R15 and R3.) This was because the facility has no staff member to complete the MDS Assessments. Care and treatment of pressure injury On 4/4/22, R1 was admitted to the facility with medical diagnoses that include but are not limited to Paraplegia because of a MVA in 1981 in which he sustained a C-Spine fracture, COPD, Chronic Normocytic Anemia, PVD, Hx of MRSA infection, Hx of Renal Failure and Chronic Anticoagulant therapy. R1 was admitted with 5 pressure injuries. In reviewing R1's medical record, Surveyor noted the following: - There was no MDS completed (29 days after admission). - There was no Braden Risk Assessment completed. - There was no initial comprehensive wound assessment of the wounds to identify location, size, and wound description. - There is no Care Plan for wound care. - There are no weekly wound assessments to indicate to the staff if the wounds are healing or worsening. This in turn prevents a critical nursing analysis of the wounds to determine if a treatment needs to be changed or a Physician needs to be more involved to assist with the healing. - Treatment orders were not entered into the record until 4/7/22 Observations made of R1 included the following concerns: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The foam boot used for the heel was a simple eggcrate bootie fastened with Velcro over the top of the foot. It was not a heel-floating boot. - There was no Heel floating observed during the length of the survey (4/26 - 4/28). - Treatment was observed on 4/27/22 at 6:25 PM, and was not completed as ordered Interview with Resident 1: A/O and his own person -He stated he received no treatments to his wounds for the first four or five days. Stated that the shoulder wound smelled like rotting flesh. He stated the treatments are to be done every day but he is lucky if they get completed twice a week. - R1 is unable to take a shower either on a shower chair or bathing trolley. Interview with R1 indicated that he does not receive daily bathing related to staff shortages. DON did document the treatments on Day 1 of admission; however, the treatment orders were not entered into R1's medical record until 4/7/22. Between that time, there was no evidence that R1 received treatments to his wounds. - R1 also stated .My first two days here I went hoarse from shouting at the top of my lungs for someone to answer my light. It was over 1 1/2 hours that I yelled before anyone came in to help me .this is on the evening shift . I do have pain control when they give it . but it's just getting them to respond to my light. The other day, I put on the light at 5:00 PM. It took them 1 hour to come in here and turn it off, telling me I don't have time now. At 6:00 PM I put it on again and waited until 7:30 PM before someone came in to turn it off and they said they told a nurse. I put it right back on again. I still didn't have my pain medication that night. I then called my sister and she called over here and the nurse told her that nobody told her that I needed pain medication . An interview with DON B (Director of Nursing) was conducted on 4/27/22 at 12:45 PM, in which DON B stated that there are no staff currently doing MDS's (Minimum Data Set Assessments) and she has mentioned her concerns to Corporate. They do have a new staff starting this week to do these. DON B also mentioned there is no nurse on staff that is experienced with wound care and assessments. As a result, there is no consistency with assessing wounds and there are missing assessments and care plans. DON B expressed during the interview, that she really does not know who completes care plans in the facility. She has been doing them as I have no nurses to do it. It's only me right now to ensure things get done. I am only one person, we are so short-staffed . Interview with HR H (Human Resources) on 4/27/22 at 1:50 PM verified that the former nurse that was responsible for completing MDS Assessments and Wound Care stepped down from the role on 4/8/22. There have been no staff to replace this nurse but the facility did recently hire an individual to fill the MDS Coordinator role, who begins employment next week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/27/22 at 5:10 p.m., Surveyor observed LPN F administer medications. During this time, LPN F stated to Surveyor that she was the only nurse on duty and there were 2 admissions also on this date. LPN F commented that It is too much. LPN F stated she would be the only nurse on duty for the weekend (dates of 04/30/22 and 05/01/22 from 6;00 a.m. to 6:00 p.m.), and there were more admissions scheduled at that time. LPN F stated she can't understand why the facility is admitting when there is no staff and current staff can't take care of the residents in the facility. Call light response On 4/27/22 at 10:00 AM, Surveyor interviewed R20 regarding call light response. R20 stated, There is a very long wait for staff to respond to call lights. We (residents) have concerns about receiving care. One resident fell and staff didn't respond for about 1 hour. The other day, a resident eloped from the building and staff didn't respond for over an hour for him. They found him laying in a ravine near the highway. Truthfully, we're afraid if something happens like a fall or a heart attack or stroke or something, how long before we get help or someone comes to help us? . On 04/27/22 at 7:00 p.m., Surveyor heard R3 yelling from in R3's room. No staff observed attending to R3. Surveyor went to R3's room and R3 was sitting in his wheelchair with only a torn brief on. Surveyor had to locate a staff member to attend to resident. Surveyor located a nurse, RN R, who went to R3's room to attend to him. On 04/28/22 at 1:15 p.m., Surveyor interviewed R3's Family Member (FM) T Surveyor asked R3's FM T if there were any concerns or issue. R3's FM T stated the only thing was when R3 has his Sundowning (yelling, agitation, inability to calm, inability to distract) episodes, the facility always calls her to calm him down. and deal with it. FM T feels the facility should be doing this. Surveyor noticed FM T was in the doorway of R3's room with a box sitting on a chair. Surveyor asked if FM T was waiting for staff. FM T stated, Yes. Surveyor asked if FM T had been waiting long and FM T stated that is all the time. FM T stated the facility does what they can, but everyone has to wait. 30570 Lack of supervision for high risk elopement residents On 4/27/22 at 9:30 a.m., NHA A reported an incident of R8 eloping from the facility on 4/26/22 at approximately 9:00 p.m. Surveyor reviewed R8's record and noted progress note as follows: 4/26/ 22: Incident: which was noted 4/27/22 at 2:00 a.m. Resident was outside of facility, resident got outside of facility and fell outside of building by green hall door at approximately 9:00 p.m. Found lying on his back, in the ravine, wheelchair was upside down . On 4/27/22 at 2:25 p.m., Surveyor spoke with DON B who was called by Registered Nurse (RN) O reporting R8's elopement incident, assessment as well as R8's transfer to ER. DON B indicated she asked RN O how R8 got out of the building. RN O told DON B the door at the end of the 400-hall alarm was not set. DON B indicated she did not direct RN O to begin an investigation into the potential root causes of the elopement as she was aware the 400 wing door alarm was not set. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/27/22 at 4:10 p.m., Surveyor spoke with Anonymous CNA S regarding sufficient staffing to meet resident needs. CNA S reported insufficient staffing to meet basic resident needs, residents go days without being washed or clothing changed, toileting and repositioning is delayed by hours and it is not possible to keep an eye on residents who wander. CNA S further stated there are 12 residents who require 2 people to transfer them, when staff are in the room transferring these residents no one is available to keep an eye on residents, to answer call lights or to provide care to the other residents. On 4/27/22 at 4:57 p.m., Surveyor spoke with RN O about R8's elopement incident. RN O identified R8 went out the 400 wing door as reported in the progress note. RN O expressed R8 was located in a ravine tipped over in his wheelchair and was flat on his back. R8 was assessed and found to have facial abrasions and a goose egg that was bruised with abrasion below his eye on his cheek. 911 was called and R8 was transferred to the ER. RN O indicated the root cause of the elopement/fall was the door alarm at the end of 400 wing was not set. RN O also reported lack of sufficient staffing to properly supervise residents at risk for elopement. RN O indicated there were 2 certified nursing assistants in the building, along with RN O at the time of the incident. RN O reported it is not possible for staff to care for all the residents and try to keep residents from leaving with current staffing levels. RN O further reported it is not uncommon for the facility to have 1 nurse and 1 CNA in the building from 6:00 p.m. to 10:00 p.m. which is not possible to care for the residents and supervise residents at risk for elopement. On 4/27/22 at 7:20 p.m., Surveyor spoke with RN R regarding residents at risk for elopement and sufficient staffing to supervise residents and meet their needs. RN R indicated she is full time and works 6:00 pm to 6:00 am. RN R reported the staff in the building on 4/27/22 is greater than usual due to surveyors being in the building. Usual staff on p.m. shift is 2 or 1 CNA and 1 nurse. RN R indicated there is not enough staff to keep up with the residents who wander to keep them safe and provide the needed care for all residents. The surveyor requested and reviewed a list of residents at risk for elopement from the facility. The list identified 6 residents at risk for elopement. (R3, R8, R11, R12, R14 and R15). On 5/03/21 at 11:23 a.m., Surveyor spoke with NHA A regarding R8's elopement and facility investigation into the incident. NHA A indicated he is the person who is responsible to investigate caregiver misconduct. NHA A indicted he did not conduct staff interviews or do a thorough investigation into all potential root causes of R8's elopement as he was told R8 eloped through a door on 400 wing as the alarm was not set. On 5/03/22 at 12:00 p.m., Surveyor spoke with Director of Nursing (DON) B about sufficient staffing in the facility to meet resident needs. DON B verified it is not unusual to have 2 Certified Nursing Assistants (CNA) and a Nurse in the building across all shifts. At times there is only 1 CNA and 1 nurse in the facility. The facility resident census ranges from approximately 41-45 residents. Current staffing can not meet resident needs, such staffing is not good and not adequate to meet resident needs. There is not enough staff and all aspects of resident care is affected. The facility continues to admit residents and there are not enough staff to care for those in-house. Surveyor conducted an investigation into R8's elopement with a citation issued at F689 failure to provide appropriate supervision to prevent the elopement at a level J (immediate jeopardy/isolated). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staffing Patterns Surveyor requested and reviewed nurse staffing schedules from 4/13/22 to 5/02/22. Surveyor noted the following: 4/15/22: AM shift/PM shift and Night shift: 2 CNA/1 nurse 4/16/22: AM shift/PM shift and Night shift: 2 CNA/1 nurse 4/17/22: AM shift/Night shift: 2 CNA/I nurse, PM shift with 2 CNA and 1.25 Nurse 4/18/22: AM shift/Night Shift: 2 CNA/1 nurse, PM shift with 2 CNA and 1 nurse from 2:00pm to 6:00pm 4/19/22: PM shift: 2 CNA/1 nurse from 2:00 p.m. to 6:00 p.m. and 1 CNA/1 nurse from 6:00 p.m. until 10:00 p. m./Night shift with 2 CNA/1 nurse 4/20/22: AM shift: 1 CNA and 2 nurse (1 in training) from 6:00 am to 10:00 am and additional CNA worked 10:00 am until 2:00 pm/PM shift 2 CNA and 1 nurse/night shift: 1 CNA and 1 nurse 4/21/22: AM: 2 CNA and 2 nurse/PM: 2:00 pm to 6:00 pm 2 CNA plus one for an hour and 1 nurse/Night shift 2 CNA and 1 nurse. 4/22/22: AM: 2 CNA and 2 nurses/PM:2 CNA and 1 nurse/Night: 2 CNA and 1 nurse. 4/23/22: AM: 2.25 CNA and 1 nurse/PM: 2 CNA and 1 nurse/Nights: 2 CNA and 1 nurse. 4/24/22: AM: 2 CNA and 1 nurse/PM: 2 CNA and 1 nurse/Nights: 2 CNA and 1 nurse 4/25/22: AM: 2 CNA and 1 nurse/PM: 2 CNA 2:00 pm to 6:00 pm and 1 nurse/Nights: 1.5 CNA and 1 nurse 4/26/22:(The pm R8 eloped) AM: 2 CNA and 2 nurse/PM: 1 CNA and 1 nurse from 2:00-6:00 pm and 2 CNA and 1 Nurse from 6:00-10:00pm /Nights: 2.5 CNA and 1 nurse After the survey team entered for complaint survey: 4/27/22: AM: 1.5 CNA and 3 nurse/PM: 2 CNA and 1 nurse with an additional CNA from 6:00 to 10:00 pm/Nights: 2.5 CNA and 1 nurse 4/28/22: AM: 3 CNA and 1 nurse/PM: 3 CNA and 1 nurse/Nights: 2.5 CNA and 1 nurse 4/29/22: AM: 2 CNA and 2 nurse/PM: 3.75 CNA and 1 nurse/Nights: 2.5 CNA and 1 nurse (Surveyors not in building) 5/01/22: AM: 2 CNA and 1 nurse/PM: 2.5 CNA and 1 nurse/Nights: 2 CNA and 1 nurse (Surveyors not in the building) 5/02/22: AM: 2 CNA and 1 nurse/PM: 2.5 CNA and 1 nurse/Nights: 2 CNA and 1 nurse (Surveyors back in the building) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Room Cleanliness On 5/2/2022 at 10:53 a.m., Surveyor observed R5's room. The following items were noted to be scattered on the floor around the room and under the bed: a clothing protector, multiple straw wrappers, used tissues, napkins, a fork, a stuffed animal, and a birthday card. There was also a white substance dried onto the floor and areas of yellow staining on floor near R5's urinary drainage bag. On 5/2/2022 at 2:18 PM, Surveyor observed R4's room. A full trash bag was tied up and sitting on floor outside room. While in room, R4's roommate had a visitor. Visitor expressed concern with cleanliness of room, and stated when she arrived the garbage was overflowing, so she tied it up and set it by the door. Surveyor noted another garbage can near entryway was full and some trash was lying on the floor next to trash can. With light streaming into room from window, streaks and soiled areas were visible on floor. After standing in room and talking to visitor, Surveyor's shoes stuck to floor. On 4/27/22 at 10:00 a.m., Surveyor observed R8's room and noted dried leaves all over the floor, with dried grass pieces scattered around on the floor of the room. Surveyor looked into the bathroom and observed multiple personal wipes scattered on the bathroom floor along with the packet of disposable wipes. Surveyor noted the toilet lid had dried feces on it in several areas. On 4/27/22 at approximately 10:15 a.m., Surveyor observed R10's room. Upon entering, Surveyor could see the garbage can in the room was overflowing. Surveyor could observe used incontinent products in the garbage can. The floor had scattered items of used Kleenexes, and other discarded items on the floor. The floor had visible spilled items that had dried onto the floor. This was visible in 3 areas of the room. Surveyor interviewed R10, who expressed she would like the garbage empty and a clean floor. On 5/03/22 at 9:48 a.m., Surveyor spoke with Lead Housekeeper/Laundry (LHL) I regarding the facility's cleaning schedule of resident rooms. LHL I indicated she has been on staff 6 years and leads the housekeeping services at the facility. LHL I expressed she works a couple days a week doing laundry and a couple days a week doing housekeeping. LHL I explained there is one other part time housekeeper who generally works 2 days a week. LHL I explained the resident rooms are on a cleaning schedule which allows cleaning every other day. The cleaning includes sweeping/mopping, wiping down surfaces, cleaning the bathroom and taking out garbages. LHL I expressed there are several resident rooms that need daily cleaning to maintain cleanliness in the rooms; however, there are not enough housekeeping staff to clean each room daily and keep the rooms clean. 41945

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 17661 Based on resident and staff interviews and record reviews, the facility did not provide pharmaceutical services to meet the needs for 1 of 5 residents reviewed for medication procurement (R1). R1 is a veteran and suffers from extreme anxiety. Upon admission to the facility, R1 had orders for Lorazepam (Ativan) to be given at bedtime. The medication was unavailable for 9 days and the facility did not procure other methods to obtain the medication. This is evidenced by: Example 1 R1 was admitted to the facility on [DATE] with medical diagnoses that include but are not limited to paraplegia because of a motor vehicle accident in 1981 in which he sustained a cervical-spine fracture and chronic obstructive pulmonary disease. On 4/27/22 at 10:21 AM, Surveyor interviewed R1 regarding various aspects of his life in the facility. R1 indicated that he had been receiving Lorazepam for many years related to anxiety that stemmed from his years in the armed service. He stated he continued to receive the medication while in the hospital for the past 4 months but when he came to this facility, the medication was discontinued. He was angry and indicated that a doctor that he has never seen, made changes to his medication regimen without discussing it with him first. R1 stated, . I went at least a week without my Ativan. I have severe anxiety related to my years in the service and they just discontinued it without coming to talk to me about it. I was crawling out of my skin. It was terrible. I now have it back but that week without it was horrible . On 4/27/22 at 2:00 PM, Surveyor reviewed R1's Narcotic Count form with RN C (Registered Nurse) and noted the medication started being given to R1 on 4/13/22. In reviewing R1's medication orders, it was noted that the Lorazepam was never discontinued. However, according to the Medication Administration Record (MAR) 4/4/22 - 4/12/22 (9 days), the nurse documented a 9 under the dates of administration. This refers the interested party to refer to the Nursing Progress Notes (NPNs). Surveyor then reviewed the NPNs and noted that for each day, the medication was not in the facility to give and continued to be on order. On 4/27/22 at 2:36 PM, Surveyor spoke to DON B regarding her knowledge regarding the medication. DON B stated that their pharmacy (PharmAmerica) did not deliver the medication until 4/13/22. She stated that she . called the pharmacy on the 8th or 9th and they indicated they would send the medication, but then never did. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON B stated the facility does not hold Lorazepam in their contingency box and that there was no contact with the physician regarding this medication not being given. She also stated that the facility does not have a back-up pharmacy to use in these instances.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview and record review the facility administration did not ensure residents received care and services to promote quality of life and ensure 41 of 41 residents (R) maintained their highest practicable level of physical, mental, and psychosocial well-being. The facility administration did not have systems in place to address concerns related to resident safety, pressure injuries and skin care, adequate staffing, pain, and nutrition. The facility administration did not ensure residents had appropriate physician oversight of their care, had regular assessments and care plans to direct their care. The facility administration did not appropriately investigate and report resident incidents. This is evidenced by: Over the past year the facility received the following, repeated high-level citations: F684-G on 07/14/21, F684-G on 12/20/21, F684-G on 3/09/22, and F684-G on current survey. F686-D on 6/14/21, F686-E on 07/14/21, F686-D on 03/09/22, and F686-J on current survey. F689-G on 06/14/21, F689-E on 07/14/21, F689-G on 03/09/22, and F689-J on current survey. F725-G on 6/14/21, F725-L on 7/14/21, F725-F on 03/9/22, and F725-F on current survey. Safety: The facility did not have a system in place to activate or monitor the door alarm system to prevent residents from exiting the building unsupervised. This affected R8, R11, R12, R3, R14 and R15. This resulted in R8 having an actual elopement from the facility on 04/26/22. R8 had been wandering throughout the building earlier exhibiting exit seeking behavior and staff did not increase supervision. Facility staff lacked knowledge on how to operate the door alarm system. The facility did not have a process to ensure bed rails, mattress and bed frames were compatible. The facility did not have a process to ensure that bed rails were installed correctly and inspected regularly. This affected R2, R7, R10, who all had bed rails with air mattresses on their beds. As a result, R2 had an actual entrapment incident on 05/01/22, which resulted in an injury and hospitalization . (Cross reference with F689, F700) Pressure Injuries and skin: (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility did not comprehensively assess wounds, develop a care plan to direct staff on care and treatment to promote healing and prevent new Pressure Injuries (PIs) from developing, and perform treatments to the wounds as ordered by the Physician. This affected the following six residents: R7, R1, R16, R17, R6, and R4. R7 did not have his skin assessed for the risk for the development of PIs upon admission and the facility did not implement a Care Plan (CP) to direct staff in the care and interventions to assist in the prevention and healing of PIs. As a result, R7 developed 6 unstageable PIs. R1 was admitted with 8 wounds of various stages to his legs, feet and back. Upon hospital discharge, he had two Stage 4 PIs to his back. The facility did not complete an initial comprehensive assessment of these wounds, nor were there weekly wound assessments. R16 was admitted to the facility with multiple chronic wounds. There were no skin assessments on the medical record and no skin care plan. R17's skin integrity was not comprehensively assessed upon admission and weekly skin assessments were not conducted. Also, the facility did not develop a CP for R17 to direct staff in the care and interventions to assist in prevention and healing of PIs for each resident. As a result, R17 developed 3 new Stage 2 PIs. R6 developed an unstageable pressure injury on right heel. No routine skin assessments of heel were performed by facility as per current professional standards of practice. R4 had areas of skin breakdown on ankle and toes; areas were not routinely assessed in a manner consistent with current professional standards of practice. Facility did not promptly identify R19's skin impairment, resulting in R19's incontinence associated dermatitis skin breakdown to increase in size due to the lack of assessment and interventions to promote skin integrity for R19. (Cross reference with F689 and F684) Sufficient Staffing: R20 stated there was a very long wait for staff to respond to call lights, and residents had concerns about receiving care. R20 stated one resident fell and staff didn't respond for about 1 hour, and another resident eloped from the building and staff didn't respond for over an hour. The facility did not complete Minimum Data Set Assessments (MDSA) for 5 of 7 residents reviewed (R1, R11, R12, R15 and R3.) This was because the facility had no staff member to complete the MDS Assessments. There was no nurse on staff experienced with wound care and assessments. As a result, there was no consistency with assessing wounds and there were missing assessments and care plans. R8 eloped from the facility on 4/26/22. Insufficient staffing was identified as part of the cause for the elopement. Surveyor observed only one Licensed Practical Nurse on duty for an evening shift on 04/27/22. That LPN was responsible for medication and treatment administration for all residents in the building, plus two new admissions. (Cross reference with F725) Pain, Nutrition, and personal hygiene cares: (continued on next page)

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	525678	A. Building B. Wing	05/10/2022

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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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R1 had severe pain related to extensive wounds. There was no pain assessment or care plan to direct staff on managing R1's pain. R9 was admitted with chronic pain. There was no pain assessment or interventions in place for pain control. Both residents were observed showing signs of pain such as grimacing and moaning, and both expressed dissatisfaction with pain control. R5 reported weight loss, and sometimes no help from staff with eating. Meal intakes were not consistently recorded. No nutritional assessments were found in R5's medical record over the past year. Physician Orders with a start date of 2/15/2021 included: Monthly weight one time a day starting on the 15th and ending on the 15th every month for monitoring. No weights were recorded since 5/15/2021. R1 required staff assistance to meet most basic daily tasks of bathing, personal hygiene, dressing and toileting. R1 was on bedrest and was unable to sit upright in a chair. R1 preferred bed bathing, and stated, I do want to get washed up every day, but that doesn't happen. Most times they give me a washcloth to wash my face and that's it. The staffing is so short here, they don't have time to spend with me . it's rare I get washed up like it should be . I flat out don't get the care I need (Cross reference with F677, F692, and F697) Physician oversight, assessments and care plans: The facility did not ensure the Physician reviewed the residents' total program of care, including medications and treatments; and wrote, signed, and dated progress notes at each visit. This occurred for R4 and R5. The facility did not ensure residents R4 and R5 were seen by a Physician at least every 60 days. The facility did not complete Minimum Data Set Assessments (MDSA) for R1, R11, R12, R15 and R3. R1 was admitted to the facility following an extensive hospitalization for wound care. There was not a comprehensive care plan developed for R1 to direct staff in R1's care and needs. R3 was admitted to the facility on [DATE] with a history of elopement while at home. A Fall Risk Assessment completed on admission indicated R3 was at a high risk for falls. R3 sustained a fall on 04/15/22 and was sent to the emergency room for evaluation. A care plan for fall risk was not completed until 04/21/22, and a care plan for elopement/wandering was not completed until 04/27/22. (Cross reference F711, F712, F636, and F657) Investigation and Reporting: The facility did not report potential misconduct incidents involving R8 and R2 to the state's Office of Quality Caregiver (OCQ) via the states Misconduct Incident Reporting (MIR) system immediately upon learning of the incidents. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R8 eloped from the facility through a door that was not alarmed on 4/26/22 at 9:00 PM. Although the facility administration learned of the elopement incident on 4/26/22 at 9:26 PM., they did not report the incident to OCQ until Surveyor inquired about the reporting. The reporting did not occur until 5/02/22 at 1:37 PM. The facility did not investigate how the door was left unarmed from the alarm system. The facility did not conduct staff interviews in attempts to determine how the door was left unarmed from the alarm system. The facility did not report a thorough investigation of the incident to OCQ. R2 was found 05/01/22 between 6:00 a.m. and 6:30 a.m. wedged between R2's bed and the wall. R2's face was noticed to be swollen. R2 sustained right and left temporal bruising and bruising on right shoulder. R2 was hospitalized for overnight observation. This incident was not reported to OCQ, and no investigation of the incident was started. (Cross reference F711, F712, F689, and F700) On 05/10/22, Surveyor interviewed Director of Nursing (DON) B, who stated she had only been in the position since the end of March. DON B stated in the short time in the position, there had been efforts to improve quality of care for the residents, but not much had been accomplished because the administrator had not provided much leadership or direction. On 05/10/22, Surveyor interviewed Activities (A) staff member V, who reported the staff had no real input on quality concerns with administration due to constant turnover of management. A V reported they had been chronically short staffed and trying the best they could to take care of the residents, but received no support or direction from management. On 05/10/22, Surveyor interviewed [NAME] President of Operations (VPO) U about the repeated high-level citations over the past year and the serious deficiencies noted above from the current survey. VPO U stated he and a new Corporate Clinical Director Registered Nurse were hired by the owners in mid to late December 2021. VPO U stated they were both brought on board to help get clinical operations on track. VPO U stated a previous administrator and DON were both terminated because they were not doing their jobs effectively. VPO U stated prior to his hire there was no corporate oversight to identify problems in the facility. There were frequent changes in administration, and DONs not paying attention to what was happening. VPO U stated the previous corporate nurse consultant was not in the building providing oversight and consultation. VPO U stated they were putting band aids on issues that needed serious attention.

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F 0837 Level of Harm - Minimal harm or potential for actual harm 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. 40181 Based on observation, interview, and record review, the facility Governing Body failed to implement policies related to the management and operation of the facility and were not actively engaged and involved in the daily operations of the facility which affected the quality of life of all 41 residents. The facility had frequent turnover of administrative staff over the past year and was without an administrator, who was licensed by the state, for a period of seven days. The facility had multiple high level repeated citations over the past year without evidence of Quality Improvement efforts to improve the deficiencies. The facility assessment was not updated since December 2018. The facility had multiple high level citations due to lack of staffing and continued to admit residents. This is evidenced by: The policy and procedure titled, Governing Body Policy and Procedure was reviewed. The policy states, in part, The governing board and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives .Their responsibilities include, setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as opportunities for improvement. Administration: The facility has had four different administrators in the past 10 months. The most recent Nursing Home Administrator (NHA) A left the building during this current survey and resigned the position effective 05/03/22. The current Interim Nursing Home Administrator (INHA) Y of record had not been in the building yet, as of 05/10/22. The facility has not had consistent oversight or management for the past year. The facility had multiple high level citations due to lack of staffing and continued to admit residents On 05/10/22, Surveyor interviewed Occupational Therapist (OT) W. OT W stated she had not heard of, or met INHA Y in the building. On 05/10/22, Surveyor interviewed Activities (A) staff V. A V stated she had not seen NHA A in the building since Surveyors were in the building last week. A V stated staff was told of INHA Y yesterday morning in a meeting. A V stated they were expecting that person to be INHA, but had not met that person in the building yet. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/10/22, Surveyor interviewed Social Services Director (SSD) K. SSD K stated NHA A was no longer working in the facility. SSD K stated they were told yesterday during morning meeting the name of INHA Y, but SSD K had not met INHA Y in the building yet. On 05/10/22, Surveyor interviewed Housekeeper/Laundry staff I, who stated she had not seen NHA A in the building since Surveyors were in the building last week. On 05/10/22, Surveyor interviewed Dietary Staff X, who stated he had not seen NHA A in the building since last week. On 05/10/22 at 11:45 AM, Surveyor interviewed [NAME] President of Operations (VPO) U, who stated he was currently acting as interim NHA, but was not licensed as a NHA in Wisconsin. VPO U stated NHA A left the position on 05/03/22, and they had contracted with a company for INHA Y to act as the Interim NHA as of 05/03/22. VPO U stated INHA Y was from the Milwaukee area, and thought INHA Y did come to the facility last week for one day, but was not sure which day. VPO U stated INHA Y then had a family emergency and would no longer be able to fill the role of Interim NHA. VPO U stated INHA Y had been providing oversight via telephone and remote access to the electronic medical record system. VPO U stated because INHA Y would no longer be able to fill the position, they had contracted with a new person who would be filling the Interim NHA position as of today. VPO U stated that person was enroute to the facility and would arrive today. VPO U stated they had hired a permanent NHA, who will begin on 05/24/22, so the new Interim NHA would be in place from today through 05/24/22. On 05/10/22 at 1:45 PM, Surveyor interviewed INHA Y over the phone. INHA Y stated she had never assumed the Interim NHA role for the facility. INHA Y stated she had been approached by a recruiter about the position and was in the onboarding process to assume the role. INHA Y stated the facility halted the onboarding process because she had a medical exemption for the COVID-19 vaccination, and the facility was trying to determine if they would accept that. INHA Y stated she was supposed to receive a new onboarding packet last Friday from the facility but never received it. INHA Y stated over the weekend she had a family emergency, and informed the facility that she would no longer be able to accept the position. INHA Y stated she informed the facility they should not list her as the NHA of record with the state. INHA Y stated she did not have any oversight or input to the facility's current Immediate Jeopardy citations and had never been to the building. Repeated Citations: On 05/10/22, Surveyor interviewed Director of Nursing (DON) B, who stated she had only been in the position since the end of March. DON B stated in the short time in the position, there had been efforts to improve quality of care for the residents, but not much had been accomplished because the administrator had not provided much leadership or direction. On 05/10/22, Surveyor interviewed A V, who reported the staff had no real input on quality concerns with administration due to constant turnover of management. A V reported they had been chronically short staffed and trying the best they could to take care of the residents, but received no support or direction from management. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/10/22 at 2:15 PM, Surveyor interviewed VPO U about the repeated high-level citations over the past year and the serious deficiencies noted above from the current survey. VPO U stated he and a new Corporate Clinical Director Registered Nurse were hired by the owners in mid to late December 2021. VPO U stated they were both brought on board to help get clinical operations on track. VPO U stated a previous administrator and DON were both terminated because they were not doing their jobs effectively. VPO U stated prior to his hire there was no corporate oversight to identify problems in the facility. There were frequent changes in administration, and DONs not paying attention to what was happening. VPO U stated the previous corporate nurse consultant was not in the building providing oversight and consultation. VPO U stated they were putting band aids on issues that needed serious attention. (Cross reference F835 and F867) Facility Assessment: The facility did not review and update the facility assessment since 12/20/2018. The facility assessment must reflect the resident population and the resources needed to care for this population. The facility assessment must be reviewed at least annually and as needed. On 5/10/22 at 4:40 PM, VPO U indicated a search to locate an updated facility assessment. Per VPO U, the facility assessment, which aids a facility in self-identifying staffing and resource needs, was not located. (Cross reference F838)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 44863 Based on interview and record review, the facility did not ensure the facility-wide assessment was reviewed and updated at least annually. This had the potential to affect all 41 residents. The facility did not review and update the facility assessment since 12/20/2018. The facility assessment must reflect the resident population and the resources needed to care for this population. The facility assessment must be reviewed at least annually and as needed. Findings include: The last facility assessment was dated 12/20/18. On 5/10/22 at 4:40 PM, [NAME] President of Operations (VPO) U indicated a search to locate an updated facility assessment. Per VPO U, the facility assessment, which aids a facility in self-identifying staffing and resource needs, was not located. No evidence of an updated facility assessment was provided to the survey team.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40181 Based on interview and record review, the facility did not identify issues to which quality assessment and assurance activities are necessary or develop and implement appropriate plans of action to correct identified quality deficiencies. The was evidenced by the number and seriousness of citations at this current survey, and repeated high-level citations over the past year. This had the potential to affect all 41 residents in the facility. This is evidenced by the following: During this complaint and extended survey, from 4/27/22 through 5/10/22, one deficiency was cited at immediate jeopardy level/pattern, F689. Two additional deficiencies were cited at immediate jeopardy level/isolated, F686 and F700. One deficiency was cited at harm level/isolated, F684. The facility also received seventeen additional citations, including: F604, F609, F610, F636, F657, F677, F692, F697, F711, F712, F725, F755, F835, F837, F838, F867 and F921. Over the past year the facility received the following, repeated high-level citations: F684-G on 07/14/21, F684-G on 12/20/21, F684-G on 3/09/22, and F684-G on current survey. F686-D on 6/14/21, F686-E on 07/14/21, F686-D on 03/09/22, and F686-J on current survey. F689-G on 06/14/21, F689-E on 07/14/21, F689-G on 03/09/22, and F689-J on current survey. F725-G on 6/14/21, F725-L on 7/14/21, F725-F on 03/9/22, and F725-F on current survey. The policy titled, Quality Assurance & Performance Improvement (QAPI) was reviewed. The policy stated, in part, .QAPI Mission The facility will maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems .The administrator is responsible for assuring that this facility's QAPI Program complies with federal, state and local regulatory agency requirements . The policy titled Governing Body Policy and Procedure was reviewed. The policy stated, in part, .The Governing Body should foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as opportunities for improvement .It is the policy and procedure of Minocqua Health and Rehabilitation to appoint the administrator as the quality assurance and performance committee chair QAPI . The facility has had four different administrators in the past 10 months and was without an administrator, who was licensed by the state, for a period of seven days. (Cross reference F837) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/10/22, Surveyor interviewed Director of Nursing (DON) B, who stated she had only been in the position since the end of March. DON B stated in the short time in the position, there had been efforts to improve quality of care for the residents, but not much had been accomplished because the administrator had not provided much leadership or direction. On 05/10/22, Surveyor interviewed Activities (A) V, who reported the staff had no real input on quality concerns with administration due to constant turnover of management. A V reported they had been chronically short staffed and trying the best they could to take care of the residents, but received no support or direction from management. On 05/10/22 at 2:15 PM, Surveyor interviewed [NAME] President of Operations (VPO) U about the facility's efforts for quality improvement. VPO U reported the facility QAPI committee consisted of the Nursing Home Administrator (NHA), DON, Medical Director, and all department heads. VPO U stated the committee met monthly, and the Medical Director attended quarterly. Surveyor asked for documentation to show the committee had met monthly, but no documentation was received. VPO U stated the NHA reported to the Governing Board on the quality improvement efforts, and any problems or concerns. Surveyor asked VPO U what the Governing Board and facility QAPI Committee had done about the repeated high-level citations over the past year and the serious deficiencies noted above from the current survey. VPO U stated he and a new Corporate Clinical Director Registered Nurse were hired by the owners in mid to late December 2021. VPO U stated they were both brought on board to help get clinical operations on track. VPO U stated a previous administrator and DON were both terminated because they were not doing their jobs effectively. VPO U stated prior to his hire there was no corporate oversight to identify problems in the facility. There were frequent changes in administration and DONs not paying attention to what was happening. VPO U stated the previous corporate nurse consultant was not in the building providing oversight and consultation. VPO U stated they were putting band aids on issues that needed serious attention. VPO U had begun tracking to ensure facility level quality improvement was being completed. VPO U stated they had held their first corporate level QAPI meeting last week, May 3rd through May 5th. (Cross reference F835 and F837) The facility Quality Assurance Committee has failed to identify key areas of deficient practice and implement action plans to correct these deficient practices.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 31088 30570 Based on observations and interviews, the facility did not provide a sanitary and comfortable environment for residents, staff, and the public. This affected R5, R4, R8, and R10. This is evidenced by: On 4/27/22 at 10:00 a.m., Surveyor observed R8's room and noted dried leaves all over the floor, with dried grass pieces scattered around on the floor of the room. Surveyor looked into the bathroom and observed multiple personal wipes scattered on the bathroom floor along with the packet of disposable wipes. Surveyor noted the toilet lid had dried feces on it in several areas. On 4/27/22 at approximately 10:15 a.m., Surveyor observed R10's room. Upon entering, Surveyor could see the garbage can in the room was overflowing. Surveyor could observe used incontinent products in the garbage can. The floor had scattered items of used Kleenexes, and other discarded items on the floor. The floor had visible spilled items that had dried onto the floor. This was visible in 3 areas. Surveyor interviewed R10, who expressed she would like the garbage empty and a clean floor. On 5/2/2022 at 10:53 a.m., Surveyor observed R5's room. The following items were noted to be scattered on the floor around room and under the bed: a clothing protector, multiple straw wrappers, used tissues, napkins, a fork, a stuffed animal, and a birthday card. There was also a white substance dried onto the floor and areas of yellow staining on floor near R5's urinary drainage bag. On 5/2/2022 at 2:18 p.m., Surveyor observed R4's room. A full trash bag was tied up and sitting on floor outside room. While in room, R4's roommate had a visitor. Visitor expressed concern with cleanliness of room, and stated when she arrived the garbage was overflowing, so she tied it up and set it by the door. Surveyor noted another garbage can near entryway was full and some trash was lying on the floor next to trash can. With light streaming into room from window, streaks and soiled areas were visible on floor. After standing in room and talking to visitor, Surveyor's shoes stuck to floor. On 5/03/22 at 9:48 a.m., Surveyor spoke with Lead Housekeeper/Laundry (LHL) I regarding the facility's cleaning schedule of resident rooms. LHL I indicated she has been on staff 6 years and leads the housekeeping services at the facility. LHL I expressed she works a couple days a week doing laundry and a couple days a week doing housekeeping. LHL I explained there is one other part time housekeeper who generally works 2 days a week. LHL I explained the resident rooms are on a cleaning schedule which allows cleaning every other day. The cleaning includes sweeping/mopping, wiping down surfaces, cleaning the bathroom, and taking out garbages. LHL I expressed there are several resident rooms that need daily cleaning to maintain cleanliness in the rooms; however, there are not enough housekeeping staff to clean each room daily and keep the rooms clean.