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	02/16/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 42037 Based on observation, interview and record review, the facility did not ensure the most recent State Survey results were readily accessible to residents, family members and legal representatives This had the potential to affect all 88 residents who resided in the facility at the time of the survey. The facility State Survey results were not readily assessable for review. Findings include: On 2/15/22, at 3:50 PM, Surveyor conducted an interview with R2. Surveyor asked if R2 knew where the state survey results were located for resident review. R2 responded they did not know where the state survey results could be accessed. On 2/15/22, at 4:00 PM, Surveyor asked Receptionist-Y where state survey results would be kept for residents to review. Receptionist -Y told Surveyor that the state survey results are kept on a desk in the facility's front lobby. Surveyor looked for the state survey results on the desk in the facility's front lobby and was unable to locate the state survey results. On 2/16/22, at 11:30 AM, Surveyor looked for the state survey results on the desk in the facility's front lobby and was unable to locate the state survey results. On 2/16/22, at 3:30 PM, Surveyor asked NHA (Nursing Home Administrator)-A where state survey results would be kept for residents to review. NHA-A responded that the state survey results binder is usually kept on a desk in the facility's front lobby but they had the binder in their office to update the latest results from the facility's previous complaint survey. Surveyor shared concern that the survey results binder had not been accessible to residents from 2/14/22-2/16/22.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observations, interview and record review, the facility did not ensure that residents who are unable to carry out activities of daily living received the necessary services to maintain good grooming, personal and oral hygiene for 8 of 8 residents reviewed. R2, R3, R9, R11, R12 did not receive showers and personal hygiene care in accordance with their plan of care. R4 was not provided with bathing/showers since admission on 1/20/22. R10 was not provided with bathing/showers in the last 30 days. R6 was provided with only one shower in 30 days on 1/25/22. Findings include: The facility policy, entitled, Activities of Daily Living, dated May 2018, stated: showers and baths are scheduled and assistance is provided. The facility provided the shower schedule to the Survey Team which divided showers into Day shift (7 am-7 pm) and Night shift (7 pm-7 am). Surveyor noted the shower dates and times were not listed on the CNA (Certified Nurse Assistant) care card, therefore CNAs would need to take the time to refer to the schedule in order to provide bathing/showers. 1. R2 was admitted to the facility 1/5/22, with diagnoses that include: pneumonia, sepsis and diabetes mellitus. R2's admission MDS (Minimum Data Set) assessment, dated 1/8/22, indicates R2 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R2 is cognitively intact and able to participate in daily decision making. R2 has limited range of motion to bilateral lower extremities. R2's care plan indicated that R2 requires extensive assistance of 2 staff for bed mobility and transfers. R2's care plan indicates that R2 requires extensive assist of one staff for dressing, toilet use and personal hygiene. On 2/15/22, at 10:15 am, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. On 2/15/22, at 12:30 pm, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. R2 has food particles present on their hospital gown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/15/22, at 2:00 pm, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. R2 has dried food particles present on their hospital gown. On 2/15/22 at 3:30 pm, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. R2's fingernails are untrimmed and dirty. R2 has dried food particles present on their hospital gown. On 2/15/22, at 4:05 pm, Surveyor conducted an interview with R2. R2 was up in a wheelchair and dressed in a shirt and pants. R2 remained unshaven at this time with untrimmed, dirty fingernails. Surveyor asked R2 if they are usually in bed until late afternoon. R2 responded, I get up whenever they have time to get me up. Surveyor asked if R2 is receiving assistance with showers and personal hygiene. R2 told Surveyor that R2 can't remember when they were last showered. On 2/16/22, at 7:15 am, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, at 9:30 am, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, at 11:40 am, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, at 1:00 pm, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, Surveyor reviewed R2's shower records from 1/18/22-2/16/22. Surveyor notes per documentation that R2 has not received a shower from 1/18/22-2/16/22 (29 days). On 2/16/22, at 3:30 pm, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R2's disheveled appearance. Surveyor made NHA-A aware there is no documentation of R2 receiving showers from 1/18/22-2/16/22. No additional information was provided to Surveyor at this time. 2. R3 was admitted to the facility on [DATE], with diagnoses that include: metabolic encephalopathy, hypertension and dementia. R3's MDS (Minimum Data Set) assessment dated [DATE], indicates R3 requires extensive assistance of 2 staff with bed mobility and total assistance of 2 staff with transfers. R3 requires total assistance of 1 staff with dressing, toileting and personal hygiene. R3 has limited function to upper and lower extremities on 1 side of their body. On 2/16/22, at 7:40 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/16/22, at 9:45 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. On 2/16/22, at 10:30 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 11:15 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 11:45 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 12:25 pm, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 1:20 pm, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 1:35 pm, CNA (Certified Nursing Assistant)-U and Wound Care Nurse-P performed incontinence cares for R3. Surveyor conducted an interview with CNA-U. Surveyor asked CNA-U how often R3 should be repositioned while in bed. CNA-U responded that R3 should be repositioned at least every 2 hours. Surveyor asked when R3 had last been repositioned. CNA-U responded that they had last repositioned R3 around 7:30 am and that they do not have enough help to provide care to R3 sometimes as R3 requires 2 staff members to assist in turning and repositioning. CNA-U confirmed that R3 had not been repositioned from 7:30 am to 1:35 pm on 2/16/22, as they were the only CNA working on the unit and caring for 22 residents this morning. Surveyor asked CNA-U how often a residents should be receiving a bath. CNA-U told Surveyor they should receive a bath at least once a week. Surveyor asked CNA-U how often R3 should be receiving oral care. CNA-U responded that they should have oral care every shift but they had not gotten around to it yet today. On 2/16/22, Surveyor reviewed R3's shower records from 1/18/22-2/16/22. Surveyor notes per documentation that R3 has received 1 documented shower from 1/18/22-2/16/22 (29 days). On 2/16/22, at 3:30 pm, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R3's disheveled appearance. Surveyor made NHA-A aware there is only documentation of R3 receiving 1 shower from 1/18/22-2/16/22. Surveyor shared additional concerns of lack of oral care for resident and that no documentation was noted related to oral care from 2/14/22-2/16/22. No additional information was provided to Surveyor at this time. 3. R9 was admitted to the facility 2/7/22, with diagnoses of: Schizophrenia, left femur fracture and urinary retention. R9's Admission MDS (Minimum Data Set) assessment, dated 2/14/22, documents: R9 has a Brief Interview of Mental Status (BIMS) score of 11, indicating R9 is moderately impaired for daily decision making skills. R9 requires extensive assistance and a two person physical assist for bed mobility and transfer needs, extensive assist of one staff person for locomotion on the unit and dressing, limited assistance of one staff for personal hygiene and set up assistance with eating. R9 has limited range of motion of one side of the lower extremities. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/15/22, at 12:45 PM, Surveyor observed R9 sitting in wheelchair in the common area of unit. Surveyor observed R9's appearing disheveled with hair uncombed and beard unshaven in a hospital gown with their back exposed. On 2/15/22 at 3:50 PM, Surveyor observed R9 sitting in wheelchair in the common area of unit. Surveyor observed R9's appearing disheveled with hair uncombed and beard unshaven in a hospital gown with their back exposed. Surveyor reviewed R9's shower documentation from 2/7/22-2/16/22 (10 days). Surveyor could not identify documentation of R9 receiving a shower since admission on 2/7/22 into the facility. On 2/16/22 at 3:30 pm, Surveyor informed NHA-A of concerns related to R9's disheveled appearance. Surveyor made NHA (Nursing Home Administrator)-A aware that there is no documentation of R9 receiving showers from 2/7/22-2/16/22. No additional information was provided to Surveyor at this time. 4. R11 was admitted to the facility 12/29/21, with diagnoses of rheumatoid arthritis, hemiplegia and fibromyalgia. R11's quarterly MDS (Minimum Date Set) assessment, dated 1/1/22, indicates R11 requires extensive assistance of 1 staff with bed mobility and extensive assistance of 2 staff with transfers. R11 requires extensive assistance of 2 staff with bathing. On 2/15/22 at 10:45 am, Surveyor made observations of R11 in their room. R11's appeared to be disheveled with uncombed hair that appeared greasy and long, untrimmed fingernails. On 2/16/22, Surveyor, was provided by facility with R11's bathing documentation from 1/18/22-1/31/22. Surveyor could not identify documentation of R11 receiving a shower from 1/18/22-1/31/22 (14 days) On 2/16/22, at 3:30 pm, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R11's disheveled appearance. Surveyor made NHA-A aware that there is no documentation of R11 receiving showers from 1/18-1/31/22. No additional information was provided to Surveyor at this time. 5. R12 was admitted to the facility on [DATE], with diagnoses of dementia, legal blindness and seizures. R12's quarterly MDS (Minimum Data Set) assessment, dated 2/2/22 indicates R12 requires extensive assistance of 1 staff with personal hygiene. On 2/16/22, R12 approached Surveyor in the hallway while ambulating with a cane. R12 was disheveled with uncombed hair and unshaven. R12 requested Surveyor find a way that they could get a haircut. On 2/16/22, Surveyor reviewed R12's shower records from 1/18/22-2/16/22. Surveyor notes per documentation that R12 has not received a shower from 1/18/22-2/16/22 (30 days). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/16/22, at 3:30 pm, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R12's disheveled appearance. Surveyor made NHA-A aware that there is no documentation of R12 not receiving showers from 1/18/22-2/16/22. No additional information was provided to Surveyor at this time. 41439 6. R4 was admitted on [DATE] and no bathing/showers were documented since admission. R4's orthopedic physician consult on 2/2/22 indicated it was OK to get right hip incision wet as staples had been removed. R4 was scheduled for showers on Tuesday and Friday on night shift. On 2/15/22, at 8:35 AM, Surveyor interviewed R4 who was cognitively intact. R4 was lying in the bed with long greasy hair hanging in strings. R4 had the call light on. R4 informed Surveyor R4 was in need of the bedside table to be adjusted as still in bed and unable to eat with the tray at the current level. R4 stated R4 had not received a shower since admission on 1/30/22 and never had hair washed or cleaned. R4 stated the staff put me in a disposable brief so I don't have to wait so long and wet the bed. On 2/16/22, at 11:49 AM, Surveyor observed R4 lying in the bed, R4's hair remains unclean with greasy strands. 7. R10 was readmitted to the facility on [DATE], with diagnoses that include: End Stage Renal Disease, Dementia, Parkinson's disease. R10's Readmission Minimum Data Set assessment, dated 12/30/21, documents R10 has a Brief Interview of Mental Status score of 5, indicating R5 is severely cognitively impaired; requires extensive assist of one staff for bed mobility, toileting and personal hygiene; extensive assist of two staff for transfers; one person assist for bathing. Surveyor was unable to locate documentation R10 was provided assistance with bathing/showers for the last 30 days. R10 was scheduled for showers on Monday and Friday Night shift. On 2/16/22, at 8:00 AM, Surveyor observed R10 sitting in at a dining room table in a wheelchair, unshaven with several days beard growth, Foley bag lying uncovered on the floor, and yelling out for his glasses. RN (Registered Nurse)-L then went to R10's room to retrieve the eyeglasses. On 2/16/22, at 11:49 AM, Surveyor observed R10 in the wheelchair in the same position at the dining room table with Foley bag holding over 900 ml of urine, uncovered and lying on the floor. R10's mouth was dirty with brown stains and food particles and the white T-shirt had several food stains down the front. 8. R6 was admitted to the facility on [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Quarterly Minimum Data Set (MDS) assessment, dated 1/5/22, documents: R6 has a Brief Interview of Mental Status score of 15, indicating R6 is cognitively intact for daily decision making; requires extensive assist of 1 person for bed mobility, totally dependent on 2 staff for transfers, totally dependent on 1 staff for dressing and toilet needs and is totally dependent on 1 person for bathing needs. R6 was scheduled for showers on Thursday and Sunday Night shift. One shower/bath was documented on 1/25/22 in the last 30 days. On 2/14/22, at 8:35 AM, Surveyor conducted observations on R6's unit. Surveyor observed the call light monitor counting the minutes R6 was waiting since the call light was activated and R6's was on 51:08 minutes. The monitor kept trending the minutes upward as the call lights were not being answered. On 2/14/22, at 8:38 AM, Surveyor interviewed LPN (Licensed Practical Nurse)-F who stated the residents do not get the care they need on a daily basis. LPN-F stated it takes 2 staff to reposition R6 but LPN-F is not able to do so right now as R6 needs to be changed but she cannot be changed because there is only one CNA (Certified Nursing Assistant) for the whole unit. On 2/14/22, at 1:26 PM, Surveyor interviewed R6, who stated, she feels she needs to wait a long time to get staff assistance to change her brief. R6 stated, sometimes it takes hours. R6 stated, in the evening, after supper it's so quiet, no one is in the halls.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on interview and record review, the facility did not ensure that a residents with pressure injuries received necessary care and treatment to promote healing, prevent infection and prevent new pressure injuries from developing and residents without pressure injuries do not develop pressure injuries for 3 (R1, R3, R2) of 5 Residents reviewed for pressure injuries. *R1 developed pressure injuries on 12/14/21 that were not present upon admission to the facility on [DATE]. R1 did not have an individualized repositioning program. R1's wound assessments were not completed weekly. R1's wound treatments were not completed as ordered. R1 had no evidence of a pressure relieving chair cushion being provided during dialysis to prevent further pressure and breakdown of stage 2 sacral pressure injuries. *R3 was documented as having a Stage 3 pressure injury to the right buttock with no observations of turning and repositioning offered to R3. *R2 was assessed to be at risk for the development of pressure injuries and was observed without heels up cushion in place in bed and without compression stockings which were identified as pressure injury preventative measures. Findings include: 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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* 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. * 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 was admitted to the facility on [DATE], with diagnoses including Renal Failure with Hemodialysis, Diabetes, CHF (Congestive Heart Failure), Severe Protein Calorie Malnutrition, Stroke with Right-Sided Weakness, and COVID 19 (1/4/22). R1's Admission MDS (Minimum Data Set) assessment, dated 11/26/21, indicated R1 was moderately cognitively impaired. R1 required extensive assistance of 1 staff for bed mobility, dressing, and toileting. R1 was dependent on 2 staff for transfer assistance. R1's MDS Section M for skin integrity, indicated R1 was at risk for pressure injuries, had MASD (Moisture Associated Skin Damage) with pressure relief on bed and chair, ointments, but no repositioning program. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's 11/26/21, MDS CAA (Care Area Assessment) indicated R1 was a short term guest recently hospitalized for AKI/ESRD (Acute Kidney Injury/ End Stage Renal Disease) with new HD (Hemodialysis), acute on chronic CHF (Congestive Heart Failure), bilateral pleural effusions s/p (status/post) thoracentesis, C-diff (Clostridium difficile), debility, malnutrition, dysphagia, pneumonia, hematuria, GI (gastrointestinal bleed, acute blood loss anemia, weakness, hypoalbuminemia. Other medical hx (history) includes but is not limited to a-fib (Atrial Fibrillation), HLD (High Density Lipoprotein), DM2 (Diabetes Mellitus type 2), HTN (hypertension), gout, anemia, CAD (Coronary Artery Disease), GERD (Gastroesophageal Reflux Disease), and right hemiplegia following CVA(Cerebrovascular Accident). R1 triggered the pressure ulcer CAA because R1 needs assist with bed mobility and had episodes of incontinence. R1 is at risk for further functional decline and skin breakdown. Plan is for R1 to participate in MD (Medical Doctor) ordered therapies and to monitor for skin breakdown. Goal is for R1 to return to his PLOF (Previous Level of Function) (modified independence) and to not have avoidable skin breakdown. R1's Care Plan, dated 11/23/21, indicated Potential for Impairment to skin integrity r/t (related to) immobility, dated 11/23/21. Interventions included: Apply barrier cream to protect skin from excess moisture, initiated 11/23/21; Encourage activity as tolerated, initiated 11/23/21; Encourage good nutrition and hydration in order to promote healthier skin, initiated 11/23/21; Monitor skin when providing cares, notify nurse of any changes in skin appearance, initiated 11/23/21; Pressure reduction bed mattress, initiated 11/23/21; Incontinence Care every 2-3 hours and prn (as needed), cleanse peri area and apply barrier cream, initiated 1/13/22; Encourage/assist with turning and repositioning every 2-3 hours, initiated 1/13/22; Use draw sheet when turning/repositioning, initiated 1/13/22; Use pillow/cushion between bony prominences, initiated 1/13/22; Educate resident/family importance of changing positions for prevention of pressure ulcers, initiated 1/17/22; Educate resident/family/caregivers of causative factors and measures to prevent skin injury, initiated 1/17/22. R1's Care Plan Focus: RESOLVED: 12/12/21 R1 has actual impairment to skin integrity-admitted with MASD to bilateral buttocks and groin. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's November 2021, Treatment Administration Record (TAR) documents: Skin checks order, dated 11/23/21 through 1/16/22 on Wed (Wednesday)/Sat (Saturday). The ordered skin checks were not documented as being completed on 11/24/21 and 11/27/21. R1's Wound Rounds, documented on 12/14/21, indicated R1 developed a facility acquired Stage 2 Sacral Pressure Injury measuring: 1.5 cm (centimeters) x 1.5 cm x 0.1 cm, with 100% pink/red non-granulating tissue. R1's 12/14/21, progress note indicated: the open area to the sacrum as well as an additional right buttock open area measured as 0.5 cm x 0.5 cm x 0.1 cm. Right heel is dark purple measured 0.5 cm x 0.5 cm. Treatment orders for sacrum and right buttock: Cleanse with NS (Normal Saline), Skin Prep to Periwound, apply this layer of happy butt cream with foam border dressing-change every day and prn (as needed), Air mattress, Turn every 2-3 hours & (and) prn, Pressure relieving boots. The facility also documents R1's right buttock pressure injury as being on the distal sacrum. R1's Care Plan, dated 12/14/21 indicated: R1 has actual impairment to skin integrity r/t (related to) Pressure Ulcer-1. Sacrum, 2. Distal Sacrum. Interventions included: Apply barrier cream to protect skin from excess moisture, initiated 12/14/21; Educate resident/family/caregivers of causative factors and measures to prevent skin injury, initiated 12/14/21; Encourage good nutrition and hydration in order to promote healthier skin, initiated 12/14/21; Evaluate and Treat per Physician orders, initiated 12/14/21; Evaluate (R1) for signs/symptoms of possible infections, initiated 12/14/21; Keep skin (sic) & dry, Use lotion on dry skin, initiated 12/14/21; Low Air Loss Mattress, initiated 12/14/21; Prevalon Boots, initiated 12/14/21; Weekly treatment Documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue, and exudate and any other notable changes or observations by wound nurse or provider initiated 12/14/21. Skin checks on the treatment administration record (TAR), dated: 11/23/21 through 1/16/22 on Wed (Wednesday)/Sat (Saturday) were not documented as completed in R1's December 2021 TAR on 12/1/21, 12/8/21, 12/18/21, 12/22/21, 12/25/21, and 12/29/21. New treatment orders dated: 12/14/21 through 1/7/22 indicated: Sacral wounds: Cleanse with NS (Normal Saline), Medi-honey, apply foam border dressing every other day and prn (as needed). Treatments were not documented in the December 2021 TAR as being completed on: 12/18/21, 12/20/21, 12/22/21, 12/24/21, 12/28/21, 12/30/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Assessments of R1's Facility Acquired Sacral Pressure Injury in R1's Medical Records (Wound Rounds) indicated: On 12/17/21, Sacral Pressure Injury Stage 2, measured 1.4 cm x 1.4 cm x 0.1 cm with 100% pink/red non-granulating tissue. Distal Sacral Pressure Injury Stage 2 measured 0.4 cm x 0.3 cm x 0.1 cm. On 12/26/21, Sacral Pressure Injury Stage 2 measured 1.2 cm x 1 cm x 0.1 cm with 100% pink/red non-granulating tissue. Distal Sacral Pressure injury Stage 2 measured 0.4 cm x 0.3 cm x 0.1 cm. The 12/26/21 wound assessment was completed 9 days after R1's last assessment. On 1/6/22, Sacral Pressure Injury Stage 2, measured 1.2 cm x 1 cm x 0.1 cm with 100% pink/red non-granulating tissue. Distal Sacral Pressure injury Stage 2, measured 2.8 cm x 3.0 cm x 0.1 cm. The 1/6/22 wound assessment was completed 11 days after last assessment. On 1/7/22, Sacral Pressure Injury Stage 2 measured 0.3 cm x 0.3 cm x 0.1 cm with 100% pink/red non-granulating tissue. Distal Sacral Pressure injury Stage 2 measured 2.8 cm x 3.4 cm x 0.1 cm. Surveyor noted the wound round records do not include wound characteristics beyond measurements for the distal sacrum wound. The treatment to the sacral wounds was changed on 1/7/22. The new treatment order is to cleanse with NS, Medi-honey, apply foam border dressing every day and prn. On 1/9/22, R1's Braden score was 15, indicating R1 was at risk for developing pressure injuries. On 1/13/22, R1 had a pressure ulcer unavoidability form completed which indicated the new pressure injuries identified on 12/14/21, with a sacral pressure injury, stage 2 measuring 0.3 cm x 0.3 cm x 0.1 cm and a distal sacral pressure injury, stage 2 measuring 2.8 cm x 3.4 cm x 0.1 cm were unavoidable. R1's Risk Factors documented include: Renal Failure, Diabetes, Albumin Abnormality, Anemia, and Hyperlipidemia with Chronic Urinary Incontinence and Renal Dialysis. The pressure ulcer unavoidability form indicated the sacral pressure injury development was unavoidable on 12/14/21 using the wound assessment completed on 1/7/22. On 1/13/22, R1's care plan was updated: Incontinence Care. Interventions include: Incontinence care every 2-3 hours and prn, cleanse peri area and apply barrier cream, initiated 1/13/22; Encourage/assist with turning and repositioning every 2-3 hours, initiated 1/13/22; Use draw sheet when turning/repositioning, initiated 1/13/22; Use pillow/cushion between bony prominences, initiated 1/13/22. On 1/15/22, Sacral Pressure Injury Stage 2, measured 0.3 cm x 0.3 cm x 0.1 cm with 100% pink/red non-granulating tissue. Distal Sacral Pressure injury Stage 2, measured 2.0 cm x 1.6 cm x 0.1 cm. Surveyor noted there are no characteristice of the distal sacral wound identified in the assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's pressure injury assessment was completed 8 days after the last assessment. Skin checks were changed to weekly on 1/16/22. TAR interventions initiated in November 2021 indicated to complete skin checks Wednesdays and Saturdays. On 1/21/22, Sacral Pressure Injury Stage 2, measured 1.8 cm x 2.5 cm x 0.1 cm with 100% pink/red non-granulating tissue. Distal Sacral Pressure Injury Stage 2, measured 1.8 cm x 1.7 cm x 0.1 cm. On this same date also in Wound Rounds, there is an entry indicating on 1/21/22, Sacral Pressure Injury Stage 2 measured 0.8 x 2.5 cm x 0.1 cm with 100% pink/red non-granulating tissue. Surveyor noted the assessments of R1's Sacral Pressure Injury in the Wound Rounds section do not match, despite both being dated 1/21/22. On 1/21/22, NP-R's (Nurse Practitioner) progress note indicated: R1 had a wound to Sacrum and R1 felt some tenderness to buttocks and wounds are still there. Air mattress in place. On 1/28/22, R1's Sacral Pressure Injury is now documented as a facility acquired DTI (Deep Tissue Injury) Pressure injury measured 5.8 cm x 5 cm x 0.1 cm with 50% deep maroon, 50% Bright Beefy Red tissue. Surveyor noted there is no longer reference to a distal sacral wound at this time. It is not indicated if the measurements reflect two areas now joined together into one larger wound or what occurred to the distal sacral wound. On 1/28/22, NP-R's progress notes indicated R1 was having labs drawn due to some confusion. R1 on an air mattress for a few weeks with continual decline. Will request maintenance to switch bed out for an alternating pressure mattress. Discussed with staff the importance of rolling patient on to his side to offload the wound. DTI to sacrum was a full thickness wound measuring 5.8 cm x 5 cm x 0.1 cm with the base 50% deep purple/50% granular. Moderate amount of serosanguineous drainage, periwound with blanchable erythema, painful, no signs of infection. Pressure induced deep tissue damage of sacral region. Surveyor noted the change from a Stage 2 to DTI designation despite qualifying the wound as full thickness indicating inaccurate staging. A full thickness wound indicates that damage exists below the epidermis and dermis (all layers of the skin) into the subcutaneous tissue or beyond into muscle, bone, tendons. R1's Treatments were not changed/updated given the significant change and decline in the sacral wound. Despite emphasis from Nurse Practitioner on repositioning surveyor noted the intervention continued to not be individualized for R1 with possible increased frequency and continued to be turn and reposition every 2-3 hours. Surveyor noted NP-R did document they would request maintenance to switch R1's bed out for an alternating pressure mattress. Surveyor reviewed the facility bed specifications and only 2 types of beds were available: a redistribution memory foam mattress indicated for pressure injuries up to Stage 2 and a low air loss/alternating pressure air mattress which R1 was documented as being on the low air loss mattress since 12/14/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/4/22, R1's medical record documents: Sacral DTI Pressure Injury measured 8 cm x 9 cm x 0.1 cm with 90 % deep maroon, 10% bright beefy red tissue. In addition: Right Ischial tuberosity was facility acquired DTI Pressure injury measured 4.5 cm x 5.5 cm x 0.1 cm with 90 % deep maroon, 10% bright beefy red tissue. Right trochanter was facility acquired DTI pressure injury measured 5.5 cm x 4.5 cm x 0 cm with 100 % deep maroon tissue. On 2/4/22, NP-R's progress notes indicated R1 had wounds to sacrum, left hip, and left ischium with overall decline and new areas of skin breakdown. DTI to sacrum was full thickness wound measure 8 cm x 9 cm x 0. 1 cm with base 90% deep purple, 10 % granular. Moderate amount of serosanguineous drainage, periwound with blanchable erythema, painful, no signs of infection painful-Status declined, Treatment: Border foam change daily, alternating pressure mattress with aggressive turning. DTI to Left ischium was deep purple with partial thickness wound measured 4.5 cm x 5.5 cm, status new wound, Treatment: Happy Butt cream 4 times/ (per) day, offload with turning. DTI to Left hip was 5.5 cm x 5.5 cm status new wound. Treatment: offload with turning. Surveyor noted there was no changes to R1's care plan to individualize the turning & reepositioning despite NP-R indicating agressive turning in their documentation. Surveyor noted the documentation discrepancy between the pressure injuries being located on the right side of R1 versus left side of R1 with the documentation on 2/4/22. On 2/14/22, at 2:40 PM, Surveyor interviewed NP-R (Nurse Practitioner Wounds) who stated R1 declined and on 1/28/22 R1 had a DTI (Deep Tissue Injury) with full thickness wound in the center. NP-R stated on 2/4/22 that R1 developed new DTI's with further decline and multiple new areas of breakdown. NP-R stated R1 had continual decline of wounds probably due to questionable oral intake. On 2/16/22, at 9:58 AM, Surveyor interviewed LPN WC -P (Wound Care Licensed Practical Nurse-PM Supervisor) who stated she was a PM supervisor and pushed into the role of wound care nurse when the previous nurse walked out. WC-P stated she had no formal training and had to learn the wound care rounds computer program by herself. WC-P stated this facility has a standard of reposition every 2-3 hours and not individualized which she has never seen before. WC-P would prefer to train and educate at least every 2 hours repositioning for the residents. WC-P stated R1 was clinically up/down after COVID diagnosis (1/4/22) and developed C-diff diarrhea with many days too weak to get out of bed. WC-P stated R1 had significant weight loss, and was not eating. WC-P stated R1 developed wounds with the diarrhea which also hindered healing. WC-P stated R1's health was declining and it was hard to heal huge wounds with possible signs of terminal ulcer. WC-P stated R1 changed from 1/21/22 to 1/28/22 and the repositioning was not changed or individualized. WC-P stated the facility could have repositioned R1 more often. WC-P stated R1 was a little difficult to reposition. WC-P stated R1 did not have an air mattress for a few weeks. WC-P stated the facility expected R1 to get up more often and be repositioned but R1 needed an air mattress. WC-P stated treatment changes are up to NP-R and she enters the orders. WC-P stated that on 2/4/22, NP-R stated Medihoney is no longer appropriate and all there is to do is pressure relief. Surveyor was also unable to find any documentation R1 was provided a chair cushion to offload sacrum during R1's need for Dialysis 3 days/week. R1's Task list for turning and repositioning every 2-3 hours and prn indicated no documentation of R1 being turned or repositioned on 1/18/22, 1/19/22, 1/22/22, 1/23/22, 1/24/22, 1/28/22. 1/29/22, 1/30/22 and 2/3/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's January 2022 TAR indicated documentation completed by the nurses once on days and once on nights that repositioning was completed every 2-3 hours except 1/3/22 and 1/29/22 day shift. Interviews indicated R1 declined due to not eating, poor nutritional status, questionable oral intake and weight loss. On 2/14/22, at 2:40 PM, NP-R stated R1 had continual decline of wounds probably due to questionable oral intake. On 2/16/22, at 9:58 AM, WC-P stated R1 had significant weight loss and was not eating. R1 was being dialyzed with weights monitored as dry weights post-dialysis after fluid removal. R1's 12/8/21 weight was 62.8 kg = 138.16 lbs (pounds). R1's 1/8/22 weight was 61.5 kg = 135.3 lbs. R1's 2/2/22 weight was 54.5 kg = 119.9 lbs. Surveyor identified R1 had a 13.22% weight loss in 2 months. Surveyor reviewed R1's documented meal intake percentage. No meals intake percentages were recorded for R1 on: 1/19/22, 1/23/22, 1/24/22, 1/26/22, 1/27/22, 1/29/22, 1/30/22, 1/31/22, 2/1/22, 2/2/22, 2/3/22. R1's meal intake percentages were recorded as: On 1/18/22, at 11:39 AM, 76-100% percentage of meal eaten. On 1/20/22, at 9:32 AM and 2:30 PM, 51-75% percentage of meal eaten. On 1/21/22, at 12:39 PM, 51-75% percentage of meal eaten. On 1/22/22, at 2:31 PM, duplicate documentation of refusal & 76-100% percentage of meal eaten. On 1/25/22, at 12:20 PM, 51-75% percentage of meal eaten. On 2/16/22, at 4:01 PM, this Surveyor shared above concerns with VP-Q and NHA-A. 42037 2. R3 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, hypertension and dementia. R3's MDS assessment dated [DATE] indicates R3 requires extensive assistance of 2 staff with bed mobility and total assistance of 2 staff with transfers. R3 requires total assistance of 1 staff with dressing, toileting and personal hygiene. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Braden assessment, dated 2/2/22, with a score of 10 indicates R3 is at high risk for pressure injuries. Surveyor reviewed R3's skin integrity care plan, dated 12/13/21, which indicates R3 acquired a pressure injury to the buttock on 1/29/22. R3's care plan interventions include: wound treatments per order, repositioning every 1-2 hours, pressure relieving heel boots and weekly documentation of wounds. Surveyor reviewed R3's weekly wound assessments. R3's wound assessment, dated 2/2/22, notes a stage 3 pressure injury to the right buttock measuring 4.0 cm x 3.0 cm x 0.1 cm with yellow slough tissue. R3's wound assessment dated [DATE] notes a stage 3 pressure injury to the right buttock measuring 3.5 cm x 3.5 cm x 0.1 cm with yellow slough tissue. R3's wound assessment dated [DATE] notes a stage 3 pressure injury to the right buttock measuring 3.0 cm x 3.3 cm x 0.1 cm with yellow slough tissue. On 2/16/22 at 7:40 am, Surveyor observed R3 in bed laying on their right side with pressure relieving boots in place. On 2/16/22 at 9:45 am, Surveyor observed R3 in bed laying on their right side with pressure relieving boots in place. On 2/16/22 at 10:30 am, Surveyor observed R3 in bed laying on their right side with pressure relieving boots in place. On 2/16/22 at 11:15 am, Surveyor observed R3 in bed laying on their right side with pressure relieving boots in place. On 2/16/22 at 12:25 pm, Surveyor observed R3 in bed laying on their right side with pressure relieving boots in place. On 2/16/22 at 1:20 pm, Surveyor observed R3 in bed laying on their right side with pressure relieving boots in place. On 2/16/22 at 1:35 pm, CNA (Certified Nursing Assistant)-U and Wound Care Nurse-P performed incontinence cares for R3. Surveyor conducted interview with CNA-U. Surveyor asked CNA-U how often R3 should be repositioned while in bed. CNA-U responded that R3 should be repositioned at least every 2 hours. Surveyor asked when R3 had last been repositioned. CNA-U responded that they had last repositioned R3 around 7:30 am and that they do not have enough help to provide care to R3 sometimes as R3 requires 2 staff members to assist in turning and repositioning. CNA-U confirmed that R3 had not been repositioned from 7:30 am to 1:35 pm as CNA-U was the only CNA working on the unit and caring for 22 residents this morning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/16/22 at 1:25 pm, Surveyor conducted interview with Wound Care Nurse-P. Surveyor asked Wound Care Nurse-P how often R3 should be repositioned. Wound Care Nurse-P told Surveyor that she would hope that residents in bed should be repositioned at least every 2 hours. Surveyor asked Wound Care Nurse-P if R3 is dependent on staff for repositioning. Wound Care Nurse-P told Surveyor that R3 usually needs extensive to total assistance with repositioning depending on how alert R3 is. On 2/16/22 at 3:30 pm, Surveyor conducted interview with NHA (Nursing Home Administrator)-A. Surveyor asked NHA-A how often residents should be repositioned while in bed. NHA-A responded that they would think a resident should be repositioned at least every 2 hours. Surveyor notified NHA-A of concerns that R3 has a facility acquired pressure injury to the right buttock and that they were not repositioned from 7:30 am to 1:30 pm. R3's care plan indicated that R3 should be repositioned at least every 2 hours. No additional information was provided. 3. R2 was admitted to the facility 1/5/22, with diagnoses of pneumonia, sepsis and diabetes mellitus. R2's admission MDS (Minimum Data Set) assessment, dated 1/8/22, indicates has a BIMS (Brief Interview of Mental Status) score of 15, indicating R2 is cognitively intact and able to participate in daily decision making. R2 requires extensive assistance of 2 staff for bed mobility and transfers. R2 has limited function to bilateral lower extremities. On 1/5/22 , R2 has a Braden score of 17, indicating R2 is at risk for pressure injuries. R2's skin integrity care plan, dated 1/6/22, lists interventions including: application of compression stockings to be worn during the day and removed in the evening; repositioning every 2 hours and offloading heels while in bed with a heels up cushion. On 2/15/22 at 10:15 am, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. On 2/15/22 at 12:30 pm, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. On 2/15/22 at 2:00 pm, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. On 2/15/22 at 3:30 pm, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/15/22 at 4:05 pm, Surveyor conducted interview with R2. R2 was up in a wheelchair and dressed in a shirt and pants. Surveyor asked R2 if they wear compression stockings during the day. R2 showed Surveyor that they were not currently wearing compression stockings at this time. Surveyor asked R2 if staff position their feet off of the mattress while they are in bed. R2 told Surveyor that staff will sometimes apply the cushion to the bed but not always. On 2/16/22 at 7:15 am, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. On 2/16/22 at 9:30 am, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. On 2/16/22 at 11:40 am, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. On 2/16/22 at 1:00 pm, Surveyor made observations of R2 in bed with their heels directly on the mattress. A heels up cushion was noted on R2's dresser. Surveyor did not observe R2 to be wearing compression stockings at this time. On 2/16/22 at 1:25 pm, Surveyor conducted interview with Wound Care Nurse-P. Surveyor asked Wound Care Nurse-P how often R2 should be repositioned. Wound Care Nurse-P told Surveyor that she would hope that residents in bed should be repositioned at least every 2 hours. Surveyor asked Wound Care Nurse-P if R2 is dependent on staff for repositioning. Wound Care Nurse-P told Surveyor that R2 requires extensive assistance with repositioning in bed. Surveyor asked how staff would know if a resident is supposed to have skin integrity interventions in place such as a heels up cushion or compression stockings. Wound Care Nurse-P told Surveyor that this information would be found in a resident's care plan and CNA (Certified Nursing Assistant) kardex. Surveyor asked Wound Care Nurse-P why R2 would not have skin integrity interventions in place. Wound Care Nurse-P responded that it is possible that CNAs may forget to put these interventions in place or forget to check the resident's care plan. On 2/16/22, at 3:30 pm, Surveyor conducted interview with NHA (Nursing Home Administrator)-A. Surveyor asked NHA-A how staff would know if a resident is supposed to have skin integrity interventions in place such as a heels up cushion or compression stockings. Wound Care Nurse-P told Surveyor that this information would be found in a resident's care plan and CNA kardex. Surveyor shared concerns with NHA-A that R2 was observed on 2/15/22 and 2/16/22 without compression stockings or heels up cushion in place. R2's care plan indicated compression stockings and a heels up cushion were to be in place. No additional information was offered at this time.

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	525730	A. Building B. Wing	02/16/2022

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observation, interview and record review, the facility did not ensure that 2 (R9, R10) of 2 residents reviewed received appropriate treatment and services related to catheter care. * R9 was observed with his catheter bag uncovered and not emptied on 2/15/22 and 2/16/22. * R10 was observed with his Foley cather bag uncovered, not emptied, and lying on the floor throughout the day on 2/16/22. Findings include: 1. R9 was admitted to the facility 2/7/21 with Schizophrenia, left femur fracture and urinary retention. R9's Admission MDS (Minimum Data Set) dated 2/14/22 documents a BIMS (Brief Interview for Mental Status) score of 11, indicating that R9 has some cognitive deficits. Section G (Functional Status) documents that R9 requires extensive assistance and a two person physical assist for transfer needs. Section H (Bladder and Bowel) documents that R9 had an indwelling catheter placed upon admission to the facility. R9's Urinary Catheter care plan dated as initiated on 2/8/22 documents under the Intervention section, Position catheter bag and tubing below the level of the bladder and away from entrance room door. On 2/15/22 at 12:45 PM, Surveyor observed R9 sitting in wheelchair in the common area of unit. Surveyor observed R9's catheter tubing to be resting on the floor beneath wheelchair. Surveyor noted that there was no barrier between the catheter tubing and the floor. R9's catheter bag was uncovered and contained approximately 500 cc of dark yellow urine. On 2/15/22 at 3:50 PM, Surveyor observed R9 sitting in wheelchair in the common area of unit. Surveyor observed R9's catheter tubing to be resting on the floor beneath wheelchair. Surveyor noted that there was no barrier between the catheter tubing and the floor. R9's catheter bag was uncovered and contained approximately 700 cc of dark yellow urine. On 2/16/22 at 7:15 AM, Surveyor observed R9 from the entrance of his room. R9 was lying in bed with catheter tubing and bag resting on the floor . Surveyor noted that there was no barrier between the catheter tubing, bag and the floor. R9's catheter bag was uncovered and contained approximately 250 cc of dark yellow urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/22 at 9:20 AM, Surveyor observed R9 self-propelling his wheelchair in the common area of unit. Surveyor observed R9's catheter tubing to be resting on the floor beneath wheelchair. Surveyor noted that there was no barrier between the catheter tubing and the floor. R9's catheter bag was uncovered and contained approximately 400 cc of dark yellow urine. On 2/16/22 at 11:30 AM, Surveyor observed R9 self-propelling his wheelchair in the common area of unit. Surveyor observed R9's catheter tubing to be resting on the floor beneath wheelchair. Surveyor noted that there was no barrier between the catheter tubing and the floor. R9's catheter bag was uncovered and contained approximately 500 cc of dark yellow urine. On 2/16/22 at 1:50 PM, Surveyor observed R9 self-propelling wheelchair in the common area of unit. Surveyor observed R9's catheter tubing to be resting on the floor beneath wheelchair. Surveyor noted that there was no barrier between the catheter tubing and the floor. R9's catheter bag was uncovered and contained approximately 800 cc of dark yellow urine. On 2/16/22 at 3:30 PM Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. No additional information was provided as to why R9 did not receive appropriate treatment and services to prevent urinary tract infections. 41439 2. R10 was originally admitted [DATE] and readmitted [DATE] with diagnoses including sepsis, UTI (Urinary Tract Infection), Infection and Inflammatory Reaction due to Indwelling Urethral Catheter, Hematuria, Acute Kidney Failure, Dementia, Need for Assistance with Personal Care, and Paranoid Schizophrenia. R10's 12/30/21 Readmission 5 day PPS MDS (Minimum Data Set) indicated R10 was severely cognitively impaired and had an indwelling catheter. R10 required extensive assistance with one staff for toileting and extensive assistance with two staff for transfer. On 2/16/22, at 8:00 AM, Surveyor observed R10 sitting at a dining room table in a wheelchair with his Foley bag lying uncovered on the floor, and yelling out for his glasses. RN-L (Registered Nurse) went to R10's room to retrieve the eyeglasses. On 2/16/22, at 11:49 AM, Surveyor observed R10 remained in the wheelchair in the same position at the dining room table with his Foley bag holding over 900 ml of urine, uncovered and lying on the floor. On 2/16/22, at 4:01 PM, Surveyor shared concerns regarding R10 with NHA-A (Nursing Home Administrator) and VP-Q (Vice President of Operations). No further information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on interview, record review and observations, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental and psychosocial well-being for 88 residents currently residing in the facility. * Through observations and interviews, Surveyors observed and learned of concerns with delay in passing medications, nursing being able to conduct blood sugar checks timely, staff availability to answer call lights timely, Activities of Daily Living (ADLs) such as incontinence care and showers not completed, skin integrity (repositioning, heels not floated), and late meals (breakfast on 2/14/22). * A review of the facility's staffing schedules did not accurately depict the staff who were actually working on the units. The facility's staffing schedules were not consistent with the facility's assessment in regard to the number of staff needed to ensure sufficient staffing to meet the residents needs at any given time. * On 2/15/22 at 8:35 AM, R4 was observed with long greasy hair hanging in strings and with heels resting directly on the mattress. R4 was unable to eat due to the positioning of her tray. R4 indicated she has had no shower since admission on 1/30/22 and has never had her hair washed or cleaned. R4 stated staff put a disposable brief on her so she doesn't have to wait so long and wet the bed. On 2/15/22 at 12:31 pm, R4 remained in bed, was not dressed and stated she received no oral care and was just waiting for lunch. On 2/16/22 at 11:49 AM, R4 was observed in bed, heels flat on the bed, even though R4 was assessed to be at risk for the development of pressure injuries. R4's hair remains disheveled and greasy. * On 2/16/22 at 8:00 AM and at 11:49 AM, R10 was observed in the dining room with his Foley bag uncovered and lying on the floor and holding over 99 ml (milliliters) of urine. R10 was unshaven with beard growth noted. R10's mouth was dirty with brown stains and food particles and R10's white T-shirt had stains down the front. * On 2/14/22, Surveyor noted R7's call light was registering an activation time of 24 minutes and 27 seconds. When interviewed R7 was seeking assistance to get cleaned up. According to LPN F, there was only 1 CN A assigned to the unit and that at 1:20 PM, she (LPN F) was still passing noon meds. * On 2/14/22, R6 informed Surveyor she feels she needs to wait a long time to get staff assistance to change her brief. R6 stated she heard staff are leaving their jobs and just walking away. R6 stated in the evening it is so quiet with no one in the halls and that this makes her very upset and anxious thinking there isn't staff at the facility. R6 stated she has waited 4-5 hours for staff assistance for help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	* On 2/14/22 R8 informed surveyor the facility is short staffed and can wait anywhere from 5 minutes to 1 hour for staff assistance. Over the weekend, R8 stated she has waited from 7:00 AM until 9:30 AM for staff to assist her and that it pissed her off that she had to wait so long. R8 is told the facility is short staffed and that is why she must wait for assistance. * On 2/15 and 2/16/22, R2 was observed unshaven with dirty fingernails. R2 informed Surveyor staff get him up whenever they have time to get him up and could not recall the last time he received a shower. * On 2/16/22 R3 was observed in bed laying on his right side and was unshaven from 7:30 AM through 1:35 PM. R3 was also observed to have oral mucousa which was dry with thick white secretions between his lips. According to Certified Nursing Assistant (CNA) U, R3 had not been repositioned on 2/16/22 from 7:30 am to 1:35 pm. because she was the only CNA on the Sparkle Unit. CNA U also indicated residents should receive a bath at least once a week. CNA U also indicated she had not yet performed oral care for R3. Findings include: 1. The facility assessment, updated 12/1/21, indicated the staffing plan was to describe the general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Budgeted hours per Payroll (2 weeks): Administration 80 hours, RN 136 Hours, LPN 0, CNA 0, Nursing Administration 160 Hours, Dietary 120 Hours, Activities 0. Staffing Plan: The below staffing is the minimum that the facility will have on a weekly and daily basis. Licensed Nurses 13-15/day, Nurse aides 11-14/day. Plan: Average daily census of 80. Day shift (12 hours): 6-7 nurses and a Med Tech on days with a ratio of 1:10 residents for CNAs. PM shift supervisor (3-11) Night shift (12 hours): 5 nurses and with a ratio of 1:15 residents for CNAs The facility policy, Emergency Management-Staffing, March 2020, indicated it is the policy of the facility to provide safe and effective resident care during an emergency. Staff need to adjust their roles to meet demands. Determine which staff in the building will remain on duty beyond their normal operations or if call back will be necessary. Determine if situation can be managed with normal operations or if staff call back will be necessary. On 2/14/22, the facility had a census of 88 residents, which consisted of the following units: Kindle Unit - 33 Residents Ember Unit - 41 Residents (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Sparkle Unit -14 Residents The facility's Resident Census and Condition of Residents (CMS form-672) indicated: Bathing: Independent-1, Assist of 1-2 Staff-82, Dependent-5 Dressing: Independent-1, Assist of 1-2 Staff-81, Dependent-6 Transferring: Independent-1, Assist of 1-2 Staff-82, Dependent-5 Toilet Use: Independent-1, Assist of 1-2 Staff-73, Dependent-14 Eating: Independent-77, Assist of 1-2 Staff-9, Dependent-2 On 2/14/22, at 8:00 AM, Surveyor conducted initial entrance conference with BD-W (Business Development) as no other administrative staff available. Resident census was 88. Kindle Unit with 33 residents: On 2/14/22, Surveyor conducted observations on the Kindle unit and observed the call light monitoring system counting the minutes the resident was waiting since the call light was activated. Kindle resident room [ROOM NUMBER] had a bathroom call light that was activated. The call light monitor, indicated Resident room [ROOM NUMBER] call light was activated and going on 12 minutes and 47 seconds. Surveyor noted Resident room [ROOM NUMBER] indicated the call light was activated and going on 12 minutes and 36 seconds. The call light monitor kept trending the minutes upward as the call lights were not being answered. On 2/14/22, at 8:20 AM, Surveyor observed LPN-E (Licensed Practical Nurse) rushing down the Kindle hallway to the nurses' station and then back to the med cart. LPN-E stated she was working the back hall which had 16 residents but no CNAs (Certified Nurse Assistant) on the Kindle unit which was difficult. On 2/14/22, at 8:30 AM, Surveyor interviewed LPN-D who stated she was working the front hall which had 17 residents and no CNAs. LPN-D stated no CNAs can happen a lot. LPN-D stated she would notify management, pass the medications first, then she would go in and change the residents. LPN-D stated the residents were not changed all night as there were no CNAs last night on the unit. Ember Unit with 41 Residents: On 2/14/22, at 8:35 AM, Surveyor conducted observations on the [NAME] unit. Surveyor observed a resident on the floor with the paramedics assessing and preparing to transfer and transport. Surveyor observed the call light monitoring system counting the minutes the resident was waiting since the call light was activated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident room [ROOM NUMBER] indicated the call light was activated and going on 62 minutes and 25 seconds, Resident room [ROOM NUMBER] indicated the call light was activated and going on 52 minutes and 41 seconds, Resident room [ROOM NUMBER] indicated the call light was activated and going on 51 minutes and 08 seconds, Resident room [ROOM NUMBER] indicated the call light was activated and going on 48 minutes and 53 seconds, Resident room [ROOM NUMBER] indicated the call light was activated and going on 47 minutes and 16 seconds, Resident room [ROOM NUMBER] indicated the call light was activated and going on 26 minutes and 16 seconds. The call light monitor kept trending the minutes upward as the call lights were not being answered. On 2/14/22, at 8:38 AM, Surveyor interviewed LPN-F who stated she had 19 residents on the [NAME] unit. LPN-F stated there was only one CNA for all of the [NAME] unit which was pretty normal as we are usually short staffed. LPN-F stated we do the best we can but the residents are not getting the care that is needed. LPN-F stated showers are not done, not really feasible with 1 CNA. LPN-F stated that since 7:00 AM she has only been able to pass resident's meds, and she sent a resident out for change in condition. LPN-F stated the residents do not get the care they need on a daily basis. LPN-F stated she still has 12 resident blood sugars to check before breakfast but she does not know what time breakfast will be. LPN-F stated it takes 2 staff to reposition R6 but LPN-F is not able to do so right now as R6 needs to be changed but she cannot be changed because there is only one CNA for the whole unit. On 2/14/22, at 8:39 AM, Surveyor interviewed RN-G (Registered Nurse) who stated she had 22 residents on the [NAME] unit and only 1 CNA for the entire [NAME] unit. RN-G stated the [NAME] unit was short staffed and she just goes room by room as she can't be everywhere at once. RN-G stated she just keeps trying to do what she can when she goes into each room. Sparkle Unit with 14 Residents: On 2/14/22, at 8:45 AM, Surveyor conducted observations on the Sparkle unit and noted CNA-I come to the unit with coat on and purse in hand, picked up the call light light phone to ask a resident what they needed. CNA-I stated that she just got here, usually works nights and picked up a shift. On 2/14/22, at 9:16 AM, Surveyor received the computerized access code to resident clinical records as the facility matrix was being updated as the facility had so many admissions over the weekend. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/22, at 9:45 AM, ADON-B (Assistant Director of Nursing for the Kindle Unit) and ADON-C (Assistant Director of Nursing for the [NAME] Unit) came to meet with Surveyor stating the DON (Director of Nursing for the Sparkle Unit) is no longer with us. ADON-B and ADON-C stated NHA-A (Nursing Home Administrator) was in her office and overwhelmed at this time. Surveyor discussed the lack of staffing and call light times with ADON-B and ADON-C. ADON-B and ADON-C stated they were aware of the staffing issues and no CNAs on the Kindle unit. ADON-B stated she would be working as the CNA on Kindle Unit right now if the Surveyor was not here. ADON-B stated she worked the weekend on nights as there was no staff. ADON-C stated staffing goes up and down with orientation every week and he was unaware that there were no CNAs until this AM. On 2/14/22, at 10:10 AM, Surveyor met with NHA-A who stated she had been trying to deal with all the issues and called the Regional Consultants as the Human Resources staff had walked out on Friday. NHA-A stated the DON had come in this am and then walked out stating I can't do this. NHA-A stated she is aware there is no staff in the building as she had the staffing phone and started getting call offs at 4:00 AM. NHA-A stated the facility receptionist was a no show this weekend and NHA-A's daughters came in to help out. NHA-A stated she called her daughters to come in today and help as they are CNAs. NHA-A stated she still has to do payroll today. Surveyor requested a basic alpha list and a daily staffing schedule. On 2/14/22, at 10:28 AM, ADON-B provided the daily staffing schedule/sheet. Surveyor noted the daily schedule/sheet provided did not accurately reflect the actual staff caring for the residents on each unit and asked for an updated accurate copy. On 2/14/22, Residents were served breakfast after 10:30 AM. Surveyor later learned this was because 3 of the dietary staff walked out of the facility on 2/14/22. On 2/16/22, at 8:25 AM, Surveyor interviewed RD-M (Regional Dietary) who stated he came to the facility for the complaint survey to oversee dietary. RD-M stated 3 employees walked out on Monday 2/14/22 and they were not doing their job in the kitchen or picking up dishes. On 2/16/22, at 12:17 PM, Surveyor interviewed RD-M who stated the facility has 1 cook and 3 dietary aides from 6:00 AM to 2:00 PM and 12:00 PM to 8:00 PM. On 2/16/22, at 2:04 PM, Surveyor interviewed WC-P (Wound Care LPN/PM Supervisor) who stated she personally has had to cook meals for the residents. WC-P stated nursing will help pass meal trays but have no time to monitor what the residents are eating or to assist them even to the point of not having enough nursing staff to get residents out of bed for meals. On 2/14/22 at 3:30 PM, Surveyor received another daily staffing sheet for a census of 88 which documented; Kindle unit (33 residents): 2 nurses and no CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor noted according to the facility assessment, there should have been a 1:10 ratio between CNAs and residents. The Kindle should have had at least 3 CNAs. Ember Unit (41 residents): 2 nurses and 1 CNA. Surveyor noted according to the facility assessment there should have been a 1:10 ration between CNAs and residents. The [NAME] unit should have had at least 4 CNAs. Sparkle Unit (14 residents): 1 nurse, 1 Med tech, and CNA-I (arrival at 8:45 AM). The actual staffing on 2/14/22 for a Census of 88 was: Day shift: 5 nurses, 1 Med Tech, 2 CNAs. Night shift: 4 nurses, 1 Med Tech, 6 CNAs. Surveyor noted according to the facility assessment the facility should have had: Day shift: 6-7 nurses rather than 5 nurses, 1 Med Tech and 8 CNAs rather than 2 CNAs (short 6 CNAs). The daily posted staffing sheet provided 2 days later on 2/16/22 for nursing staff directly responsible for resident care from 7 AM-7 PM indicated RN-23 hours, LPN-48 hours, CNA-33.5 hours. 7 PM-7 AM RN-36 hours, LPN-12 hours, CNA-120 hours. The Survey Team was unable to reconcile the schedule with the delayed postings with the observation of the lack in nursing staff. On 2/15/22, at 8:00 AM, Surveyor requested a daily staffing sheet from BD-W who stated NHA-A stayed late last night and will be in later, ADON-B has kids so will be in around 8:15-8:30 AM, and ADON-C is not in the facility. On 2/15/22, at 8:15 AM, Surveyor interviewed NHA-A who stated ADON-B has quit as well as WC-P (LPN wound care nurse) who also served as weekend supervisor. NHA-A stated meal times as 7 AM /11AM / 445PM and 3 dietary aides have walked out. NHA-A stated she was aware 2/14/22 breakfast was served at 10:40 AM starting on Sparkle as 2 corporate staff had to come in and help however lunch was on track. NHA-A stated the facility had 7 admissions on Friday 2/11/22 although she tries to put a cap on admissions to 3 or even 5 residents due to concern on lack of staffing. NHA-A stated she was off on Friday and VP-Q (Vice President of Operations) approved the admissions. Surveyor asked if the residents were admitted safely and NHA-A stated we audit the orders and charts. NHA-A stated some issues were found but not critical and they are readdressing the admits. NHA-A stated no one missed Dialysis, no major med errors, had to add shower and turn schedules. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/22, at 8:35 AM, Surveyor interviewed R4 who was cognitively intact. R4 was lying in the bed with long greasy hair hanging in strings and heels were resting directly on the mattress. Surveyor noted R4's 1/23/22 Minimum Data Set indicated R4 was at risk for the development of pressure injuries. R4 had the call light on (trending 10 minutes and 45 seconds) and R4 stated needing the bedside table adjusted as still in bed and unable to eat with the tray at that level. R4 stated no shower since admission on 1/30/22 and definitely never had hair washed or cleaned. R4 stated the staff put me in a disposable brief so I don't have to wait so long and wet the bed. On 2/15/22, at 8:40 AM, RN-L stated she was just in R4's room with meds so she does not know what R4 could want. Surveyor shared concern regarding the bedside table and R4's inability to eat. RN-L stated a CNA just came in and they will follow up with R4. On 2/15/22, at 12:31, Surveyor observed R4 remained lying in bed flat on back with heels directly on the bed. R4 was not dressed, stated no oral care today, just waiting for lunch. On 2/15/22, at 9:20 AM, Surveyor interviewed NHA-A regarding meals and passing of ice water. NHA-A stated Styrofoam cups were on back order last weekend so no ice water was passed. On 2/15/22, at 3:06 PM, the Survey team requested posted nursing staff hours. NHA-A stated the posting of hours is by the rest room and completed by SCH-O (Scheduler). Survey team did not observe posted staffing hours. The Survey team was provided the daily staffing sheet. Surveyor noted the daily staffing sheet provided did not accurately reflect the actual staff caring for the residents on each unit and asked for an updated accurate copy. The Survey team found it difficult to determine actual staffing as CNAs were listed in more than one unit and staff listed did not match the staff observed on the units. The Survey team requested actual staff punches for the last few days from 2/10/22. On 2/15/22 at 3:15 PM, the Survey team shared staffing concerns and call light response times with NHA-A, ADON-B, ADON-C, and VP-Q. On 2/16/22, at 7:49 AM, Surveyor interviewed MT-J (Med Tech) who was working on the Kindle unit. MT-J stated she has both med cart keys as the night nurse left at 7:15 AM and there is no nurse in the back hall to pass meds. MT-J stated she does not know where the care plans are and she was not trained as a CNA so she asks the residents questions if they need help. MT-J stated lately they are short staffed. On 2/16/22, at 7:51 AM, Surveyor interviewed CNA-K (on Kindle unit) who stated we do the best we can. CNA-K stated working short is terrible as we cannot provide cares or showers and we do not have the time to look up the resident's care plan. On 2/16/22, at 7:58 AM, Surveyor conducted observations on [NAME] unit and LPN-X (LPN Trainee) was utilizing a Vital Sign Machine going from room to room. LPNT-X stated she was shadowing RN-L for the day. On 2/16/22, at 8:00 AM, Surveyor interviewed RN-L who stated she was the only nurse passing meds for the whole unit. RN-L stated two CNAs were just sent to [NAME] as they did not have any CNAs prior to that and no one to answer call lights except me. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RN-L stated she still had the resident blood sugars to perform-2 in the back half, 11 in front and breakfast is supposed to be from 7-10 AM. RN-L stated it is hard to get the blood sugars done this am and before every meal. Surveyor continued to make observations and observed R4 lying in the bed with heels flat on the bed. Surveyor observed R10 sitting in at a dining room table in a wheelchair, unshaven with several days beard growth, Foley bag lying uncovered on the floor, and yelling out for his glasses. RN-L then went to R10's room to retrieve the eyeglasses. On 2/16/22, at 9:10 AM, NHA-A provided clean copies of posted nursing hours and stated SCH-O walked out of the facility after handing NHA-A all the postings from 2-10 to 2-16 which are inaccurate. NHA-A also shared that ADON-B is stepping down from her role as DON no longer works at the facility and ADON-B will be in the facility covering Kindle unit. On 2/16/22, at 9:40 AM, VP-Q requested to speak with the Survey Team. VP-Q stated next week is NHA-A's last week and who is painting a picture that the facility is a disaster which is not accurate. VP-Q stated he reviewed the staffing sheets on Friday 2/11/22 himself for admissions and from his knowledge, it looked OK but if it did not, then that would factor into decision making. VP-Q stated later in the day, there were call-offs. VP-Q stated he had seen more staff on Monday on copies of staff schedules but concerns were not discussed and he was not aware anyone shared the concerns regarding lack of staffing and admissions. Surveyor questioned VP-Q about the facility assessment and he stated it was completed by the IDT (Interdisciplinary Team). Surveyor referenced the staffing for an average daily census of 80 would have on day shift (12 hours): 6-7 nurses and a Med Tech on days with a ratio of 1:10 residents ratio for CNAs, a PM shift supervisor (3-11), and night shift (12 hours): 5 nurses and 1:15 residents ratio for CNAs. VP-Q stated he has not seen the facility assessment and he is not sure if the facility meets the facility assessment criteria. VP-Q stated he thinks the facility meets the state minimums for staffing. Surveyor questioned what those state minimums are and VP-Q stated he did not know them off the top of his head but leaves that to the scheduler. VP-Q stated plans for 2/21/22 for a whole new team with NHA, DON, ADON, Scheduler to be put into place. On 2/16/22, at 9:58 AM, the Survey team interviewed WC-P who stated she was a PM supervisor and was pushed into the role of wound care nurse when the previous nurse walked out, she had no formal training and had to learn the wound care rounds computer program by herself. WC-P stated this facility has a standard of reposition every 2-3 hours and not individualized which she has never seen before. WC-P would prefer to train and educate every 2 hours repositioning for the residents. WC-P stated she worked on the floor Saturday 2/12 and Sunday 2/13/22. On 2/16/22, at 11:43 AM, Surveyor conducted observations on Kindle unit and MT-J stated a nurse came to help at 9:00 AM and we have 2 CNA's. On 2/16/22, at 11:45 AM, Surveyor observed on [NAME] unit and interviewed LPNT-X who stated she was familiar with the hallway and would try passing AM meds as the Med Tech assigned was having issues. Surveyor observed the computer demonstrated the list of residents meds were flagged red indicated the meds were late in being administered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/16/22, at 11:49 AM, Surveyor observed R4 lying in the bed with heels flat on the bed and R4 stated still hungry waiting for food, hair remains disheveled and greasy strands. Surveyor observed R10 remained in the wheelchair in the same position (since 8:00 AM) at the dining room table with his Foley bag holding over 900 ml of urine, uncovered and lying on the floor. R10's mouth was dirty with brown stains and food particles and the white T-shirt had several colorful food stains down the front. On 2/16/22, at 12:00 Noon, the Survey Team noted the daily staffing schedule was inaccurate and awaited the updated daily staffing schedule plan versus the actual staff on the unit. On 2/16/22, at 12:43 PM, Surveyor observed Residents are beginning to be served lunch with the [NAME] unit being served with Styrofoam dishes. NHA-A stated that happens if the kitchen runs out of dishes because they are not washed. On 2/16/22, at 2:04 PM, WC-P indicated she wished to speak to the Survey Team. WC-P stated she had resigned because staffing is known but admissions are not stopped which is not fair to the residents or the workers. WC-P stated she is tired of poor care. WC-P stated positions are posted, interviews are conducted, orientation begins but no staff actually make it to the units to work. WC-P stated SCH-O never actually gets the info to schedule staff. WC-P stated there is often no dining or housekeeping in the facility and she personally has had to clean as well cook meals for the residents. WC-P stated nursing helps pass trays but no time to monitor what the residents are eating or to assist them even to the point of not having enough nursing staff to get residents out of bed for meals. WC-P stated she came in today to do wound care for the Survey Team but she has to return at 7 PM to work as there are not enough nurses. WC-P stated the residents have no activities. On 2/16/22, at 2:40 PM, ADON-B produced a new daily staffing schedule reflecting call offs and the Survey team reviewed the staffing seen on the units versus the paper listing of staff which did not match. ADON-B stated she will follow up. The Survey Team reviewed the facility staffing sheets from 1/15/22 to 2/16/22. Multiple cross outs and duplicate entries make it difficult to determine the exact amount of direct care staff caring for the residents without payroll punches and physical observation of actual staff on the units. On 2/16/22, at 4:01 PM, the Survey Team shared concerns regarding the delay in passing medications, doing blood sugar checks timely, answering call lights, showers, skin integrity, meals, and staffing with VP-Q and NHA-A. The Survey Team requested any further information regarding concerns be provided. 38937 Ember Unit: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 2/14/22 at 1:15 PM, Surveyor observed R7's call light was on. Surveyor observed the [NAME] unit call light monitoring system which indicated R7's call light was activated 24 minutes and 27 seconds. Surveyor went into R7's room and interviewed R7 stated who stated he needed help getting cleaned up. R7 stated he was old and dirty and sticky and was getting aggravated being old and sticky. Surveyor was leaving R7's room to look for staff assistance when a staff person came into R7's room and offered assistance. 3. On 2/14/22, at 1:20 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F and asked LPN-F who the assigned CNA (Certified Nursing Assistant) was for room [ROOM NUMBER]. LPN-F stated, there is only one CNA on the unit and she is the same CNA for all of the residents on this wing. Surveyor asked LPN-F if this type of staffing was typical. LPN-F stated, yes it was and that is why she is still passing her noon medications. Kindle Unit: 4. On 2/14/22, at 1:26 PM, Surveyor interviewed R6, who stated, she feels she needs to wait a long time to get staff assistance to change her brief. R6 stated, sometimes it takes hours. R6 stated, she heard through the grapevine that staff are leaving their jobs and just walking away. R6 stated, in the evening, after supper it's so quiet, no one is in the halls. R6 states this makes her very upset and anxious thinking there isn't staff at the facility. R6 stated one day she called for assistance around 6:00 AM and waited 4-5 hours for staff assistance to get help. 5. On 2/14/22, at 1:32 PM, Surveyor interviewed R8, who stated, the facility is shorthanded, short staffed. R8 stated she can wait anywhere from 5 minutes to 1 hour for staff assistance. R8 stated over the weekends she waits from 7:00 AM until 9:30 AM for staff to assist her. R8 stated she wanted to get up and get going for the day and it pissed her off that she had to wait so long for staff. R8 stated she asks staff and they tell her the facility is short staff and that is why R8 as to wait for staff assistance. 42037 Sparkle Unit: 6. On 2/15/22, at 10:15 am, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. On 2/15/22, at 12:30 pm, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. R2 has food particles present on their hospital gown. On 2/15/22, at 2:00 pm, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. R2 has dried food particles present on their hospital gown. On 2/15/22 at 3:30 pm, Surveyor made observations of R2 in bed in a hospital gown. R2 is noted to be disheveled with uncombed hair and unshaven. R2's fingernails are untrimmed and dirty. R2 has dried food particles present on their hospital gown. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/22, at 4:05 pm, Surveyor conducted an interview with R2. R2 was up in a wheelchair and dressed in a shirt and pants. R2 remained unshaven at this time with untrimmed, dirty fingernails. Surveyor asked R2 if they are usually in bed until late afternoon. R2 responded, I get up whenever they have time to get me up. Surveyor asked if R2 is receiving assistance with showers and personal hygiene. R2 told Surveyor that they can't remember when they were last showered. On 2/16/22, at 7:15 am, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, at 9:30 am, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, at 11:40 am, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, at 1:00 pm, Surveyor made observations of R2 in bed wearing the same shirt from 2/15/22 and an incontinence brief. R2 is noted to be disheveled with uncombed hair and unshaven. R2's nails are untrimmed and dirty. On 2/16/22, Surveyor reviewed R2's shower records from 1/18/22-2/16/22. Surveyor notes per documentation that R2 has not received a shower from 1/18/22-2/16/22 (29 days). On 2/16/22, at 3:30 pm, Surveyor informed NHA (Nursing Home Administrator)-A of concerns related to R2's disheveled appearance. Surveyor made NHA-A aware there is no documentation of R2 receiving showers from 1/18/22-2/16/22. No additional information was provided to Surveyor at this time. 7. On 2/16/22, at 7:40 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. On 2/16/22, at 9:45 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. On 2/16/22, at 10:30 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 11:15 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 11:45 am, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 12:25 pm, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/16/22, at 1:20 pm, Surveyor observed R3 in bed laying on their right side. R3 is in a hospital gown and unshaven. R3's oral mucousa is dry with thick, white secretions between lips. On 2/16/22, at 1:35 pm, CNA (Certified Nursing Assistant)-U and Wound Care Nurse-P performed incontinence cares for R3. Surveyor conducted an interview with CNA-U. Surveyor asked CNA-U how often R3 should be repositioned while in bed. CNA-U responded that R3 should be repositioned at least every 2 hours. Surveyor asked when R3 had last been repositioned. CNA-U responded that they had last repositioned R3 around 7:30 am and that they do not have enough help to provide care to R3 sometimes as R3 requires 2 staff members to assist in turning and repositioning. CNA-U confirmed that R3 had not been repositioned from 7:30 am to 1:35 pm on 2/16/22, as they were the only CNA working on the unit and caring for 22 residents this morning. Surveyor asked CNA-U how often a residents should be receiving a bath. CNA-U told Surveyor they should receive a bath at least once a week. Surveyor asked CNA-U if they are able to provide showers for residents per their careplans. CNA-U responded that they do the best they can but a lot of times they will have to give residents bed baths in lieu of showers due to lack of staff. Surveyor asked CNA-U how often R3 should be receiving oral care. CNA-U responded that residents should have oral care every shift but [TRUNCATED]

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41439 The facility did not ensure the posted daily staffing information was accurate and current for the 88 residents residing in the facility. Findings include: On 2/15/22, at 3:06 PM, Survey team requested posted nursing staff hours. NHA-A (Nursing Home Administrator) stated the posting of hours is by the rest room and completed by SCH-O (Scheduler). Survey team did not observe posted staffing hours. On 2/16/22, at 9:10 AM, NHA-A provided clean printed copies of posted nursing hours and stated SCH-O walked out of the facility after handing NHA-A all the postings from 2-10 to 2-16-22. NHA-A stated they (the nurse postings) are inaccurate, not updated. NHA-A also shared that ADON-B is stepping down from her role as the former DON no longer works at the facility. The Survey Team was unable to reconcile the provided daily schedules with the delayed postings copies and the observation of the lack in actual nursing staff on the units.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on interview and record review, the facility did not maintain medical records for each resident that are complete, accurately documented, readily accessible and systematically organized in accordance with accepted professional standards and practices for 1 (R1) of 2 residents reviewed. R1 had a change in condition on 2/4/22 but no documentation of R1's disposition when R1 was no longer residing in the facility. R1 had documentation by NP-R (Nurse Practitioner Wounds) that R1 was a DNR (Do Not Resuscitate) despite conflicting facility records indicating R1 was full code. Findings include: R1 was admitted to the facility on [DATE] with diagnoses including Renal Failure with Hemodialysis, Diabetes, CHF (Congestive Heart Failure), Severe Protein Calorie Malnutrition, Stroke with Right-Sided Weakness, and COVID 19 (1/4/22), and is no longer residing in the facility. R1's Admission MDS (Minimum Data Set), dated 11/26/21, indicated R1 was moderately cognitively impaired. R1 required extensive assistance with 1 staff for bed mobility, dressing, and toileting. R1 was dependent with 2 staff for transfer. *Progress notes on 2/4/22 at 8:25 AM indicated R1 complaints of shortness of breath. Blood pressure 100/78, resp 18, pulse 88, 02 89% on room air, there was some use of accessory muscles, put 2 liters of 02 on resident, Update to NP, will continue to monitor. R1's medical record does not indicate any follow through of what happened to R1 or R1's disposition. On 2/16/22, at 1:32 PM, Surveyor requested information regarding what happened to R1 as no information was documented in R1's medical record. On 2/16/22, at 3:44 PM, Surveyor interviewed the medical group NP-AA (Nurse Practitioner) who stated the nurses alerted NP in the am that R1 had a change in condition with shortness of breath, decreased oxygenation, decline, and mottling. NP- AA stated she does not remember any other information from the afternoon for R1. NP- AA stated she would write a late entry note regarding orders to send R1 to hospital. Progress notes dated effective 2/4/22 at 3:46 PM and written on 2/16/22 at 3:48 PM by NP-AA indicated: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alerted to change of condition by floor nurse. patient noted to have low oxygen saturations and required 2 liters of oxygen. Patient reporting increased shortness of breath. Orders for STAT chest x-ray 2 view given. Patient evaluated. Able to answer questions. reporting shortness of breath. Denying chest pain. Confusion remains, but stable from previous visit. No increased lethargy or abnormal neuro symptoms. ADDENDUM: Received phone call from RN regarding worsening condition of patient. RN reporting patient's lower extremities appear mottled, confusion has worsened and shortness of breath has progressed. Orders to send patient to ER for immediate evaluation given. Surveyor reviewed R1's NP-R progress notes (1/21/22 at 8:30 PM, 1/28/22 at 9:41 PM, 2/4/22 at 11:11 AM) regarding R1's wound care and NP-R indicated R1 was a DNR (Do Not Resuscitate) when R1 was full code status. Progress notes written on 2/8/22 indicated on 2/4/22 at 12:21 PM-(Late Entry): R1 was asked what R1 wanted in regards to Advance Directive. R1 was given education while being assisted with eating lunch. R1 stated wanted DNR. paperwork was signed after education with writer and nurse in room. Sent to MD for signature. Surveyor reviewed R1's undated DNR form with R1's illegible signature. R1's records were incomplete and contained inaccurate documentation.