STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525730	A. Building B. Wing	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Suites at Oak Creek (the)	2700 Honadel Boulevard Oak Creek, WI 53154

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38937 Based on observation, interview and record review the facility did not ensure that 2 (R9, R16) of 2 residents reviewed were provided notice of rights and services both orally and in writing in a language that the resident understands. *R9 was identified as having limited English proficiency. The facility identified R9 as speaking Spanish. The facility did not provide interpreter services to allow for R9 to communicate freely with facility staff and physicians. *R16 was identified as having limited English proficiency. R16 was observed speaking Russian and the facility did not provide interpreter services to allow for R16 to communicate freely with facility staff and physicians. Findings include: The Facility policy, Providing Communication with Residents with Limited English Proficiency' dated 4/2020, documents: This facility will take reasonable steps to ensure that residents with Limited English Proficiency (LEP) have meaningful access and an opportunity to communicate their needs to facility staff. The policy of this facility is to ensure meaningful communicate with LEP residents and their authorized representatives involving their medical conditions and treatment. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and resident, representative(s) and their family members will be informed of the availability of such assistance free of charge. Language assistance will be provided through use of competent bilingual staff, staff interpreters, contacts or through arrangements with interpretation or translation services, or technology and telephonic interpretation services, as well as communication boards. All staff will be trained in effective communication techniques, including the effective use of an interpreter, or telephone interpretation services. Procedure: Identifying LEP persons and their language Ignite will promptly identify the language and communication needs of the LEP resident; (continued on next page)

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

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

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interpreter services and/or telephonic interpretation services will be provided to the LEP resident for the primary language spoken/read; Facility staff members may also be utilized to assist with interpretation services if applicable; Additional means of communication such as communication boards may also be provided to the resident; Some LEP person may prefer or request to use a family member or friend as an interpreter, however, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that resident and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility; -If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered; . -Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication; . Providing notice to LEP Persons This facility will inform LEP persons of the availability of language assistance, free of charge; . Monitoring Language Needs and Implementation . This facility will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, concerns filed by LEP persons, feedback from residents and community organizations, etc (etcetera). 1. R9 was admitted to the facility on [DATE], with diagnoses that include but are not limited to: Personal history of (healed) traumatic fracture, displaced fracture of base of neck of left femur, subsequent encounter for closed fracture with routine healing, need for assistance with personal care, difficulty walking, not elsewhere classified. R9's Admission MDS (Minimum Data Set) assessment, with an ARD (Assessment Reference Date) of 10/24/21, documents: Resident does not want or need an interpreter; preferred language: this area was left blank; speech is clear; understands others and is understood by others; BIMS (Brief Interview of Mental Status (BIMS) score of 13, indicating R9 is cognitively intact for daily decision making; PHQ-9 (Patient Health Questionnaire) score of 2, indicating minimal depressive symptoms. R9's Care Plan, dated 10/21/21, documents: The resident has communication problem r/t (related to) primary language is Spanish. Interventions include: Resident requires visual cues/signage, date initiated: 10/21/21; (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident requires (specific assistive device- this area is not completed) to communicate. Ensure availability and functioning of adaptive communication equipment, dated initiated: 10/21/21. This intervention is grayed out on R9's care plan indicating the intervention was discontinued without a discontinued date added. R9's Certified Nursing Assistant (CNA) Karadex, dated 12/7/21, documents: Communication: Resident requires visual cues/signage. On 10/21/21, at 18:46 (6:46 PM) R9's medical record documents: . The guest is alert to person. The guest speaks Spanish. On 10/21/21, at 20:50 (8:50 PM), R9's medical record documents: . Res (Resident) is Spanish speaking. Staff to use visual cues/signage. On 10/21/21, at 22:24 (10:24 PM), R9's medical record documents: . Does not speak English. The resident speaks another language. It is Spanish. Does not read English. A translator/interpreter is not needed. Does not use non-verbal communication. On 10/22/21, at 01:57 (1:57 AM), R9's medical record documents: . Guest is alert. Speaks Spanish with a few words of English. On 12/6/21, at 8:52 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-Y, who stated R9 spoke very sketchy English. CNA-Y stated R9's family would visit often and would help with the Spanish speaking translation with staff. CNA-Y stated the family came to visit frequently until COVID and then they would have window visits. CNA-Y stated R9 had a note on the phone to call the family to help with Spanish speaking concerns. CNA-Y stated at times she would try to find a staff member from another unit who spoke Spanish and they would help CNA-Y understand what R9 needed. Otherwise, staff would point or use gestures to help find out what R9's needs were. CNA-Y stated she did not use an interpreter or call an interpreter other than family or staff, when available, when attempting to communicate with R9. On 12/6/21, at 3:47 PM, Surveyor informed Nursing Home Administrator-A, Director of Nursing-B of the concern R9 was not provided the assistance of an interpreter to communicate to staff and physician when R9's primary language spoken was Spanish. 2. R16 was admitted to the facility on [DATE], with diagnoses that include but are not limited to traumatic subdural hemorrhage without loss of consciousness, nondisplaced fracture of medial malleolus of right tibia, and major depressive disorder. R16's Admission MDS (Minimum Data Set) assessment, with and ARD (Assessment Reference Date) of 10/27/21, documents: the resident does not need or want an interpreter, preferred language question was not answered; hearing with moderate difficulty; speech is clear, the resident understands other and is understood by others; BIMS (Brief Interview of Mental Status) score of 15, indicating R16 is cognitively intact; PHQ-9 (Patient Health Questionnaire) score of 3, indicating minimal depressive symptoms. On 11/30/21, at 9:50 AM, Nursing Home Administrator (NHA)-A informed survey team R16 was identified as a resident that has limited English language proficiency. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Care Plan, dated 10/21/21, does not document R16's limited English proficiency and R16's primary language spoken and understood as Russian. On 12/1/21, at 1:28 PM, Surveyor attempted to interview R16. R16 used gestures and select English words to inform Surveyor he wanted a shower. R16 would point from head to abdomen and would repeat the word clean. R16 then would lift his right leg with a cast on it and state plastic bag and clean. R16 nodded yes when Surveyor asked if R16 would like a shower and R16 stated hospital long time. R16 continued to point to his hair and state hair oil. This Surveyor was unable to determine what R16 was attempting to communicate. On 12/1/21, at 1:41 PM, Surveyor informed Licensed Practical Nurse (LPN)-AA of R16's gestures and request for a shower and Surveyor's inability to determine R16's needs related to his hair as demonstrated by R16's gestures. LPN-AA stated typically R16 does fairly well with communication and using gestures but when the staff is unable to identify what R16's needs are they will contact R16's family for assistance. LPN-AA stated R16 is typically pretty good with letting staff know his needs but R16 is very hard of hearing so the staff will contact R16's nephew to assist with translation. LPN-AA stated she would contact R16's nephew to see what R16's needs are. On 12/2/21, at 12:30 PM, Surveyor interviewed R16 who used gestures of pointing to his hair as he did yesterday. Surveyor asked R16 if he would like his hair washed or cut and R16 did not verbally respond or provide a nonverbal response as an answer to the questions. Surveyor was able to locate R16's assigned CNA, CNA-BB. CNA-BB agreed to come to R16's room with the Surveyor to determine what R16 was attempting to communicate. CNA-BB informed Surveyor R16 typically wants milk or coffee so that is most likely what R16 was attempting to communicate to Surveyor. CNA-BB and Surveyor attempted to speak to R16, who again was touching his hair and gesturing around his hair. CNA-BB asked R16 if he wanted his hair washed as R16 just had a shower. R16 continued to point to his hair and did not use any other nonverbal communication to express his needs. CNA-BB stated she was unable to determine what R16 was trying to communicate. CNA-BB stated she would go find R16's shower aid to see if she knew what R16 was attempting to communicate. CNA-BB stated she hasn't used an interpreter to communicate with R16. On 12/6/21, at 3:47 PM, Surveyor informed Nursing Home Administrator-A, Director of Nursing-B of the concern R16 was not provided the assistance of an interpreter to communicate to staff and physician when R16 primary language spoken was Russian.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on interview and record review, the facility did not notify the resident's responsible party or physician when there was a significant change in condition for 4 (R8, R1, R3 and R9) of 5 sampled residents. *R8's physician and responsible party was not notified of multiple pressure injuries that R8 acquired while residing at the facility from 10/8/21 to 11/1/21. *R1's physician and responsible party were not notified of R1's pressure injury upon admission to the facility on . R1's physician and responsible party were not notified when R1's pressure injury deteriorated. *R3's physician was not notified that a STAT laboratory draw was not performed in accordance with R3's physician orders. *R9's responsible party was not notified of a change in R9's condition or when R9's had a room change at the facility. Findings include: (Cross Reference F686) The facility's NOTIFICATION OF THE PHYSICIAN policy and procedure, revised October 2021, states It is the policy of the facility, except in medical emergency, to alert the resident, resident's physician and resident's responsible part of a change of condition. The policy states 1. Nursing will notify the resident's physician or nurse practitioner when: a. The resident is involved in an accident or incident. B. There is a significant change in resident's physical, mental or emotional status e. It is deemed necessary or appropriate in the best interest of the resident. 2. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident or responsible party if appropriate of the issue and physician orders. 3. The communication with the resident and their responsible part as well as the physician will be documented in the resident record or other appropriate documents. 4. Incidents that occur defined as non-injury occurring on the night shift may be reported on the following day shift to the responsible party or DPOA [designated power of attorney]. 5. The Care Plan Coordinator will be notified so that changes can be made to the care plan. The wound policy & procedure dated December 2020 under procedure for notification documents A written protocol is established for: * Physician notification of pressure ulcer presence and responses to treatment. * Family notification of pressure ulcer presence, treatment plan, response to treatment, and changes in treatment due to wound deterioration. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	1. R8 was admitted to the facility on [DATE] with diagnoses of respiratory failure. Viral hepatitis and weakness. R8 was previously diagnosed with COVID 19 in September 2021 prior to admission to facility. R8's Admission MDS with an assessment reference date of 10/11/21 indicates R8 required limited to extensive assistance with bed mobility, transfers, dressing, toileting, bathing and personal hygiene. R8's Admission MDS noted R8's skin to be intact upon admission to the facility and free from pressure injuries. Surveyor reviewed R8's Braden assessments conducted on 10/12/21 and 10/22/21 with scores of 16, indicating resident was at risk for pressure injuries. On 10/8/21, the facility conducted an admission assessment which noted R8's skin to be intact and free of pressure injuries. On 10/19/21, a wound assessment of R8's right heel reads: Status: Active, Type: Pressure, Source: Facility acquired, Date identified: 10/19/21, Identified by: Wound Care LPN-M, Clinical stage: Unstageable, tissue type: non-blanchable erythema 100%, exudate: moderate serosanguineous and measurements of 4.6 cm x 4. 2 cm x 0.1 cm. Surveyor reviewed R8's progress notes. On 10/19/21 Wound Care NP-X documented an unstageable pressure injury to the R8's right heel measuring 4.6 cm x 4.2 cm x 0.1 cm with full thickness tissue loss. On 10/19/21, Wound Care NP-X gave orders for R8 to wear pressure relieving boots at all times (except during therapy), daily dressing changes to the right heel, referral to the facility's registered dietician and repositioning every 2 hours. Surveyor did not identify any documentation of R8's responsible party being notified of the discovery of R8's pressure injury to the right heel. On 10/22/21, Wound assessment of R8's coccyx reads Site: Coccyx, Type: Pressure, Classification: Ulceration, Source: Present-on-admission, Date Identified: 10/19/21 by DON-B. No documentation of any measurements or wound characteristics of R8's coccyx wound were noted from 10/19/21 when it was discovered by Director of Nursing (DON)-B. On 10/22/21, wound assessment of R8's coccyx reads: Assessment date: 10/22/21, performed by: DON-B, Clinical stage: Unstageable .size: 2.5 x 4.0 x 0.2 cm with 25% epithelial tissue and 75% slough tissue Surveyor did not identify any documentation of R8's physician or responsible party being notified on of the discovery of R8's pressure injury to the coccyx. There was no treatment change. By the next wound measurement four days later the wound was 100% necrotic. On 10/26/21, wound assessment of R8's coccyx reads: Assessment date: 10/26/21, performed by Wound Nurse-LPN-M, clinical stage: unstageable .tissue types: necrotic, hard, firm, adherent, 100%, outcome: probably decline, size: 2.8 x 2.4 x 0.1 cm, unstageable , 100% necrotic with scant serosanguineous drainage. Surveyor reviewed R8's progress notes. Surveyor was not able to locate documentation of notification of R8's physician related to their unstageable coccyx pressure injury. Surveyor reviewed R8's TAR. Surveyor was unable to identify documentation of wound treatment to R8's unstageable coccyx pressure injury until 10/25/21. Surveyor did not identify any documentation of R8's physician or responsible party being notified of the deterioration of of R8's pressure injury to the coccyx. On 10/26/21, Wound assessment documentation reads: Site: Left heel, Status: Active, Type: Pressure, Source: Facility Acquired, Date identified: 10/26/21, Identified by: Wound Nurse LPN-M, Clinical stage: Deep tissue pressure injury, Tissue types: intact skin 20% Deep Maroon 60%, Exudate: none, size: 2.8 cm x 3.5 cm. Surveyor reviewed R8's TAR. A treatment order was implemented on 10/26/21 for application of skin prep swab to left heel pressure injury daily. Surveyor did not identify any documentation of R8's physician or responsible party being notified of the discovery of R8's pressure injury to the left heel. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 10/26/21, Wound assessment documentation reads: Site: Sacrum, Status: Active, Type: Pressure, Source: Facility Acquired, Date identified: 10/26/21, Identified by: Wound Nurse LPN-M, Clinical stage: unstageable, Tissue types: bright pink or red 50% slough loosely adherent 50% Exudate: scant serosanguineous, size: 0.5 cm x 0.6 cm x 0.1 cm. Surveyor did not identify any documentation of R8's physician or responsible party being notified of the discovery of R8's pressure injury to the sacrum. On 10/26/21, Wound assessment documentation reads: Site: R buttock, Status: Active, Type: Pressure, Source: Facility-acquired, Date identified: 10/26/21, Identified by: Wound Nurse LPN-M, Clinical Stage: Stage 1, Tissue types: Bright pink or red 100%, exudate: scant-serosanguineous, size: 0.5 x 1.0 x 0.1 cm. Surveyor did not identify any documentation or R8's physician or responsible party being notified of the discovery of a pressure injury to R8's right buttock. There were no treatment changes initiated on 10/26/21 for any of these wounds. On 12/2/21 at 12:55 PM, Surveyor conducted interview with Wound Nurse LPN-M. Surveyor asked Wound Nurse LPN-M if a resident's physician should be notified if they are noted with a pressure injury. Wound Nurse LPN-M told Surveyor that a physician should be notified of any new wounds. Surveyor asked Wound Nurse LPN-M if a resident has a pressure injury that deteriorates whether or not a resident's physician should be notified. Wound Nurse LPN-M responded that a physician should be made aware if a wound is deteriorating as a treatment may need to be changed. Surveyor asked Wound Nurse LPN-M why they had not notified R8's physician on 10/26/21 when R8's right heel and coccyx pressure injuries had declined. Wound Nurse LPN-M responded that they are still receiving training in capacity as the facility's wound nurse and is working closely with PM shift RNs on wound care. Wound Nurse LPN-M could not provide additional information as to why they did not notify a physician of R8's declining wounds. Surveyor asked Wound Nurse LPN-M if a resident's responsible party should be informed when they experience a change in condition, such as development or worsening of a pressure injury. Wound Nurse LPN-M responded that it would depend on if the resident is their own person whether or not they would update a resident's responsible party. On 12/3/21 at 1:30 PM, Surveyor conducted an interview with DON-B. Surveyor asked DON-B if a resident's physician should be notified if they are noted with a pressure injury. DON-B responded to Surveyor that a physician should be notified of any new wounds. Surveyor asked DON-B if a resident has a pressure injury that deteriorates whether or not a resident's physician should be notified. DON-B responded Yes. Surveyor asked DON-B if a resident's responsible party should be informed when they experience a change in condition, such as development or worsening of a pressure injury. DON-B responded, Yes, they should be made aware. On 12/7/21 at 10:25 AM, Surveyor conducted interview with Physician-CC. Surveyor asked Physician-CC if they had ever been made aware of R8's pressure injuries that developed during their stay at the facility. Physician-CC responded The facility has never called me about any of their resident's pressure injuries. The Nurse Practitioners may have been aware but I don't know anything about R8's pressure injuries. The facility does not update me. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 12/7/21 at 10:40 AM, Surveyor conducted interview with Nurse Practitioner (NP)-Z. NP-Z was R8's assigned NP while they resided at the facility. Surveyor asked NP-Z if they had been made aware of R8's pressure injuries while R8 resided at the facility. NP-Z responded that they had been made aware of R8's right heel pressure injury and had directed nursing staff to have Wound Care-NP-X assess and follow R8's wound. Surveyor asked NP-Z whether or not they would expect staff to update them if new pressure injuries were discovered or if a wound deteriorated. NP-Z responded that they would expect the facility staff to notify the wound care team including a wound care NP if there were any changes in wound status. Surveyor informed NP-Z that upon discharge from the facility that R8 had acquired 5 pressure injuries while residing at the facility. NP-Z added that they had only been made aware of R8's right heel pressure injury on 10/19/21. On 12/7/21 at 1:00 PM, Surveyor shared concerns related to lack of documentation of R8's physician being made aware of 4 of 5 facility acquired pressure injuries. Surveyor shared concerns related to R8's responsible party not being made aware of 5 of 5 facility acquired pressure injuries. No additional information was available from the facility at this time. 20483 2. R1 was admitted to the facility on [DATE] with diagnoses which include Pneumonia due to Covid 19, acute respiratory failure with hypoxia, diabetes mellitus, dehydration, metabolic encephalopathy, right below knee amputation, hypertension, peripheral vascular disease, obesity and multiple sclerosis. The Facility's face sheet lists R1's daughter as Emergency contact #1 and R1's spouse as Emergency contact #2. The admission MDS (minimum data set) with an assessment reference date of 9/21/21 documents a BIMS (brief interview mental status) score of 3 which indicates severely impaired. The admission nursing evaluation dated 9/14/21 under the skin integrity section yes is answered for the question does the resident have skin integrity concerns. Under site documents 23) Coccyx & Description documents stage 2. A second site is documented as 50) Left heel & Description documents stage 2. There is no documentation R1's physician/NP (nurse practitioner) was consulted with regarding these pressure injuries to obtain an order for a treatment. The wound assessment dated [DATE] documents site as Coccyx, clinical stage is Unstageable The length is 1.5 cm (centimeters), width 0.60 cm and depth 0.10. The tissue type is documented as 100% pale pink non granulating. There is no documentation R1's physician was consulted with regarding R1's unstageable coccyx pressure injury to obtain a treatment and there is no evidence R1's emergency contacts were notified of the unstageable pressure injury. Surveyor noted R1's physician's order does not include a treatment order for R1's unstageable pressure injury until 9/21/21. Surveyor was unable to interview the wound nurse as she is no longer employed at the Facility. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	The wound assessment dated [DATE] documents site as Coccyx, clinical stage is Unstageable The length is 7.5 cm, width 7.00 cm and depth unknown. The tissue type is documented as 90% non blanchable erythema and 10% pale pink non granulating. On 9/21/21 a treatment was ordered to cleanse wound with mild soap and water. Pat dry. Apply boarder foam dressing daily and prn (as needed) every day shift for wound care. There is no evidence R1's representative was informed of the decline in R1's coccyx pressure injury and the new treatment. The wound assessment dated [DATE] documents site as Coccyx, clinical stage is Unstageable The length is 8.5 cm, width 7.00 cm and depth unknown. The tissue type is documented as 50% slough white fibrinous and 50% necrotic hard, firm, adherent. On 9/28/21 there was a change in the treatment for R1's coccyx pressure injury. The new treatment was cleanse wound with mild soap and water. Pat dry. Apply silver calcium alginate to base of wound. Apply silicone boarder foam dressing daily and prn (as needed). There is no evidence R1's representative was informed of the decline in R1's coccyx pressure injury and change in treatment. On 10/1/21 there was a change in the treatment for R1's coccyx pressure injury. The new treatment was cleanse wound with mild soap and water. Pat dry. Medihoney to base of wound. Apply to base of wound. Apply silicone boarder foam dressing daily and prn. There is no evidence R1's representative was informed of this change in treatment. The wound assessment dated [DATE] documents site as Coccyx, clinical stage is Unstageable The length is 9.2 cm, width 7.00 cm and depth unknown. The tissue type is documented as 10% slough white fibrinous and 90% necrotic hard, firm, adherent. On 10/5/21 there was a change in treatment for R1's coccyx pressure injury. The new treatment consisted of Cleanse wound with mild soap and water. Pat dry. Santyl to base of wound. Apply silicone boarder foam dressing daily and prn. There is no evidence R1's representative was informed of the decline in R1's coccyx pressure injury and change in treatment. On 12/6/21 at 3:47 p.m. during the daily exit meeting Surveyor informed DON-B Surveyor was unable to locate R1's representative was notified of the decline in pressure injury and the change in treatments in R1's medical record. On 12/7/21 Surveyor was provided with a handwritten note which documents POA (power of attorney) activation 10/11/21 we would not have called with treatment orders. At 8:54 a.m. Surveyor asked DON-B why R1's representatives were not notified when there was a decline in the coccyx pressure injury and a change in treatment. DON-B informed Surveyor R1's POA was not activated until 10/11/21 so they wouldn't of notified anyone. Surveyor informed DON-B even if R1's POA was not activated according to regulations the resident representative should have been notified of these changes. On 12/7/21 at approximately 9:16 a.m. Surveyor informed DON-B Surveyor was unable to locate R1's physician was notified at time of admission the Stage 2 coccyx pressure injury to obtain a treatment for this pressure injury and on 9/21/21 when the pressure injury declined to unstageable to obtain a treatment for this pressure injury. 35720 (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	3. The STAT MEDICAL TEST REQUESTS policy and procedure, dated April 2020, states The facility will ensure medical vendors are able to support stat testing when ordered by the physician. The policy states 2. Stat requests will be fulfilled by the medical vendor as soon as possible, if the vendor communicates any barriers or delays in service alternative solutions to ensure testing is completed may be employed by the facility, including but not limited to transfer to the emergency department. A physician progress note on 11/13/21 for R3 documents Disorientation, unspecified: Patient disoriented, answers simple yes/no questions, states he needs to get up and go, confused, labs ordered. Progress notes on 11/13/21 at 1:43 pm document Resident noted to have a increase in confusion, calling out even after needs have been met. Resident spoke with wife and stated he wanted 911 called, 1:1 given and resident did settle down. VSS [vital signs stable]. Writer spoke with wife several times today and she stated that resident becomes confused prior to having dialysis. His regular schedule is MWF [Monday, Wednesday, Friday]. Resident did not recv [receive] dialysis Friday. NM [Nurse Manager] is aware. NP [Nurse Practitioner] is aware and is here today assessed resident and ordered stat labs .Resident currently resting quietly in bed. Physician orders document on 11/13/21 stat complete metabolic panel, complete blood count, and lactic acid were ordered. A progress note on 11/13/21 at 5:01 pm by LPN (licensed practical nurse)-O document stat cbc [complete blood count] with differential, cmp [complete metabolic panel], lactic acid STAT for confusion not able to draw labs. There is no documentation a physician was notified of R3's stat labs being unable to be drawn. On 12/6/21 at 10:03 am the surveyor interviewed LPN-O. LPN-O was unable to recall R3, any incidents with his labs, or if a physician was notified. On 12/6/21 at 3:15 pm the surveyor informed NHA-A (Nursing Home Administrator)-A and DON (Director of Nursing)-B of being unable to find notification of R3's physician being notified of stat labs being unable to be drawn. On 12/7/21 at 7:26 am NHA-A informed the surveyor of being unable to find any additional information about the labs orders on 11/13/21 for R3. 38937 4. R9's resident representative was not notified with a significant change in the resident's physical status with a need to alter R9's treatment plan and when R9 had a change in room assignment. *R9 was admitted to the facility on [DATE], with diagnoses that include but are not limited to: Personal history of (healed) traumatic fracture, displaced fracture of base of neck of left femur, subsequent encounter for closed fracture with routine healing, need for assistance with personal care, difficulty walking, not elsewhere classified. R9's Admission MDS (Minimum Data Set) assessment, with an ARD (Assessment Reference Date) of 10/24/21, documents: Resident does not want or need an interpreter; preferred language: this area was left blank; speech is clear; understands others and is understood by others; BIMS (Brief Interview of Mental Status (BIMS) score of 13, indicating R9 is cognitively intact for daily decision making; PHQ-9 (Patient Health Questionnaire) score of 2, indicating minimal depressive symptoms. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 11/8/21 at 12:07 PM, R9's medical record documents: .Guest will be moved to the COVID part of the building and be put on COVID isolation. Surveyor unable to locate documentation R9's responsible party was notified of R9's room change. On 11/9/21, at 18:42 (6:62 PM), R9's medical record documents: PT (patient) oxygen was 85% this morning on room air, no c/o (complaints of) SOB (Shortness of Breath); PT was put on 1L (1 liter) O2 (oxygen) then 93%. NP (Nurse Practitioner) [Nurse Practitioner's name] ordered STAT (immediate) cxr (chest x-ray) and labs; lab results pending and cxr results came back negative and NP aware. PT was weaned off of the O2 later in shift, VSS (vital signs stable). Surveyor was unable to locate documentation of R9's responsible party being notified of the change in condition. On 11/17/21, at 15:45 (3:45 PM), R9's medical record documents: NP [name of NP] ordered STAT CBC (Complete Blood Count), CMP (Complete Metabolic Panel), CRP (C-reactive protein) procalcitonin, and chest xray for hypoxia. NP [name of NP] also ordered to wean off of oxygen from 4L to 2L, will continue to monitor; labs and x-rays ordered and obtained; awaiting results. 11/17/21, at 18:13 (6:13 PM), R9's medical record documents: Pt oxygen 88% without supplemental O2. PT is now on 2L at 95%. 11/17/21, at 23:09 (11:09 PM), R9's medical record documents: Spoke to NP regarding lab and CXR (Chest x-ray) results. NOR (New Order Received). Pt (Patient) received first dose of Levaquin immediately. Six more doses to follow. Pt positive for pneumonia. Will push fluids and continue to monitor pt closely. 11/18/21, at 06:09 (6:09 AM), R9's medical record documents: at 0530 (5:30 AM), writer updated [R9's] son [name of son] on mother's condition and that she is positive for pneumonia. Writer relayed that mother is already on ABT (antibiotic) and her condition at this time is stable. R9 is documented to have experienced a change in condition on 11/17/21 at 3:45 PM and R9's responsible party was not notified of the change in condition until 11/18/21 at 5:30 AM after R9 was diagnosed with pneumonia and already received antibiotics. On 12/1/21, at 2:22 PM, Surveyor interviewed Social Worker (SW)-L, who stated families should be notified of any room change that occurs and any change in medical status. SW-L stated responsible parties should be informed of resident change in condition and room changes. SW-L stated such notifications are the responsibility of the nursing staff. On 12/1/21, at 2:55 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-F, who stated he would expect families/responsible parties to be notified of a residents change in condition or a room change as soon as possible. On 12/6/21, at 3:47 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern R9's responsible party was not notified of R9's room change and was not notified of R9's change in condition until after lab results were obtained, results were received and antibiotics were started.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35720 Based on observation and interview the facility did not ensure 1 of 3 units observed maintained a clean environment with the potential to affect 31 residents residing on the unit. Findings include: 1. On 11/30/21 at 9:40 am the surveyor observed R18's room. The surveyor observed a brown dried crumbled debris scattered throughout the floor in R18's room. At 1:53 pm the surveyor observed the debris remained. At 1:53 pm Family Member-C informed the surveyor the debris had been there for days. 2. On 11/30/21 at 9:38 am the surveyor observed R19's room. The surveyor observed food debris scattered throughout the floor in R19's room. The surveyor observed the food debris remained at 1:52 pm. 3. On 11/30/21 at 9:41 am the surveyor observed R20's room. The surveyor observed a cup and gloves on the floor in the room and an empty food tray on top of the garbage can. 4. On 11/30/21 at 9:42 am the surveyor observed R21's room. The surveyor observed a garbage bag that was full on the floor in R21's room. 5. On 12/1/21 at 7:51 am the surveyor observed the trash can in the 100 unit dining room full. The surveyor noted the lid of the garbage can was propped open by the garbage in the can due to being too full to close. The surveyor observed a water bottle and gloves on the floor near the garbage can. At 8:31 am the surveyor observed the trash can remained full, unable to be closed due to garbage being over the top on the container. On 12/6/21 at 9:11 am the surveyor interviewed Housekeeping-E. The surveyor asked Housekeeping-E how often rooms are cleaned. Housekeeping-E stated they try to (clean) daily, indicating they had been short staffed lately. On 12/7/21 at 8:11 am the surveyor interviewed Housekeeping Supervisor-D. The surveyor asked how often resident's rooms are cleaned. Housekeeping Supervisor-D stated daily. The surveyor asked if things happen between when the housekeeper cleans the room and the next daily cleaning who is responsible. Housekeeping Supervisor-D stated if housekeeping is there they should be cleaning it, otherwise other available staff should be. The surveyor informed Housekeeping Supervisor-D of the above observation. Housekeeping Supervisor-D stated there would not be a good answer for that.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the Facility did not ensure that a resident who enters the Facility with a pressure injury receives necessary care and treatment and Residents without a Pressure Injury (PI) does not develop pressure injuries, and receives appropriate care, treatment & preventative measures to promote healing for 3 (R1, R8, & R11) of 3 Residents reviewed for pressure injuries. * R1 was admitted to the facility on [DATE] with a Stage 2 pressure injury on R1's coccyx & left heel. There was no treatment implemented to the Stage 2 pressure injury on R1's coccyx & left heel when R1 was admitted . The admission nursing evaluation was completed by an LPN. There was no Registed Nurse (RN) assessment until 2 days later on 9/16/21 when the coccyx pressure injury declined to unstageable with measurements of 1.5 cm (centimeters) x (times) 0.6 cm x 0.1 cm. There was no treatment started on 9/16/21. On 9/21/21 R1's coccyx pressure injury was assessed by the wound RN and wound Nurse Practitioner (NP). R1's coccyx pressure injury had further declined and the measurements are now 7.5 cm x 7.0 x unknown depth. A treatment was ordered on 9/21/21. The Facility did not revise R1's actual skin integrity care plan after 9/23/21 even though R1's pressure injury continued to decline and treatments were not consistently initialed as being completed. On 10/12/21 R1's coccyx pressure injury measured 9.5 cm x 6.2 cm x 3.00 cm. R1 was transferred to the hospital where the pressure injury was debrided and R1 was placed on IV antibiotics. R1's hospital final diagnosis is documented as Necrotizing fasciitis. * R8 was admitted to the facility on [DATE] and was assessed to be at risk for developing pressure injuries. On 10/19/21, R8 was identified with 2 facility acquired unstageable pressure injuries to the right heel and coccyx. The facility did not implement ordered interventions including daily dressing changes, pressure relieving boots, repositioning schedule and an air mattress as ordered by facility's Wound Care Nurse Practitioner on 10/19/21. On 10/26/21, R8 was noted with 3 additional facility acquired pressure injuries, with no physician contact for treatment orders. R8 was discharged from the facility on 11/1/21 with a total of 5 facility acquired pressure injuries. The facility did not implement preventative interventions prior to the development of 5 facility acquired pressure injuries. The Facility's failure to measure or assess R1's coccyx pressure injury upon admission, have an RN assess the pressure injury until 2 days after admission, obtain a treatment until seven days after admission, initially identify how often R1 should be repositioned, to revise the care plan after 9/23/21 and implement treatment orders; and The Facility's failure to identify R8's pressure injuries until they were unstageable, obtain an appropriate mattress timely, obtain timely treatments and implement these orders, and to document R8's alleged refusal of repositioning and develop approaches addressing these refusals created a finding of Immediate Jeopardy (IJ) which began on 9/16/21. The Surveyor notified Administrator-A, DON (Director of Nursing)-B, ADON (Assistant Director of Nursing)-F and ADON-N on 12/7/21 at 1:32 p.m. of the IJ for R1 & R8. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate jeopardy was removed on 12/14/21. The deficient practice continues at a scope and severity of a G (harm/isolated) as the facility continues to implement its action plan and for R11 as evidenced by; * R11 developed a Facility acquired unstageable sacrum pressure injury. The Facility did not implement preventative interventions prior to the pressure injury being developed. Findings include: (Cross Reference F580) The Facility's Wound Policy & Procedure dated December 2020 documents under policy The facility is committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcer, unless the individual's clinical condition demonstrates they are unavoidable. Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Typically the goal is one of promoting healing and preventing infection unless a resident's preferences and medical condition necessitate palliative care as the primary focus. A commitment to the Wound Management Program is demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines and interdisciplinary involvement. Under procedure for Admission Wound Assessment and Management documents * At the time of admission, the discharge records from the prior facility are reviewed for information relating to wounds or alteration in skin integrity. Staging from another facility is not adopted for use in the facility. * Any wounds assessed will be captured in the PCC (point click care) nursing evaluation, in progress notes, or by completing in Wound Rounds via Quick Shot (within 2-6 hours of admissions). * The admission wound assessment should include at a minimum: Interview of resident or family about history of skin alterations. * Physical evaluation to include identification of: Skin alterations present on admission, skin discoloration and any evidence of scarring on pressure points. Signs/symptoms/diagnosis of peripheral vascular disease. Bed mobility. Continence. Recent surgical procedure. Head to toe skin assessment. Nutritional status and issues. * Completion of Braden or [NAME] Skin Risk Assessment Tool. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Comprehensive assessment of any wound to include: Location of wound. Length, width, depth measurements recorded in centimeters. Direction and length of tunneling and undermining. Appearance of the wound base. Type and percentage of tissue in wound. Drainage amount and characteristics including color, consistency, and odor. Appearance of wound edges. Description of the peri-wound condition or evaluation of the skin adjacent to the wound. Presence or absence of new epithelium at wound rim. * Risk reduction measures such as use of heel protectors (designed for friction/shear reduction versus pressure reduction), elevation of lower extremities, participation in bowel and bladder program, etc are initiated if determined appropriate. * Discussion with the attending physician and resident/representative includes notification of any skin impairment identified on admission. * Orders are verified or obtained as needed. * An admission/interim/baseline care plan is developed. * Assessments and interventions implemented are documented in the resident clinical record. 1. R1 is a [AGE] years old admitted to the facility on [DATE] with diagnoses which include Pneumonia due to Covid 19, acute respiratory failure with hypoxia, diabetes mellitus, dehydration, metabolic encephalopathy, right below knee amputation, hypertension, peripheral vascular disease, obesity and multiple sclerosis. The hospital after visit summary dated 9/14/21 for coccyx pressure injury dated 9/14/21 documents Stage 2, wound bed granulated, pink, wound status is improving, topical agent is barrier cream with zinc and wound dressing is foam with border dressing. There are no hospital measurements documented on 9/14/21. The facility's admission nursing evaluation dated 9/14/21 under the skin integrity section yes is answered for the question does the resident have skin integrity concerns. Under site documents 23) Coccyx & Description documents stage 2. A second site is documented as 50) Left heel & Description documents stage 2. There are no measurements of R1's pressure injuries, no description of the wound bed and no treatment initiated. This evaluation was completed by Wound Nurse LPN (Licensed Practical Nurse)-M. There was no treatment ordered for R1's coccyx or left heel pressure injuries on 9/14/21 and the pressure injuries were not assessed by an RN (Registered Nurse). Surveyor noted R1's left heel pressure injury healed on 9/21/21. The baseline potential for impairment to skin integrity care plan initiated 9/14/21 has the following interventions, all dated 9/14/21, of: * Apply barrier cream per facility protocol to help protect skin from excess moisture. * Encourage activity as tolerated. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Encourage good nutrition and hydration in order to promote healthier skin. * Ensure proper fitting footwear. * Monitor skin when providing cares, notify nurse of any changes in skin appearance. * Pressure reduction bed mattress. R1's September TAR (treatment administration record) includes with an order date of 9/14/21 Barrier cream apply after incontinent episodes as needed per nursing judgement as needed for skin protective ointment. Surveyor noted there are no initials as this treatment being applied anytime during September. The nurses note dated 9/15/21 documents Resident PAD (post admission day) #1, post covid pneumonia and respiratory failure. Resident is alert, but staff has to anticipate Residents needs. VSS (vital signs stable). Skin warm and dry. Resident needs assistance with feeding. Resident on continuous O2 (oxygen). Resident incontinent of bowel and bladder. Will continue to monitor. The nurses note dated 9/16/21 documents, Guest seem to be resting well but, awake for the most part. Guest has an OA (open area) on her buttocks and the area as (sic was) cleansed per order. Surveyor attempted to speak to with LPN-W on 12/6/21 who wrote this note as there is no physician order for R1's wound care and there is no documented treatment on the September TAR (treatment administration record) until 9/21/21 Surveyor was unable to leave a message on LPN-W's phone as the mailbox was full. The wound assessment dated [DATE] documents site as Coccyx, clinical stage is Unstageable The length is 1.5 cm (centimeters), width 0.60 cm and depth 0.10. The tissue type is documented as 100% pale pink non granulating. Exudate is scant serosanguineous. This assessment was completed by RN (Registered Nurse)/Prior Wound Nurse-V who is no longer employed at the Facility. A treatment was not started until 5 days later on 9/21/21 when R1's coccyx pressure injury had declined to unstageable. The potential for impairment to skin integrity care plan initiated 9/20/21 has the same interventions dated 9/20/21 as the baseline potential for impairment to skin integrity care plan initiated on 9/14/21. The actual impairment to skin integrity care plan initiated 9/20/21 documents the following interventions: * Encourage good nutrition and hydration in order to promote healthier skin. Initiated 9/20/21. * Nurse to assess/record/monitor wound healing with dressing changes. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements or declines to MD (medical doctor). Initiated 9/20/21. * Use a draw sheet or lifting device to move resident. Initiated 9/20/21. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, by wound nurse or provider. Initiated 9/20/21. * Low Air Loss Mattress - ensure functioning properly. Initiated 9/23/21. The CNA (Certified Nursing Assistant) kardex printed on 12/7/21 under bed mobility documents * Bed Mobility: Physical Assist. Under the skin section documents * Low Air Loss Mattress - ensure functioning properly. The skin/wound note dated 9/21/21 documents Writer and wound NP (nurse practitioner) to see guest. Guest just received a bed bath upon arrival. Guest is laying is (sic in) bed on right side. Guest does not verbally respond when asked if she has any pain, fever or chills at this time. Guest does not seem to be in any distress at this time. Wound care provided. Treatment plan in place. Guest is laying in bed positioned on the left side upon departure with call light within reach. Guest has heel protecting boot in place and pillows for positioning. This note was written by RN/Prior Wound Nurse-V who is no longer employed at the Facility. Wound Care NP-X is no longer at the Facility. The wound assessment completed by RN/Prior Wound Nurse-V dated 9/21/21 documents site as Coccyx, clinical stage is Unstageable The length is 7.5 cm, width 7.00 cm and depth unknown. The tissue type is documented as 90% non blanchable erythema and 10% pale pink non granulating. Exudate is scant serosanguineous. Wound Care NP-X note dated 9/21/21 includes documentation of Sacral deep tissue injury unstageable. The area measures 7.5 cm x (times) 7.0 cm by less than 0.1 cm unstageable. There is a small area that is with pink tissue with 90% remainder of the tissue as deep purple in color or necrotic. No peri wound erythema present. Minimal to moderate serosanguineous drainage is present. Status-patient did have an area present on admission however now with deep tissue injury. Plan cover with a border foam and change every day. Patient will get an alternating pressure reducing mattress. Will ensure that the patient is wearing her left heel offloading boot. And also she has a pressure reducing cushion for in the wheelchair. Every 2 hours. Keep the area clean and dry. Reposition frequently. Surveyor noted the treatment of border foam is 5 days after R1's coccyx pressure injury was identified as being unstageable. R1's actual skin impairment care plan was not revised until 9/23/21, two days later. Review of R1's September TAR (treatment administration record) reveals the border foam dressing is not initialed as being completed on 9/24/21. On 12/6/21 at 4:03 p.m. Surveyor called LPN-FF to inquire if she completed R1's treatment on 9/24/21. Surveyor left a message on LPN-FF's phone asking for a return call. LPN-FF did not return Surveyor's call. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The admission MDS (Minimum Data Set) with an assessment reference date of 9/21/21 documents a BIMS (brief interview mental status) score of 3 which indicates severely impaired. R1 is coded as not having any behavior including not refusing care. R1 requires extensive assistance with two plus person for bed mobility, is dependent with two plus person physical assist for transfer, doesn't ambulate, is dependent with one person physical assist for toilet use and requires extensive assistance with one person physical assist for eating. Yes is checked for indwelling catheter and R1 is coded as always continent of bowel. R1 is at risk for pressure injury development and is coded as having one unstageable slough and or eschar present on admission. Surveyor noted R1's admission evaluation dated 9/14/21 documents Stage 2. R1's September TAR starting on 9/22/21 indicates R1 should be repositioned every 2 hours for wound care. On 9/25/21 R1 had an unwitnessed fall. R1 hit her head on the floor and sustained a large hematoma above the let eye. R1 was transferred to the hospital and returned on 9/26/21 with an order for an antibiotic due to pneumonia. Surveyor did not note a skin assessment completed when R1 returned on 9/26/21. The pressure ulcer/injury CAA (care area assessment) dated 9/27/21 for analysis of findings under nature of the problem/condition documents 63 y/o (year old) female admitted for short term rehab after recent hospital stay for COVID-19 (9/1/21) with pneumonia and respiratory failure, sepsis, catheter-related UTI (urinary tract infection), dehydration, metabolic encephalopathy. Will need PT, OT, ST (physical therapy, occupational therapy, speech therapy); Other medical hx (history): cavitary lung lesion, PVD (peripheral vascular disease), GERD (gastroesophageal reflux disease), chronic pain, anemia, OSA (obstructive sleep apnea), OA (open area), endometrial cancer, right BKA (below knee amputation), HTN (hypertension), hx (history of) PE/DVT (pulmonary embolism/deep vein thrombosis), HLD (hyperlipidemia), colon polyp, insomnia, constipation, gastric bypass, lumbar stenosis/DDD (degenerative disc disease), MS (multiple sclerosis), seizures, sinusitis, latent TB (pulmonary tuberculosis) lung, CAD (coronary artery disease). The ADL (activity daily living) CAA triggered because [R1] has pressure injury to her coccyx/left heel and needs limited to extensive assistance with ADL's mobility and B & B (bowel and bladder) management. [R1] is at risk for additional pressure injury and skin breakdown. The plan is for nursing to monitor her skin integrity with appropriate treatments. The goal is for [R1] to remain free of additional skin breakdown with optimal healing of the left heel and coccyx areas while participating in therapy to regain her strength and return to the community at PLOF (prior level of functioning) (A) (assist). Will proceed to care plan. The NP note dated 9/27/21 under review of systems for skin documents Positive for color change (Bruising and contusion to left forehead) and wound (Pressure ulcer to sacrum). Negative for rash. There is no assessment of R1's pressure injury in this NP note. The Braden assessments dated 9/28/21, 10/4/21, & 10/12/21 all have a score of 14 which indicates moderate risk. The wound assessment completed by RN/Prior Wound Nurse-V dated 9/28/21 documents site as Coccyx, clinical stage is Unstageable The length is 8.5 cm, width 7.00 cm and depth unknown. The tissue type is documented as 50% slough white fibrinous and 50% necrotic hard, firm, adherent. Exudate is none. There was no revision in R1's actual skin integrity care plan. (continued on next page)

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	525730	A. Building B. Wing	12/15/2021

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound Care NP-X note dated 9/28/21 includes documentation of Sacral deep tissue injury unstageable. The area measures 8.5 cm x 5.7 cm x 0.1 unstageable. Malodorous today. Scant purulent drainage. No peri wound erythema 50% dry eschar to the wound bed 50% yellow nonviable tissue. No overt signs or symptoms of infection. Status-declined. Plan: Wash the area with dermal wound cleanser and pat dry. Place silver alginate to the base of the wound, followed by a large border foam to cover the area. Change every day and as needed. Follow-up in 1 week for recheck. The previous alternating pressure air mattress was removed because patient did fall out of bed. Will discuss with the wound nurse the possibility of reissuing the alternating air pressure given that the wound has declined. The wound nurse will get her a bariatric pressure reducing mattress to help reduce the potential of falling out of bed. The skin/wound note dated 9/28/21 documents Writer and wound NP to see guest. Guest laying in bed upon arrival. Guest does not verbally respond when asked does she have any pain, fever, or chills at this time. Guest does not seem to be any (sic in) any distress or pain at this time. Wound care provided. Air mattress replaced. Heel protecting boot in place. Guest provided with pillows for support. Floor mat in place. Staff educated on turning and repositioning schedule and proper positioning. Treatment in place. This note was written by RN/Prior Wound Nurse-V who is no longer employed at the Facility. R1's September TAR for treatment of cleanse wound with mild soap & water, pat dry, apply silver calcium alginate to base of wound and apply silicone border foam dressing daily & prn (as needed) is not initialed as being completed on 9/29/21 & 9/30/21. The nurses note dated 9/29/21 documents Writer updated [name of telehealth] MD (medical doctor) [name of physician] on lab results for 9/28/21. NOR (new order received) for Protein shakes BID (twice daily). Surveyor noted the 9/28/21 comprehensive metabolic panel includes albumin with a low result of 2.5. The reference range is 3.4-4.8 gm/dl (grams/deciliter). The skin/wound note dated 10/1/21 documents Writer to see guest. Guest laying in bed. Guest denies any fever, pain or chills at this time. Wound NP contacted. New treatment plan in place. Guest bed in lowest position, call light within reach upon departure. This note was written by RN/Prior Wound Nurse-V. There is no documented assessment of the wound bed or measurements of R1's coccyx pressure injury on this date. The new treatment ordered on 10/1/21 was cleanse wound with mild soap and water. Pat dry. Medihoney to base of wound. Apply to base of wound. Apply silicone boarder foam dressing daily and prn. R1's October TAR for the treatment of cleanse wound with mild soap and water, pat dry, medihoney to base of wound, and apply silicone border foam dressing daily & prn is not initialed as being completed on 10/3/21 & 10/5/21. The nurses responsible for the treatment on 10/3/21 & 10/5/21 are no longer employed at the Facility. The wound assessment completed by RN/Prior Wound Nurse-V dated 10/5/21 documents site as Coccyx, clinical stage is Unstageable The length is 9.2 cm, width 7.00 cm and depth unknown. The tissue type is documented as 10% slough white fibrinous and 90% necrotic hard, firm, adherent. Exudate is none. There was no revision in R1's actual skin integrity care plan. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound Care NP-X note dated 10/5/21 includes documentation of Sacral deep tissue injury unstageable. The area measures 9.2 cm x 7.0 cm x 0.1 cm unstageable. Malodorous today. Copious amount of drainage today, serosanguineous drainage preset. 90 percent eschar 10 granular around the edges. No peri wound erythema present no overt signs or symptoms of infection. Alternating pressure mattress will be moved from previous room to current room. Status- declined. Plan: Interventionist to move the air mattress from her previous room to the current room. Position patient every 2 hours. Wheelchair cushion when up patient is on a pressure reducing mattress bed today. Wash area with dermal wound cleanser, pat dry. Place Santyl to the base of the wound follow by border foam. The skin/wound note dated 10/5/21 documents Writer and wound NP to see guest. Guest in bed upon arrival. Guest denies any pain at this time. Guest will be placed back on alternating air mattress. Wound care provided. Guest does not have a fever at this time. treatment plan in place. Guest bed in lowest position with call light within reach upon departure. This note was written by RN/Prior Wound Nurse-V who is no longer employed at the Facility. R1's October TAR for the treatment of cleanse wound with mild soap and water, pat dry, Santyl to base of wound, and apply silicone border foam dressing daily & prn is not initialed as being completed on 10/6/21, 10/7/21 & 10/9/21. The nurse on 10/7/21 is no longer employed at the Facility. See interview below with LPN-S for 10/6/21 & 10/9/21. The NP note dated 10/8/21 under review of systems for skin documents Positive for color change (Bruising and contusion to left forehead) and wound (Pressure ulcer to sacrum). Negative for rash. There is no assessment of R1's pressure injury in this NP note. The nurses note dated 10/10/21 documents VSS throughout the shift. Wound care and [name of telehealth company] aware of bottom wound drainage. The NP note dated 10/11/21 under review of systems for skin documents Positive for color change (Bruising and contusion to left forehead) and wound (Pressure ulcer to sacrum). Negative for rash. There is no assessment of R1's pressure injury in this NP note. The wound assessment completed by RN/Prior Wound Nurse-V dated 10/12/21 documents site as Coccyx, clinical stage is Unstageable The length is 9.5 cm, width 6.2 cm and depth 3.00 cm. The tissue type is documented as Bright pink or red 10% Necrotic Hard, firm, adherent 90%. Exudate is Moderate, Purulent. There is no assessment from Wound Care NP-X on 10/12/21 in R1's medical record. The skin/wound note dated 10/12/21 documents Writer and Wound NP to see guest. Guest in bed upon arrival. Guest VSS. Guest wound decline. Daughter and husband notified. Attending NP notified. [Name of ambulance company] contacted for transport to [name of hospital] ER (emergency room). ER updated on guest arrival. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The emergency department provider note dated 10/12/21 at 12:08 p.m. under history of present illness documents [R1] is a [AGE] year old female with a hx (history) of right lower extremity amputation below the knee who presents to the ED (emergency department) for evaluation of a bedsore. There are no further complaints or modifying factors at this time. Under physical exam for skin documents General: Skin is warm and dry. Findings: No erythema. Comments 10 cm (centimeter) by 10 cm necrotic wound of sacral area Serous drainage from the bottom aspect. Under radiology results for CT abdomen pelvis with contrast (final result) under impression documents 1. A decubitus ulcer overlies the coccyx and extends deep to the surface of the coccyx where focal osseous destruction compatible with osteomyelitis involves the fist coccygeal segment. 2. Extending laterally and caudally from the decubitus ulcer is extensive soft tissue gas and a large abscess within the right gluteus maximus muscle measuring approximately 4.5 x (times) 3 x 8 cm. The differential diagnosis for the gas extending into the regional subcutaneous tissues includes necrotizing fascitis. The final diagnosis is documented as Necrotizing fasciitis. On 12/2/21 at 1:06 p.m. Surveyor asked WN (Wound Nurse)/LPN (Licensed Practical Nurse)-M about her role as wound nurse when R1 was admitted . WN/LPN-M explained she was floor nurse and in mid October she was promoted to weekend supervisor. WN/LPN-M informed Surveyor the same week she was promoted RN/Prior Wound Nurse-V walked out and she was asked to cover wound rounds the next day. WN/LPN-M informed Surveyor she kind of kept doing wound rounds. Surveyor inquired about the admission nursing evaluation dated 9/14/21 which WN/LPN-M completed. WN/LPN-M explained the floor nurses complete the admission nursing evaluation and what is entered under the skin assessment automatically goes into wound rounds which is triggered for the wound nurse. Surveyor asked if she visualized R1's pressure injuries. WN/LPN-M informed Surveyor she did. Surveyor informed WN/LPN-M Surveyor did not note any measurements or assessment of the wound bed. WN/LPN-M informed Surveyor she typically doesn't do this and explained the wound nurse would follow up with measurements. WN/LPN-M informed Surveyor the wound nurse would go back, assess and start the treatment. Surveyor asked who would revise the skin integrity care plan. WN/LPN-M informed Surveyor the wound nurse would be responsible for this care plan and the nurse managers update the other care plans. On 12/6/21 at 8:19 a.m. Surveyor asked DON-B if she could provide Surveyor with a timeline of when R1 received an air mattress and when it was changed. DON-B informed Surveyor she would get back to Surveyor. On 12/6/21 at 8:45 a.m. Surveyor asked CNA-Y if she remembered R1. After showing CNA-Y a picture of R1 in the computer, CNA-Y informed Surveyors she worked with R1. CNA-Y informed Surveyor R1 didn't receive a shower but a bed bath. CNA-Y informed Surveyor she was the shower aide when R1 was at the Facility. CNA-Y informed Surveyor she used to help feed her, combed her hair, and placed creams on her body. Surveyor asked if she helped reposition R1. CNA-Y replied yes. Surveyor asked how often. CNA-Y informed Surveyor every two hours. On 12/6/21 at 10:03 a.m. Surveyor asked DON-B who is responsible for revising care plans. DON-B informed Surveyor any of the nurses, managers and MDS does care plans as well. DON-B informed Surveyor for skin integrity care plans the wound nurse would be responsible for revising these. Surveyor informed DON-B R1 was admitted on [DATE] and Wound nurse LPN-M completed the admission nursing evaluation. Surveyor inquired when would a RN assess R1's pressure injury. DON-B informed Surveyor an RN would look at the evaluation within 24 hours to verify the assessment is correct. Surveyor inquired where the RN assessment could be found. DON-B informed Surveyor may be in the progress note and they are pretty much verifying the assessment is correct. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/6/21 at 12:34 p.m. Surveyor informed DON-B R1's 10/10/21 nurses note indicates [name of telehealth company] was notified of R1's wound drainage but Surveyor was unable to locate a note from the telehealth doctor. Surveyor asked if there is a note from [name of telehealth company]. DON-B informed Surveyor she will look into this and get back to Surveyor. Surveyor asked for the education provided which is referenced in Prior Wound Nurse/RN-V's 9/28/21 skin/wound note. On 12/6/21 at 2:33 p.m. Surveyor asked DON-B when a Resident goes to the hospital do they complete a skin assessment upon their return. DON-B informed Surveyor if a resident is not in the hospital for 24 hours then they would not do a skin assessment upon their return. On 12/6/21 at 3:47 p.m. DON-B informed Surveyor she could not find a note from [name of telehealth doctor] and will look in her email. Surveyor informed DON-B R1's actual skin impairment care plan includes an intervention of nurse to assess/record/monitor wound healing with dressing changes. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements or declines to MD. Surveyor asked where this documentation could be located. DON-B informed Surveyor it's the weekly assessment. Surveyor informed DON-B this intervention is in regards to dressing change. DON-B informed Surveyor she was not able to locate any education sheets and isn't sure what Prior Wound Nurse/RN-V educated staff on. On 12/7/21 at 7:51 a.m. Surveyor asked CNA (Certified Nursing Assistant)-EE if she remembered R1. CNA-EE informed Surveyor she does remember R1 but didn't really help her as she is in the front line up. CNA-EE informed Surveyor if someone needed help she would assist and thinks R1 was a feeder. CNA-EE informed Surveyor she doesn't remember R1 getting out of bed and informed Surveyor there's a lot of Residents that come and go. Surveyor asked CNA-EE if she remembers R1 refusing anything. CNA-EE informed Surveyor she wouldn't eat sometimes and didn't think she talked very much. CNA-EE informed Surveyor she did have to help reposition R1 but doesn't know if R1 was a reposition every two hours. On 12/7/21 at 7:51 a.m. Surveyor informed LPN-S, Surveyor had noted the 10/10/21 nurses note she wrote about R1's wound drainage and asked if she could explain about the drainage. LPN-S informed Surveyor she remembers R1 had a wound on her bottom, doesn't remember everything exactly and knows the wound was cultured. Surveyor asked when a culture was taken for R1's pressure injury. LPN-S informed Surveyor she doesn't remember. Surveyor asked LPN-S if she spoke with someone at [name of telehealth company] or did she have to leave a message and if she left a message did [name of telehealth company] get back to her. LPN-S informed Surveyor all she remembers is the wound culture and she told the wound nurse about it. Surveyor asked LPN-S if she knew why R1's coccyx pressure injury declined. LPN-S informed Surveyor she didn't know. Surveyor informed LPN-S she was the nurse on duty responsible for R1's pressure injury treatment on 9/30/21, 10/6/21, & 10/9/21. Surveyor informed LPN-S the treatment is not initialed as being completed on these dates and asked if she remembers doing the treatment. LPN-S informed Surveyor she knows she did treatments but doesn't know about these dates. On 12/7/21 at 8:08 a.m. Surveyor asked LPN-AA if she remembers R1. LPN-AA replied no. Surveyor informed LPN-AA Surveyor was going to ask her if she completed R1's treatment on 9/29/21. LPN-AA replied Sorry, I don't remember her. On 12/7/21 at 8:25 a.m. Surveyor asked LPN-T if she remembers R1. LPN-T informed Surveyor the name sounds familiar then looked at R1's picture in the computer. LPN-T informed Surveyor she took care of R1 a couple of times. LPN-T informed Surveyor she remembers R1 was a feeder and didn't talk much. Surveyor asked if R1 refused to be repositioned. L [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on Observations, Record Review and Interview, the facility did not conduct thorough and complete fall investigations for 3 of 4 residents reviewed for accidents. *R18 has sustained multiple falls while residing at the facility. The facility did not conduct thorough and complete fall investigations for R18's falls including witness statements and staff interviews to determine whether or not previous care planned fall interventions were in place at the time of the fall and to conduct a root cause analysis of the fall. *R10 sustained 2 falls while residing at facility. The facility did not conduct thorough and complete fall investigations for R10's falls and did not determine whether or not previous fall interventions were in place for R10 at the time of the fall and to conduct a root cause analysis of the fall. *R1 sustained a fall at the facility on 9/25/21. The facility did not conduct a thorough and complete fall investigation for R1 and determine whether or not previous fall interventions were in place at the time of the fall and to conduct a root cause analysis of the fall. Findings include: The Facility's Post-Fall Policy dated November 2020 reads: Policy: Each resident residing at this facility will be provided services and care that ensures that the residents environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility and after every fall in the facility. Each resident of this facility who experiences a fall will be treated and assessed to adequately treat any current injuries, either physical or psychosocial, and comprehensively assessed to determine causal effects of the fall to develop interventions to prevent further falls. 1. R18 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis affected right dominant side, need for assistance with personal care, muscle wasting and atrophy. R18's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/28/21 indicates R18's BIMS (Brief Interview for Mental Status) score of 00, which indicates R18 is severely compromised with the ability to make daily decisions. R18's Admission MDS indicates R18 requires extensive assistance of 2 staff members with bed mobility and transfers. R18 was noted with sustaining 2 or more falls during the seven days following admission to the facility. A fall risk score of 22 was noted on 10/21/21 indicating R18 to be at high risk for falls. The MDS indicates R18 has unclear speech, sometimes understands and is sometimes able to make self understood. R18's EMR (Electronic Medical Record) was reviewed including clinical progress notes, physician orders, comprehensive care plans and fall risk assessments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Risk for fall care plan with an initiation date of 10/22/21 lists the following interventions: Follow facility fall protocol, Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure footwear fits properly, ensure bed brakes are locked. Anticipate and meet the resident's needs. On 12/6/21 at 10:00 AM, Surveyor requested information regarding any of R18's falls from 10/21/21 to 12/6/21 including incident reports with thorough fall investigations, including staff interviews and root cause analysis. Surveyor received copies of incident reports related to R8's falls on 10/22/21, 10/23/21, 10/24/21 (2 falls sustained), 10/26/21, 11/18/21, 11/21/21, 11/26/21, and 12/3/21. On 10/22/21 at 3:56 AM, R18 was observed on the floor next to their bed. Facility fall investigation indicates that R18 had been seen in bed approximately 45 minutes prior to being observed on the floor. R18 did not sustain any injuries. A new intervention was added to R18's care plan on 10/24/21 to educate on importance of using call light for all needs. Surveyor could not locate any witness statements and/or staff interviews related to R18's observation on the floor from 10/22/21. The facility's investigation does not address whether the fall care planned interventions had been in place upon the discovery of R18 on the floor such as whether R18's call light was within reach and whether R18 had been able to activate the call light, whether the bed brakes were locked, whether R18 was incontinent, when the last time R18 had been toileted, etc. The facility did not complete a root cause analysis. On 10/23/21 at 11:17 PM, R18 was observed on the floor next to their bed. Facility fall investigation indicates that R18 had been seen in bed approximately 30 minutes prior to being observed on the floor. R18 did not sustain any injuries. A new intervention was added to R18's care plan on 11/2/21 for resident to be positioned to middle of bed on staff rounds. Surveyor could not locate any witness statements and/or staff interviews related to R18's observation on the floor from 10/23/21. The facility's investigation does not address whether the fall care planned interventions had been in place upon the discovery of R18 on the floor such as whether R18's call light was within reach and whether R18 had been able to activate the call light, whether the bed brakes were locked, whether R18 was incontinent, when the last time R18 had been toileted, etc. The facility did not complete a root cause analysis of the fall. On 10/24/21 at 6:14 AM, R18 was observed on the floor next to their bed. Facility fall investigation indicates that R18 had been seen in bed approximately 1 hour prior to being observed on the floor sleeping. R18 was incontinent of bladder when they were discovered on the floor on 10/24/21. R18 did not sustain any injuries. A new intervention was added to R18's care plan on 11/2/21 for staff to offer resident early AM cares. Surveyor could not locate any interviews related to R18's unwitnessed fall from 10/24/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/21 at 8:37 AM, R18 was observed by a staff member sliding out of a wheelchair in the dining room. R18 was incontinent of bladder when they had slid out of their wheelchair in the dining room on 10/24/21. R18 did not sustain any injuries. A new intervention was added to R18's care plan on 11/2/21 for resident to have all items within reach when up with early cares and for staff to be present if R18 in common area. Surveyor could not locate any witness statements or interviews related to R18's witnessed fall on 10/24/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. On 10/26/21 at 1:55 AM, R18 was observed by staff sliding from bed to floor landing on their buttocks. R18 was incontinent of bladder at this time. R18 did not sustain any injuries. A new intervention was added to R18's care plan on 11/2/21 for resident to have pillows define borders of bed for safety. Surveyor could not locate any witness statements or interviews related to R18's witnessed fall on 10/26/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. On 11/18/21 at 10:48 AM, R18 was observed by staff lying face down on their bedroom floor after attempting to go to the bathroom. R18 did not sustain any injuries. A new intervention was added to R18's care plan on 11/19/21 for Staff to offer R18 toileting after meals. Surveyor could not locate any witness statements or interviews related to R18's witnessed fall on 11/18/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. On 11/21/21 at 1:00 PM, R18 was observed kneeling next to their bed on the floor. R18 sustained abrasions to both right and left knees related to their fall. R18 had been seen approximately 20 minutes prior to being observed kneeling on the floor. An intervention was added to R18's care plan on 11/23/21 for placement of a floor mat. Surveyor had noted in previous fall investigations that R18 had already had a floor mat in place next to their bed. Surveyor could not locate any witness statements or interviews related to R18's unwitnessed fall on 11/21/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. R18's fall care plan indicates R18 sustained an unwitnessed fall on 11/22/21. R18's fall care plan was updated on 11/23/21 indicating that an early sense bed monitoring system was initiated after R18's unwitnessed fall on 11/22/21. Surveyor was unable to locate an incident report for this fall including any staff interviews for R18's unwitnessed fall on 11/22/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. (continued on next page)

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	525730	A. Building B. Wing	12/15/2021

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Medical Suites at Oak Creek (the)	2700 Honadel Boulevard Oak Creek, WI 53154

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/26/21 at 8:32 PM, R18 was observed sitting on the floor in front of their wheelchair in their bedroom. R18 did not sustain any injuries. R18 had been seen approximately 1 hour and 30 minutes prior to being observed on the floor. Incident report indicates new intervention of staff assisting R18 with nightly rituals, to be toileted prior to bed and have all items within reach. R18's fall care plan was not updated to reflect these interventions from R18's 11/26/21 fall. R18's fall care plan had previously been updated to reflect the implementation of keeping R18's personal items within reach from R18's 10/24/21 fall. Surveyor could not locate any staff interviews related to R18's unwitnessed fall on 11/26/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. On 12/3/21 at 8:45 PM, R18 was observed lying on the floor on their left side several feet from their bed. R18 d id not sustain any injuries. R18 had been seen approximately 1 hour and 30 minutes prior to being observed on the floor. R18's fall care plan was updated on 12/5/21 for Visual Signage to deter resident from attempting to get up without assist. Surveyor could not locate any witness statements or interviews related to R18's unwitnessed fall on 12/3/21. The facility's investigation did not address whether previous care planned interventions had been implmented. The facility did not compelte a root cause analysis of the fall. On 12/7/21 at 9:20 AM, Surveyor conducted interview with Director of Nursing (DON)-B. DON-B told Surveyor that they are in charge of conducting fall investigations for the facility. Surveyor asked DON-B why individual staff interviews and/or witness statements are not being conducted as part of the facility's fall investigation. DON-B responded that they interview staff members over the phone and summarize the information that they learn from staff as part of their investigative process. DON-B added that they think in the future when they investigate falls that they will conduct individual staff witness statements to aid fall investigations and be more through. Surveyor asked DON-B who is in charge of updating resident care plans. DON-B responded that MDS nurses initiate care plans and unit managers or nursing staff would update care plans with any changes. Surveyor asked DON-B why R18's fall care plan interventions are not being updated immediately after R18 has a fall. DON-B told Surveyor that they had input some of the interventions in at a later date because they had been out of the facility and that they like to update the care plans so that they stay organized and neat looking. Surveyor asked DON-B why there was not a fall investigation noted for R18's unwitnessed fall on 11/22/21. DON-B said they will have to look for this information. Surveyor noted without complete thorough investigations into R18's falls and identifying root cause analysis, it will be difficutly for the facility to determine the effectivness of current fall precaution interventions and to develop ongoing effective interventions to prevent the potential for further falls. Surveyor asked how staff are made aware of changes to resident care plans and updated fall interventions. DON-B said that they would need to get back to Surveyor with additional information. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/7/21 at 10:50 AM, Surveyor asked NHA-A if there was any additional information related to R18's falls, including thorough and complete fall investigations with witness statements and staff interviews. NHA-A did not have any further information to share at this time. 2. R10 was admitted to the facility on [DATE] with diagnoses of Encephalopathy, Congestive Heart Failure and Debility. R10 discharged from the facility on 11/6/21. R10's Admission Minimum Data Set (MDS) indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating that R10 is cognitively intact for daily decision making. R10 required extensive assistance of staff with bed mobility, transfers, dressing toileting and bathing. R10 required use of a wheelchair for mobility due to weakness. R10's Risk for fall care plan with an intiaited date of 10/18/21 contained the following interventions: .Follow facility fall protocol, Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure footwear fits properly, ensure bed brakes are locked. Anticipate and meet the resident's needs. On 12/1/21 at 10:33 AM, Surveyor requested information regarding any of R10's falls from 10/26/21 to 11/6/21 including incident reports with thorough fall investigations, including staff interviews and root cause analysis. R10 sustained unwitnessed falls on 10/31/21 and 11/5/21. On 10/31/21 at 1:15 AM, R10 was found on floor in front of recliner chair after an unwitnessed fall. R10 was not wearing appropriate footwear at this time. Staff had noted R10 in recliner chair approximately 1 hour prior to being discovered on floor. On 11/1/21, R10's care plan was updated to initiate intervention to encourage R10 to wear gripper socks. Surveyor did not note a thorough fall investigation including staff interiews. The Facility did not conduct a thorough investigation of R10's fall as there are no other staff statements as to when R1 was last seen prior to the fall, when she was last provided cares, etc. The Facility did not determine the root cause of R10's fall and did not determine if previous care plan interventions were in place. On 11/5/21 at 3:06 AM, R10 was found on floor in front of bed after an unwitnessed fall. R10 sustained a skin tear to the right hand. Staff had noted R10 in bed approximately 1 hour prior to being discovered on floor. Surveyor did not note a thorough fall investigation including individual staff statements. On 11/5/21, R10's care plan was updated to initiate intervention for staff to apply pillows to define bed borders. The Facility did not conduct a thorough investigation of R10's fall as there are no other staff statements as to when R1 was last seen prior to the fall, when she was last provided cares, etc. The Facility did not determine the root cause of R1's fall and did not determine if previous care plan interventions were in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/7/21 at 9:20 AM, Surveyor conducted interview with Director of Nursing (DON)-B. DON-B told Surveyor that they are in charge of conducting fall investigations for the facility. Surveyor asked DON-B why individual staff interviews are not being conducted as part of the facility's fall investigation. DON-B responded that they interview staff members over the phone and summarize the information that they learn from staff as part of their investigative process. DON-B added that they think in the future when they investigate falls that they will conduct individual staff statements to aid fall investigations and be more through. On 12/7/21 at 10:50 AM, Surveyor asked NHA-A if there was any additional information related to R18's falls, including thorough and complete fall investigations with witness statements. NHA-A did not have any further information to share at this time. 20483 3. R1 was admitted to the facility on [DATE] and discharged on [DATE]. The fall risk evaluation dated 9/14/21 has a score of 16 which indicates high risk. The at risk for falls care plan initiated 9/20/21 has the following interventions: * 9/25/21 intervention: Bed in lowest position with mats to both sides. Initiated 9/28/21, * Anticipate and meet the resident's needs. Initiated 9/20/21. * Ensure bed brakes are locked. Initiated 9/20/21. * Ensure footwear fits properly Initiated 9/20/21. * Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. There resident needs prompt response to all requests for assistance. Initiated 9/20/21. * Follow facility fall protocol. Initiated 9/20/21. The CNA (Certified Nursing Assistant) kardex printed on 12/7/21 under safety documents * 9/25/21 intervention: Bed in lowest position with mats to both sides. *Seizure precautions: Do not leave resident alone during a seizure, Protect from injury, If resident is out of bed, help to the floor to prevent injury Remove or loosen tight clothing, Don't attempt to restrain resident during a seizure as this could make the convulsions more severe, Protect from onlookers, draw curtain etc. The admission MDS (minimum data set) with an assessment reference date of 9/21/21 documents a BIMS (brief interview mental status) score of 3 which indicates severely impaired. R1 requires extensive assistance with two plus person for bed mobility, is dependent with two plus person physical assist for transfer, doesn't ambulate and is dependent with one person physical assist for toilet use. R1 is coded as not having any falls since admission. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 9/25/21 documents Resident had un-witnessed fall. Resident hit her head on the floor. Resident has large hematoma above left eye. VSS (vital signs stable). Resident is alert. [Name of telehealth] doctor notified and Dr. evaluated her via face call. New orders to send Resident out 911. Case manager called and message left regarding fall and going to hospital. The telehealth evaluation note dated 9/25/21 documents under primary chief complaint documents Fall with head injury. Under history of present illness documents Staff reports patient was sitting up in the bed, leaning to the left, and a few minutes later patient was found on the floor by the staff, unwitnessed fall and patient noted to have a head injury with swelling on the left forehead above the eye, swelling appears to be increased since she is transferred on to the bed and patient barely opening eye, Patient is on Xarelto and ASA (aspirin) per chart review and staff. Under orders documents Transfer to ED (emergency department) for evaluation and management with immediate CT scan to r/o (rule out) ICH (intracerebral brain hemorrhage). The nurses note dated 9/25/21 documents Resident sent out to [name of hospital]. Spoke with [name of daughter] updated regarding situation. The nurses note dated 9/26/21 documents Resident returned from the hospital with ABT (antibiotic) for pneumonia. CT and x-rays negative. Resident is alert. Staff to anticipate Resident's needs. Resident has hematoma above left eye. VSS (vital signs stable), Neuro check negative. Resident at baseline. Spoke with Pharmacist [name], okay to start Resident on ABT for pneumonia. No allergies noted. The falls CAA (care area assessment) dated 9/27/21 for analysis of findings under nature of the problem/condition documents 63 y/o (year old) female admitted for short term rehab after recent hospital stay for COVID-19 (9/1/21) with pneumonia and respiratory failure, sepsis, catheter-related UTI (urinary tract infection), dehydration, metabolic encephalopathy. Will need PT, OT, ST (physical therapy, occupational therapy, speech therapy); Other medical hx (history): cavitary lung lesion, PVD (perpherial vascular disease), GERD (gastroesophageal reflux disease), chronic pain, anemia, OSA (obstructive sleep apnea), OA (open area), endometrial cancer, right BKA (below knee amputation), HTN (hypertension), hx (history of) PE/DVT (pulmonary embolism/deep vein thrombosis), HLD (hyperlipidemia), colon polyp, insomnia, constipation, gastric bypass, lumbar stenosis/DDD (degenerative disc disease), MS (multiple sclerosis), seizures, sinusitis, latent TB (pulmonary tuberculosis) lung, CAD (coronary artery disease). The falls CAA triggered because [R1] needs limited to extensive assistance with ADL's (activities daily living), mobility and B & B (bowel and bladder) management. [R1] is at risk for falls with and without injury The plan is for nursing to monitor her safety. The goal is for [R1] to remain free of falls while participating in therapy to regain her strength and return to the community at PLOF (prior level of function) (A) (assist). Will proceed to care plans. On 12/2/21 at 3:14 p.m. during the daily exit meeting Surveyor asked Administrator-A and DON (Director of Nursing)-B for R1's 9/25/21 fall investigation. On 12/6/21 Surveyor reviewed R1's incident report dated 9/25/21 at 19:30 (7:30 p.m.). Under incident description for nursing description documents Resident had unwitnessed fall, Resident on the floor next to bed. For resident description documents Resident unable to give description. Under other info (information) documents Resident has air-mattress, bed elevated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under notes documents IDT (interdisciplinary team) note concerning unwitnessed fall with hematoma noted above the left eye on 9/25/21. Resident was noted to be on the floor in room next to bed. Resident unable to say what she was trying to do at the time of the fall. Resident able to move all extremities without difficulty, no c/o (complaint of) pain or discomfort, and Neuro checks negative at time of fall. MD (medical doctor) aware of the fall and resident being sent to ER (emergency room), Intervention to be put in place r/t (related to) this fall is for bed to be placed in lowest position and to have floor mats placed on both side of be (sic bed) when in bed. Resident/family are aware of interventions put in place. Care plan and kardex have been updated. Along with the incident report is a statement dated 9/26/21 by ADON (Assistant Director of Nursing)-N which documents This writer asked the nurse when her last interaction with resident was prior to the fall. The nurse stated, prior to the fall, she gave the resident her medication and insulin. Resident was last seen eating supper and was in bed at the time. Resident had the call light within reach and has an air mattress. Resident was unable to say what she was trying to do at the time of the fall. Surveyor noted the statement does not indicate what time the nurse saw R1. The Facility did not conduct a thorough investigation of R1's fall as there are no other staff statements as to when R1 was last seen prior to the fall, when she was last provided cares, etc. The Facility did not determine the root cause of R1's fall and did not determine if previous care plan interventions were in place. On 12/6/21 at 3:47 p.m. during the daily exit meeting Surveyor asked Administrator-A and DON-B if there was any additional information regarding R1's 9/25/21 fall. Surveyor was not provided with any additional information.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35720 Based on interview and record review the facility did not ensure a resident received appropriate services to restore bladder continence for 1 (R18) of 1 residents who experienced a decline in bladder function. Findings include: The facility BOWEL AND BLADDER RETRAINING policy and procedure, with a revision date of November 2018, To establish a regularity of bowel and bladder function for the incontinent resident states; 1. An initial bowel and bladder assessment is done all new admissions and updated quarterly thereafter. 2. After the assessment, the Rehab Nurse in conjunction with the Interdisciplinary Team makes a recommendation for a bowel and/or bowel [sic] retraining program. PROCEDURE- BLADDER RETRAINING: .3. Toilet resident every 2-3 hours or as needed .6. Program should be documented on care plan. R18 has diagnoses that include hemiplegia and hemiparesis following cerebral infarction, need for assistance with personal care, muscle wasting and atrophy, and difficulty in walking. R18's Nursing Evaluation (Admit/Readmit, Quarterly, Annual, Significant Change), signed as completed on 10/21/21 under the Bladder/Bowel/Dialysis section documents No to Is the resident continent of bladder? The evaluation documents Unable to Determine Explain: New admit to Does the resident have any of the following symptoms concerns? Burning or pain on urination, increased frequency, dribbling, interrupted stream, difficulty initiating flow, hematuria, recurrent UTIs [urinary tract infection]. The evaluation documents Unable to determine Explain: new admit to Changing characteristics of urine: Cloudy, Foul smelling, Concentrated. Review of R18's record did not contain any other documentation of a bladder assessment. R18's admission Minimum Data Set Assessment (MDS), with an assessment reference date of 10/28/21, documents R18 was occasionally incontinent of urine, and that a toileting program has not been attempted. The assessment documents R18 requires total dependence of 1 persons physical assistance for toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Urine Incontinence Care Area Analysis, signed as completed 10/30/21, documents Nature of the problem/condition: 77 y/o [year old] male admitted for short term rehab after recent hospital stay for right-sided weakness, dysphagia and cognitive deficits following CVA [cerebrovascular accident]. Seizure. Will need PT [physical therapy], OT [occupational therapy], ST [speech therapy]; Other medical hx [history]: HTN [hypertension], DM2 [diabetes mellitus type 2], alcohol abuse, right MCA [middle cerebral artery] stenosis. The urinary incontinence CAA [care area analysis] triggered because [R18] has incontinence and needs limited to extensive assistance with ADL's [activities of daily living], mobility and B&B management. [R18] is at risk for urinary complications including infection and skin breakdown. The plan is for nursing to monitor his urinary status and skin integrity. The goal is for [R18] to remain free of urinary complications and skin breakdown while participating in therapy to regain his strength and return to the community at PLOF [prior level of functioning] (MI). Will proceed to care plans. R18's plan of care includes a focus area for The resident has an ADL self-care performance deficit and limited physical mobility r/t [related to] weakness from recent hospitalization for CVA. initiated 10/22/21. The plan of care includes an intervention for Toileting: Resident requires physical assistance with toileting initiated 10/22/21. The plan of care does not include interventions on promoting R18's continence. R18's bladder continence documentation for 11/7/21-12/6/21 documents R18 being continent 1 time during the 30 day period and incontinent all other days. On 12/6/21 at 4:05 pm the surveyor interviewed ADON (Assistant Director of Nursing)-F. The surveyor asked if somebody comes in occasionally incontinent what things are done to promote their continence. ADON-F stated they would try to come up with a bladder training regimen. On 12/7/21 at 12:31 PM the surveyor interviewed DON (Director of Nursing)-B. DON-B informed the survey bladder assessments are completed by nursing originally upon admission. The surveyor informed DON-B of R18's admission assessment stating unable to determine in areas related to bladder and being unable to find any other bladder assessments. The surveyor informed DON-B of R18 having declined in his urinary continence from being occassionally incontinent of urine on the 10/28/21 MD to being continent of bladder only 1 time in a 30 day period from 11/7/21 to 12/6/21.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not provide dialysis consistent with professional standards of practice for 3 (R2, R3, & R15) of 3 Residents reviewed for dialysis. * R2 was admitted on [DATE] and discharged on [DATE]. While at the Facility R2 did not receive dialysis as ordered. Licensed staff were not monitoring R2's left arm AV fistula for thrill, bruit, and complications such bleeding, hematoma, swelling, pain or redness at site on 11/19/21 & 11/20/21. * R3 admission orders does not include orders for dialysis or monitoring of the access site. On 11/12/21 R3 did not receive dialysis, assessment of the access site or documentation of dressing change. On 11/13/21 R3 was noted to have increase in confusion, calling out after needs were met and was discharged to the hospital. * R15's physician orders did not include orders for dialysis or monitoring of the access site until 12/4/21. R15's medical record does not include documentation of the assessment of R15's access site. Findings include: The Dialysis Protocol policy with revision date of November 2018 under policy documents 1. Dialysis residents will have their pre and post weights completed at dialysis unless otherwise specified. 2. Medications for dialysis residents will be given and/or held based on physician order. 3. Any line dressings for dialysis residents will be done at dialysis unless specifically ordered to be done at the facility. the dressing may, however be reinforced. 4. The dialysis site (permacath) will be checked daily for signs and symptoms of infection or bleeding. 5. The dialysis site (fistula/graft) will be monitored daily for thrill and bruit. 6. For residents with fistulas or grafts, a colored wrist band will be applied on the dialysis arm noting arm precaution. Arm precaution includes no blood pressure on the fistula arm, no IV (intravenous) lines, and no application of pressure on the arm with fistula or graft. 7. Communication with the dialysis center will be done by nursing, dietary and/or social services on a monthly basis. 8. The resident's care plan will reflect their dialysis needs. 1. R2 was admitted to the facility on [DATE] (Thursday) and discharged on [DATE] (Saturday). Diagnoses includes Covid 19, end stage renal disease and dependence on renal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital discharge summary dated 11/18/21 under hospital course documents, 75 yo (year old) female with ESRD (end stage renal disease) on HD (hemodialysis) presented admitted with 2 days of weakness and fall at home. She also has URI (upper respiratory infection) symptoms, cough, and SOB (shortness of breath) and was found to have COVID-19 pneumonia with hypoxia. Patient was treated with Decadron with improvement and will complete a 10 day course She also completed IV (intravenous) abx (antibiotics) for acute UTI (urinary tract infection). She continued on HD MWF (Monday Wednesday Friday). She is not stable on RA (room air). She remains weak and will dc (discharge) to SAR (subacute rehab). She will dc on 2 weeks of Eliquis as per COVID DVT (deep vein thrombosis) prophylaxis protocol and will finish a course of oral steroids. The physician orders include with an order date of 11/18/21 Dialysis M, W, F. The nurses note dated 11/18/21 includes documentation of The guest has Dialysis Monday, Wednesday, and Friday and it has been arranged with in house Dialysis per manager ([ADON (Assistant Director of Nursing)-N]). The nursing evaluation dated 11/18/21 under section I Bladder/Bowel/Dialysis for dialysis yes is answered for the question is the resident receiving dialysis. Type of dialysis documents hemodialysis, frequency of dialysis documents 3 days a week Monday, Wednesday, & Friday. Under clinical/dialysis company documents [Name of prior dialysis company] before being admitted to Ignite Medical Resorts. Scheduled for in house dialysis. Access for hemodialysis documents AV Fistula and location of access documents L (left) arm. Yes is answered for the questions bruit present and thrill present. No is answered for signs symptoms of bleeding, hematoma, swelling, pain or redness at site. During review of R2's medical record there is no evidence licensed nursing staff were monitoring R2's left arm AV fistula for thrill, bruit, and complications such bleeding, hematoma, swelling, pain or redness at site on 11/19/21 & 11/20/21. The physician telehealth evaluation dated 11/20/21 under history of present illness documents 75 yo (year old) woman on HD MWF. Pt (patient) missed her dialysis on Friday (11/19/21) but unclear why. Pt herself does not know why, but per nurse she is very angry and insisting on going to the hospital for dialysis. Under diagnosis, Assessment/Plan documents Missed dialysis yesterday. Pt very angry, does not want to talk to me and insisting on going to the hospital for dialysis. Under disposition documents Transfer to Emergency Department. The nurses note dated 11/20/21 documents Pt sent to [name of hospital] for dialysis per [Telehealth Medical Company] Pt. stated that she has not gone to dialysis since Wednesday. The e interact note dated 11/20/21 under nursing observations, evaluation, and recommendations documents PT stated that she missed dialysis on Friday. Last dialysis was Wednesday. On 11/30/21 at 8:25 a.m. Surveyor asked LPN (Licensed Practical Nurse)-T how dialysis is arranged for new admissions. LPN-T replied you know what, that was a question I had for the DON (Director of Nursing) as I didn't know how to put it in. LPN-T explained she asked DON-B yesterday because there was a new admission which she doesn't usually do. LPN-T looked at the text messages on her phone and informed Surveyor the dialysis orders are already in the batch orders they scan. Surveyor asked LPN-T how does dialysis staff (an outside company provides in house dialysis at the Facility) know about the dialysis order. LPN-T informed Surveyor she doesn't know. (continued on next page)

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	525730	A. Building B. Wing	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Suites at Oak Creek (the)	2700 Honadel Boulevard Oak Creek, WI 53154

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/21 at 8:56 a.m. Surveyor asked LPN-R how dialysis is arranged for a new admission. LPN-R informed Surveyor she just found that out recently. LPN-R explained Admissions will contact the in house dialysis and they set it up and if the Resident goes to an outside dialysis center LPN-R thinks the dialysis is prearranged prior to the Resident being admitted . On 12/1/21 at 10:28 a.m. Surveyor spoke with FM (Family Member)-U on the telephone regarding R2's dialysis. FM-U informed Surveyor [R2] informed him she was not going to get dialysis until Monday. [R2] called the doctor and the doctor scheduled her to go back to the hospital. FM-U informed Surveyor [R2] was upset, didn't want to go back to the Rehab Center and went home. On 12/1/21 at 1:25 p.m. Surveyor asked ADON (Assistant Director of Nursing)-F how dialysis is arranged for new admissions. ADON-F explained admissions takes care of this before the Resident comes to the floor and nursing sees the Resident. On 12/2/21 at 9:12 a.m. Surveyor asked DN (Dialysis Nurse)-G how they are aware there is a new admission who requires dialysis. DN-G informed Surveyor she just had an issue with this. DN-G explained she receives a note from Corporate a new admission is potentially coming in. DN-G explained the note from Corporate lets her know the Resident is clinically and financially approved. DN-G explained she would get a note from AC (Admissions Coordinator)-P with the name of the Resident and room number. DN-G informed Surveyor the policy is they are to send notification 24 hours before admissions so she can get the equipment ready. Surveyor informed DN-G Surveyor is inquiring about the process as R2 was admitted on Thursday 11/18/21 and did not receive dialysis on Friday 11/19/21. Surveyor informed DN-G Surveyor noted a nurses note indicating in house dialysis was set up. DN-G informed Surveyor she never saw [R2] and by the time she was aware of [R2] she had already went to the hospital. Surveyor asked DN-G if she received a note from AC-P R2 was being admitted . DN-G look at her messages and replied no. DN-G informed Surveyor on 11/16/21 she received an email from [name of dialysis company] R2 was financially approved and was COVID positive. DN-G explained Residents who are COVID 19 positive receive their dialysis treatment on Tuesday, Thursday, and Saturday. DN-G informed Surveyor if anyone would have called her regarding R2 she would have gone to the unit to speak with R2 and would have also called the nephrologist. On 12/2/21 at 10:15 a.m. Surveyor asked AC-P if she is involved with setting up dialysis for a new admission. AC-P informed Surveyor for potential Residents on dialysis they request information from the hospital and emails this information to [name of dialysis company]. [Name of dialysis company] lets her know if they need additional information and if they are approved for dialysis. AC-P explained on their master room roster dialysis Residents are highlighted in green so everyone knows they receive dialysis. AC-P informed Surveyor on the day the Resident is coming in she sends out an admission note. Surveyor asked if dialysis receives this note. AC-P replied yes and explained everyone in the building should be on the email list. On 12/2/21 at 10:43 a.m. Surveyor spoke with ADON-N regarding the nurses note 11/18/21 which indicates she set up dialysis. ADON-N informed Surveyor she would not have set up dialysis. Surveyor asked if she was involved with R2's admission. ADON-N indicated she didn't think so. Surveyor asked ADON-N if anyone asked her about R2's dialysis. ADON-N replied no, not on that patient. On 12/2/21 at 3:14 p.m. Administrator-A and DON (Director of Nursing)-B were informed of R2 not receiving dialysis and staff not monitoring her dialysis site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/21 at 7:20 a.m. Administrator-A provided Surveyor with an email dated 11/16/21 from admissions at [name of dialysis company] indicating R2 was clinically and financially approved for hemodialysis treatment at Ignite Oak Creek. This email also documents Please note: It is the facility's responsibility to notify [name of dialysis company] at least 24 hours prior to requiring dialysis treatment. The facility is also responsible for scheduling or otherwise arranging the treatment. The facility must request that a patient by scheduled for dialysis by speaking (either by phone or verbally) or emailing with a member of the [name of dialysis company] unit. [Name of dialysis company] will make every effort to monitor your census to review when patients requiring dialysis are admitted to the facility. However the facility is responsible for scheduling and bring such patients to the [name of dialysis company] unit. [Name of dialysis company] is not responsible for a patient's dialysis care if the facility does not seek to have that patient scheduled for dialysis services. Surveyor was also provided with an email list sent on 11/18/21 at 3:55 p.m. with the master room roster and census report. On 12/6/21 at 3:47 p.m. during the daily meeting with Administrator-A and DON-B Surveyor informed staff Surveyor still has the concern R2 did not receive dialysis and staff were not monitoring R2's dialysis site. 35720 2. R3 has diagnoses that include chronic kidney disease, end stage renal disease, and dependence on renal dialysis. R3 was admitted to the facility on [DATE]. R3 was hospitalized [DATE]-[DATE]. R3's hospital discharge summary documents .Nephrology was consulted for arranging hemodialysis, pt [patient] remained anuric [not urinating] and was started on MWF [Monday, Wednesday, Friday] schedule .Per Pt and [involved party's] wishes, it has been arranged for the pt to return to his previous SNF [skilled nursing facility] and continue HD [hemodialysis], wound care and PT [physical therapy/OT [occupational therapy]. R3's physician orders upon return to the facility did not include orders for dialysis, or orders for monitoring R3's access site. On 11/12/21 R3's plan of care was updated to include a focus area for The resident needs hemodialysis r/t [related to] End Stage Renal Disease. Interventions implemented on 11/12/21 include: Check and change dressing daily at access site. Document; Do not draw blood or take B/P [blood pressure] in arm with graft; Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis 3x weekly. Review of R3's medical record did not indicate R3 received dialysis on 11/12/21 (a Friday), and did not include documentation of assessment to R3's access site, or documentation of dressing changes completed as indicated per R3's plan of care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes on 11/13/21 at 1:43 pm document Resident noted to have a increase in confusion, calling out even after needs have been met. Resident spoke with wife and stated he wanted 911 called, 1:1 given and resident did settle down. VSS [vital signs stable]. Writer spoke with wife several times today and she stated that resident becomes confused prior to having dialysis. His regular schedule is MWF [Monday, Wednesday, Friday]. Resident did not recv [receive] dialysis Friday. NM [Nurse Manager] is aware. NP [Nurse Practitioner] is aware and is here today assessed resident and ordered stat labs .Resident currently resting quietly in bed. R3 was discharged to the hospital on 11/13/21. R3's medical record did not contain documentation of R3 receiving dialysis upon return from the hospital on 11/11/21 (Thursday) through his discharge on 11/13/21 (Saturday). On 12/2/21 at 10:00 am the surveyor interviewed the facility in house Dialysis Nurse-G. Dialysis Nurse-G informed the surveyor she gets information about residents needing dialysis through Admissions Coordinator-P and the resident then gets approved by the dialysis company. Dialysis Nurse-G informed the surveyor R3 was never brought to her attention and had never been submitted to get approval from the dialysis company. Dialysis Nurse-G stated she became aware of R3 needing dialysis when a nurse asked when R3 should come to dialysis. Dialysis Nurse-G informed the surveyor that was when she first became aware of R3 as he was not in their system. On 12/2/21 at 10:41 am the surveyor interviewed Admissions Coordinator-P. Admissions Coordinator-P informed the surveyor when a patient comes in requires dialysis, Admissions Coordinator-P gets the information and sends it to the dialysis company. Admissions Coordinator-P stated related to R3 it could have been an overlook on their part. Admissions Coordinator-P stated Director of Business Development-Q would review the hospital paperwork and let her know of a resident requiring dialysis. On 12/2/21 at 10:48 am the surveyor interviewed Director of Business Development-Q. Director of Business Development-Q stated she recalled R3 was started on dialysis at the hospital and that information was not in the initial referral from the hospital and was not conveyed in conversations with the hospital social worker. Director of Business Development-Q stated the nurse who does the admission should be following up for any changes from the referral to discharge summary. The surveyor was unable to interview the nurse who admitted R3 to the facility on [DATE] due to the nurse no longer being employed at the facility. On 12/2/21 at 3:10 pm the surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the concern related to R3 not receiving dialysis. 3. R15 has diagnoses that include acute kidney failure, end stage renal disease, and dependence on renal dialysis. R15's plan of care includes a focus are for The resident needs hemodialysis r/t [related to] End Stage Renal Disease initiated 11/23/21. Interventions initiated on 11/23/21 include: Check and change dressing daily at access site. Document; Do not draw blood or take B/P in arm with graft.; Encourage resident to go for the schedules dialysis appointments. Resident receives dialysis MWF [Monday, Wednesday, Friday]. (continued on next page)

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