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	08/15/2022

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not treat 1 (R24) of 3 Residents with dignity and respect. R24 had items removed from his over bed table when R24 was not in the room and no staff spoke with R24 why the items were removed prior to R24 inquiring. Findings include: R24 was admitted to the facility on [DATE] with diagnoses which includes diabetes mellitus, chronic obstructive pulmonary disease, end stage renal disease, anxiety disorder, and gastro-esophageal reflux disease. The admission MDS (minimum data set) with an assessment reference date of 7/31/22 documents a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. On 8/2/22 at 10:22 a.m. Surveyor spoke with R24 and asked how he was. R24 replied not good. R24 informed Surveyor when he came back from dialysis yesterday he was missing items on the over bed table. Surveyor asked R24 what he was missing. R24 informed Surveyor alka seltzer, cough syrup, and medication for itching. R24 stated it was gone. R24 informed Surveyor a tall guy said he would come back to talk to him but that was two hours ago. R24 indicated he thought it was a nurse. R24 informed Surveyor he didn't know they could come into his room when when he was not in his room. R24 stated he thought his things would be secure and they were taken without an explanation. Surveyor observed a box of imodium on R24's over bed table and inquired about the imodium. R24 replied Funny they left it. I have to have those things as I know how my body reacts. Surveyor asked if anyone spoke to him about the items which were removed from his over bed table. R24 informed Surveyor no one spoke with him and that they just took the items. R24 stated I'm not impressed with this place. As soon as I can I'm out of here. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/22 at 11:26 a.m. Surveyor asked ACNO (Assistant Chief Nursing Officer)-O if he was aware of R24's items being removed from his over bed table. ACNO-O informed Surveyor he received a message from the night nurse and R24 informed him there were two medications on his table, alka seltzer and cough medicine, when he went to dialysis. ACNO-O informed Surveyor he told R24 he would follow up with him today. ACNO-O informed Surveyor from his understanding R24 had a bag with quite a few medications in that R24 wanted to keep in his room. Surveyor asked ACNO-O if anyone should remove items from R24's room if he is not in his room. ACNO-O replied no, nothing should be taken out or removed if not aware. ACNO-O informed Surveyor he will follow up. ACNO-O informed Surveyor sometimes items will be moved to the medication room and the resident should be notified they were removed. On 8/2/22 at 1:17 p.m. ACNO-O informed Surveyor R24 went to dialysis. While at dialysis housekeeping went in to clean his room, noticed the items on the over bed table and spoke to the nurse. The nurse removed the items, inventoried them and placed them in the locked cabinet. ACNO-O informed Surveyor the failure was the nurse did not let R24 know. ACNO-O informed Surveyor he spoke with R24 and R24 is understanding of it. On 8/2/22 at 4:04 p.m. Surveyor asked R24 if ACNO-O spoke to him. R24 replied ya, didn't like the answers, didn't like that someone came in when I wasn't here.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not make prompt efforts to resolve grievances made by residents or ensure written grievance decisions included the steps taken to investigate the grievance, a statement as to whether the grievance was confirmed or not confirmed, and any corrective action taken by the facility as a result of the grievance for 1 (R1) of 9 residents reviewed for grievances. *R1 family member filed a grievance with the facility on 6/20/2022 that was not promptly or thoroughly investigated. Findings: The facility policy and procedure entitled Grievances dated 4/2022 states: The Grievance Official will initiate the appropriate notification and investigation processes per individual circumstance and facility guidelines. The investigation will consist of at least the following: -A review of the completed complaint report -An interview with the person or persons reporting the grievance -Interviews with any witnesses to the concern -A review of the medical record if indicated -A search of resident room (with resident permission) -Interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident -Interview with the resident roommate, family members and visitors -Completion of a root cause analysis of all circumstances surrounding the concern As necessary, the Grievance Official and facility leadership will take immediate action to prevent further potential continuations of any additional and like resident concerns while the grievance is being investigated. RESOLUTION The Grievance Official will complete a response to the resident and/or resident representative which includes: -Date of grievance (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Summary of grievance -Investigation steps -Findings -Resolution outcome and actions taken with date decision was determined. R1 was admitted to the facility on [DATE] with diagnoses of acute posthemorrhagic anemia, gastrointestinal hemorrhage with chronic ulcer, acute kidney failure, diabetes, severe protein-calorie malnutrition, diverticulosis, and heart disease. R1's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and needed limited assistance with most activities of daily living. On 6/20/2022, BOM-HH filled out the Resident Grievance Form after a message was left on BOM-HH's voicemail on 6/16/2022. The Statement of Grievance section was hand-written by BOM-HH and stated R1 was not shaved frequently; clothes were not changed often enough; R1 wanted to go to the doctor a few weeks back and was told R1 did not need to go; R1 had heart, lung, and kidney disease and needed to see doctors but was told R1 could only see the primary doctor at the facility; the food was always cold; and the family member was questioning if the appeal does not go through, what were they responsible for paying. BOM-HH wrote an asterisk and stated BOM-HH left a brief message for R1's family member informing them on what they would be responsible for paying, told the family member they could call back, and R1's insurance would be exhausted on 7/1/2022 and R1 would then be private pay. The complaint was investigated by a nurse on 6/24/2022. The Summary of Resolution was hand-written by the nurse and stated the nurse assessed R1 and R1 had clean clothing on and appeared to be shaven; and the in-house physician followed R1's medical needs and would be referred to a specialist as needed. The nurse investigating the grievance was no longer employed by the facility and unavailable for interview. Nursing Home Administrator (NHA)-A signed the grievance form on 6/27/2022. No documentation was found indicating staff were interviewed to determine the validity of the grievance or actions were taken to rectify the grievance: Certified Nursing Assistants (CNAs) were not interviewed to determine how often R1 was shaved or clothes were changed, R1 was not interviewed to determine R1's preferences regarding facial hair or what clothes R1 preferred to wear; dietary staff were not interviewed to determine the temperature of food when it was served or if other residents had similar concerns with food; and R1's family member was not communicated with to determine which doctors R1 needed or wanted to follow up with. No documentation was found indicating R1's family member was followed up with to determine if the grievance was resolved to their satisfaction. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/2/2022 at 1:40 PM, BOM-HH stated BOM-HH deals with the insurance aspects of resident stays and their benefits. Surveyor asked BOM-HH if a resident or family member had a concern or grievance, what would BOM-HH do with the concern. BOM-HH stated depending on the type of complaint, BOM-HH would direct it to whichever department the concern related to. Surveyor asked BOM-HH if there was a specific form that was filled out when there was a grievance. BOM-HH stated yes, there is a form, but residents and family members typically did not come to BOM-HH with concerns. Surveyor asked BOM-HH if BOM-HH recalled getting a voicemail from R1's family member. BOM-HH could not recall any voicemail from R1's family member. Surveyor showed BOM-HH the Resident Grievance Form dated 6/20/2022. BOM-HH stated yes, BOM-HH had filled that form out. BOM-HH stated BOM-HH had forgotten about getting that voicemail and had left a message for R1's family member regarding the financial aspect of R1's stay. In an interview on 8/3/2022 at 8:44 AM, Social Worker (SW)-GG stated SW-GG had been employed by the facility since the beginning of 6/2022. Surveyor asked SW-GG if SW-GG recalled R1. SW-GG stated SW-GG had only been in the facility for one week prior to R1 discharging. (R1 discharged from the facility on 6/28/2022.) Surveyor asked SW-GG what the process was for filing a grievance. SW-GG stated there is a grievance form and anyone can take a concern. SW-GG makes a copy of the grievance form and gives the original to the department the concern relates to. SW-GG puts the grievance in a log and follows up on the grievance daily at stand-up. SW-GG stated when the grievance is completed, the paperwork is returned to SW-GG. Surveyor asked SW-GG how a grievance by a family member is handled. SW-GG stated a lot of family members overstep their boundaries and want something other than what the resident wants; the resident has rights and those take priority over what the family member wants. Surveyor asked SW-GG if the family member that filed the grievance is contacted for follow up when the grievance is resolved. SW-GG stated it is on a case-by-case basis if the family member is called back or not. SW-GG stated if the resident says they will tell the family, then the facility does not call the family back. Surveyor asked SW-GG if the family member files a grievance and they are not called back after the grievance is followed up on, how is it determined the grievance has been resolved. SW-GG stated if the resident is happy, the grievance process is complete. In an interview on 8/3/2022 at 11:11 AM, NHA-A stated SW-GG was the grievance official for the facility. On 8/4/2022 at 10:10 AM, Surveyor reviewed with DON-B the concerns with R1's grievance from 6/20/2022: the facility did not address the full extent of the grievance or follow up on all the aspects of the complaint. DON-B agreed the follow-up was not thorough and by reviewing the grievance form, it could not be determined if the family member that filed the grievance was contacted after the concerns were addressed to see if the grievance was resolved. No further information was provided at that time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview & policy review, the Facility did not ensure 1 (R27) 2 allegations of abuse were immediately reported to the Administrator and State Survey Agency. Findings include: The Abuse and Neglect policy and procedure dated April 2020 documents Reporting and Response: It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported per Federal and State law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Survey Agency and adult protective services in accordance with State law through these established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility per agreement with the local law enforcement agency. R27's admission MDS (minimum data set) with an assessment reference date of 7/13/22 documents a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 8/2/22 at 3:50 p.m. Surveyor spoke with R27 and asked if there is anything she is not happy with. R27 informed Surveyor she had just realized money was stolen from her purse. Surveyor inquired how much money was taken. R27 replied 62 dollars and explained she had her purse in a canvas bag. Surveyor asked R27 when she realized the her money was missing. R27 replied last Thursday (July 28th) when she went out for an out patient appointment. Surveyor asked R27 if she reported her money was missing to anyone. R27 replied yes, of course. R27 explained she reported the missing money to the care giver last Thursday and she didn't know she had to report this to the head nurse. R27 informed Surveyor this has gotten straightened out as the missing money was reported to ACNO (Assistant Chief Nursing Office)-O and the higher ups came to interview her. Surveyor asked R27 if she knew the name of the caregiver she reported the missing money to. R27 informed Surveyor CNA (Certified Nursing Assistant)-P's first name but R27 doesn't know the last name and it was last Thursday (July 28th). R27 informed Surveyor she doesn't expect to get the money back and kind of believes in [NAME]. R27 indicated she is not going to [NAME] over it and it's too bad someone felt the need to take her money. On 8/2/22 at 4:10 p.m. Surveyor asked ACNO-O if anyone reported R27 is missing money. ACNO-O informed Surveyor it was reported to him on Monday (August 1st) R27 was missing $62.00. ACNO-O thinks it was two twenties, two tens, and two singles. ACNO-O indicated R27 never leaves the room but did have one appointment. ACNO-O informed Surveyor he along with another staff member went to speak with R27 and asked if they could look in her room. Surveyor asked ACNO-O if he reported R27's missing money to Administrator-A. ACNO-O replied yes, immediately. ACNO-O informed Surveyor he is in the process of obtaining staff statements. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/3/22 at 7:57 a.m. Surveyor asked Administrator-A for the Facility's 24 hour report to the State agency regarding R27's missing money. On 8/3/22 at 3:00 p.m. Surveyor reviewed the Facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report (F-62617) and noted the Report Submitted Date documents 8/1/2022 4:03:42 PM. On 8/4/22 at 7:47 a.m. Surveyor spoke with CNA-P on the telephone. Surveyor asked CNA-P if when R27 returned from an outside appointment on Thursday, July 28th if she reported to her she was missing money. CNA-P informed Surveyor R27 informed her she had gone to the doctors with her purse and when she got back from the doctors she was missing 60 something dollars was missing. CNA-P informed Surveyor she told the nurse after that. Surveyor asked CNA-P if she knew the name of the nurse she reported R27's missing money to. CNA-P informed Surveyor the first name of LPN (Licensed Practical Nurse)-Q. CNA-P informed Surveyor LPN-Q told her they have to contact human resource in the morning. On 8/4/22 at 7:55 a.m. Surveyor spoke with LPN-Q on the telephone. Surveyor asked LPN-Q if anyone told her R27 was missing money. LPN-Q informed Surveyor she thinks a CNA told her something about missing money or a wallet. LPN-Q informed Surveyor this happened before she arrived for her shift. Surveyor asked if CNA-P was the CNA that told her about R27's missing money. LPN-Q informed Surveyor it may have been CNA-P that mentioned it. Surveyor asked LPN-Q if she reported R27's missing money to anyone. LPN-Q replied I did not. Surveyor asked LPN-Q why she didn't report R27's missing money. LPN-Q explained when the CNA told her it was like a previous event that may have happened the day before and was already taken care of. On 8/4/22 at 8:26 a.m. Surveyor asked ACNO-O if a CNA reports a Resident is missing money what should the nurse do. ACNO-O informed Surveyor the nurse needs to report to an ACNO (Assistant Chief Nursing Officer), if they aren't available this should be reported to who ever is covering for them. ACNO-O informed Surveyor the nurse can go directly to DON (Director of Nursing)-B or Administrator-A. Surveyor asked ACNO-O if he became aware of R27's missing money on Monday (August 1st). ACNO-O replied correct. Surveyor asked how ACNO-O how he became aware of R27's missing money. ACNO-O replied by staff in the morning. Surveyor asked ACNO-O who told him. ACNO-O replied it as all my staff in huddle. Surveyor asked ACNO-O if he was aware of R27's missing money before Monday (August 1st). ACNO-O replied not to my recollection. On 8/4/22 at 1:41 p.m. Surveyor asked Administrator-A when he became aware of R27's missing money. Administrator-A informed Surveyor he became aware on Monday (August 1st). Surveyor informed Administrator-A Facility staff were aware of R27's missing money on Thursday, July 28th. Administrator-A replied If I was made aware would of reported. R27's missing $62.00 should have been reported to the State Agency on 7/28/22.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not immediately investigate 1 (R27) of 1 Residents reviewed for an allegation of misappropriation of Resident's property when Facility staff became aware of the allegation. Facility staff became aware of R27's missing money on Thursday, 7/28/22 but R27's missing money was not reported to ACNO-O and Administrator-A until 8/1/22 at which time an investigation began. An investigation regarding R27's missing $62.00 should have been started on 7/28/22. Findings include: The Abuse and Neglect policy and procedure dated April 2020 documents Investigation: It is the policy of this facility that all allegations and reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. R27's admission MDS (minimum data set) with an assessment reference date of 7/13/22 documents a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 8/2/22 at 3:50 p.m. Surveyor spoke with R27 who informed Surveyor she had just realized money was stolen from her purse. Surveyor inquired how much money was taken. R27 replied 62 dollars and explained she had her purse in a canvas bag. Surveyor asked R27 when she realized the her money was missing. R27 replied last Thursday (July 28th) when she went out for an out patient appointment. Surveyor asked R27 if she reported her money was missing to anyone. R27 replied yes, of course. R27 explained she reported the missing money to the care giver last Thursday and she didn't know she had to report this to the head nurse. R27 informed Surveyor this has gotten straightened out as the missing money was reported to ACNO (Assistant Chief Nursing Office)-O and the higher ups came to interview her. Surveyor asked R27 if she knew the name of the caregiver she reported the missing money to. R27 informed Surveyor CNA (Certified Nursing Assistant)-P's first name but R27 doesn't know the last name and it was last Thursday (July 28th). R27 informed Surveyor she doesn't expect to get the money back and kind of believes in [NAME]. R27 indicated she is not going to [NAME] over it and it's too bad someone felt the need to take her money. On 8/2/22 at 4:10 p.m. Surveyor asked ACNO-O if anyone reported R27 is missing money. ACNO-O informed Surveyor it was reported to him on Monday (August 1st) R27 was missing $62.00. ACNO-O thinks it was two twenties, two tens, and two singles. ACNO-O indicated R27 never leaves the room but did have one appointment. ACNO-O informed Surveyor he along with another staff member went to speak with R27 and asked if they could look in her room. Surveyor asked ACNO-O if he reported R27's missing money to Administrator-A. ACNO-O replied yes, immediately. ACNO-O informed Surveyor he is in the process of obtaining staff statements. On 8/3/22 at 7:57 a.m. Surveyor asked Administrator-A for the Facility's 24 hour report to the State agency regarding R27's missing money. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/3/22 at 3:00 p.m. Surveyor reviewed the Facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report (F-62617) and noted the Report Submitted Date documents 8/1/2022 4:03:42 PM. On 8/4/22 at 7:47 a.m. Surveyor spoke with CNA-P on the telephone. Surveyor asked CNA-P if when R27 returned from an outside appointment on Thursday, July 28th if she reported to her she was missing money. CNA-P informed Surveyor R27 informed her she had gone to the doctors with her purse and when she got back from the doctors she was missing 60 something dollars. CNA-P informed Surveyor she told the nurse after that. Surveyor asked CNA-P if she knew the name of the nurse she reported R27's missing money to. CNA-P informed Surveyor the first name of LPN (Licensed Practical Nurse)-Q. CNA-P informed Surveyor LPN-Q told her they have to contact human resource in the morning. On 8/4/22 at 7:55 a.m. Surveyor spoke with LPN-Q on the telephone. Surveyor asked LPN-Q if anyone told her R27 was missing money. LPN-Q informed Surveyor she thinks a CNA told her something about missing money or a wallet. LPN-Q informed Surveyor this happened before she arrived for her shift. Surveyor asked if CNA-P was the CNA that told her about R27's missing money. LPN-Q informed Surveyor it may have been CNA-P that mentioned it. Surveyor asked LPN-Q if she reported R27's missing money to anyone. LPN-Q replied I did not. Surveyor asked LPN-Q why she didn't report R27's missing money. LPN-Q explained when the CNA told her it was like a previous event that may have happened the day before and was already taken care of. On 8/4/22 at 8:26 a.m. Surveyor asked ACNO-O if a CNA reports a Resident is missing money what should the nurse do. ACNO-O informed Surveyor the nurse needs to report to an ACNO (Assistant Chief Nursing Officer), if they aren't available this should be reported to who ever is covering for them. ACNO-O informed Surveyor the nurse can go directly to DON (Director of Nursing)-B or Administrator-A. Surveyor asked ACNO-O if he became aware of R27's missing money on Monday (August 1st). ACNO-O replied correct. Surveyor asked how ACNO-O became aware of R27's missing money. ACNO-O replied by staff in the morning. Surveyor asked ACNO-O who told him. ACNO-O replied it as all my staff in huddle. Surveyor asked ACNO-O if he was aware of R27's missing money before Monday (August 1st). ACNO-O replied not to my recollection. Surveyor informed ACNO-O Facility staff was aware of R27 missing $62.00 on Thursday, July 28th and the investigation should have started immediately on this date. On 8/4/22 at 1:41 p.m. Surveyor asked Administrator-A when he became aware of R27's missing money. Administrator-A informed Surveyor he became aware on Monday (August 1st). Surveyor informed Administrator-A Facility staff were aware of R27's missing money on Thursday, July 28th. ACNO-O and Administrator-A were not aware of R27's missing money until 8/1/22 and started an investigation on this date but the investigation should have been started on 7/28/22 when staff became aware of R27's missing money.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45647 Based on interview, and record review, the facility did not ensure 1 (R15) of 18 residents reviewed for ADL (Activities of Daily Living) assistance received the necessary services to maintain good grooming and personal hygiene. *R15 did not receive a shower while at the facility per their plan of care. Findings include: The facility policy, entitled Bathing, with a revision date of 11/2018, states: Policy: 1. All residents are offered a bath in accordance with their preference 2. If a resident doesn't have a specific bathing preference, the facility bathing schedule will be used. 3. Residents will be kept clean and well groomed. R15 was admitted to the facility on [DATE], and has diagnoses that include cerebral infarction, diabetes, aphasia, and dysphagia. R15's admission MDS (Minimum Data Set) dated, 4/28/22, documents a BIMS (Brief Interview for Mental Status) score of 09, indicating R15 is moderately impaired for daily decision making. Section G (Functional Status) documents R15 requires extensive assistance of one-person physical assist for personal hygiene needs and requires physical help in part of the bathing activity of one-person physical assist. ADL (Functional / Rehabilitation Potential CAA (Care Area Assessment) under the Care Plan Considerations section, .The ADL CAA triggered because R15 needs limited to extensive assistance with ADLs, mobility, and bowel and bladder management . Section F0400 (Interview for Daily Preferences): C. How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Very Important. R15's ADL care plan documents, The resident has an ADL self-care performance deficit and limited physical mobility related to impaired mobility, deconditioning, and weakness. The interventions section documents, Personal Hygiene: Set up. R15's CNA (Certified Nursing Assistant) tasks, which directs CNAs how to care for R15, documents under the bathing section that R15 should receive a shower on Monday and Friday, night shift. Surveyor was unable to interview R15 because they discharged from the facility. Surveyor requested R15's CNA task documentation and/or bath sheets while R15 was in the facility from DON (Director of Nursing)-B. (continued on next page)

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	525730	A. Building B. Wing	08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R15's CNA tasks documentation that was provided by the facility. Surveyor noted that R15 was to have a shower 4/25/22, 4/29/22, and 5/2/22. Those dates on the CNA tasks documentation were blank for R15. On 8/2/22, at 2:20 p.m., Surveyor interviewed CNA-L. CNA-L reported that if a resident refuses a shower, it is documented under tasks in the CNA charting that the resident refused. CNA-L showed surveyor charting for another resident who refused a shower today (8/2/22) and that it is documented as refused. On 8/3/22, at 3:00 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. There was no additional information provided by the facility.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on observation, interview and record review the facility did not ensure 3 (R26, R5 and R24) of 26 residents reviewed received the treatment and care in accorance with professional standards of prctice, the comprehensive person-centered care plan, and the resident's choices. On [DATE] R26 was diagnosed with COVID-19 and there was no RN comprehensive assessment of R26 on [DATE] and [DATE]. Once diagnosed with COVID-19 nursing never asked if the resident wanted an antiviral medication. STAT lab orders were obtained on [DATE] due to a high pulse rate. The lab results indicated a critical result of WBC (white blood count) at 20.1 and the ordering physician was not notified of the lab result. On [DATE] R26 was found deceased . The Facility's failure to comprehensively assess R26 while he was experiencing COVID-19 symptoms, not asking if R26 wanted an antiviral medication, and the failure to notify a physician of the result of a critical lab created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA (Nursing Home Administrator) A of the immediate jeopardy on [DATE] at 12:30 p.m. The immediate jeopardy was removed on [DATE]; however the deficient practice continues at a scope/severity of D (potential for harm/isolated) as the facility continues to implement its action plan and as evidenced by; * R24 did not have an assessment or treatment to wounds on the toes. * R5 did not have consistent and completed wound care treatment. Findings include: 1) The facility's policy regarding notification of the physician with date of [DATE] indicate: 1. Nursing will notify resident's physician or nurse practitioner when: a. The resident is involved in an accident or incident. b. There is a significant change in the resident's physical, mental or emotional status. c. There is a pattern of refusing treatment or medication. d. The resident wants to be discharged or leave AMA e. It is deemed necessary or appropriate in the best interest of the resident. 2. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident and family of the issue and physician orders. 3. The communication with the resident and their responsible party as well as the physician will be documented in the resident record or other appropriate documents. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The care plan coordinator will be notified so that changes can be made to the care plan. R26, who was [AGE] years-old, was admitted to the facility on [DATE] with diagnoses of muscular dystrophy, TBI (traumatic brain injury) and right femur fracture. The quarterly MDS (minimum data set) dated [DATE] indicates R26 is alert and oriented and is his own decision maker. It also indicates R26 needs extensive assistance with bed mobility, dressing and hygiene. The medical record indicates R26 had a signed DNR (do not resuscitate) form dated [DATE] and refused the Covid vaccines. The nurses note dated [DATE] indicates R26 tested positive for COVID-19 after the facility tested all residents and staff because of a COVID-19 outbreak. There is no documentation that staff asked R26 if he wanted an antiviral medication for COVID-19. The vital signs summary indicate on [DATE] at 6:14 a.m. R26 BP ,d+[DATE], pulse 118, respiration 18, temperature 98 and pulse ox 97% on room air. On [DATE] at 10:05 a.m. R26 BP ,d+[DATE], pulse 106, respiration rate 16, temperature 98.1 and pulse ox 92% on room air. R26's pulse oxygen has dropped from 97% to 92%. There was no assessment of R26's lung sounds. The facility's Daily COVID assessment dated [DATE] at 10:37 a.m. indicates R26 had the following symptoms: headache and cough with temperature of 98.1. No other assessment information is documented. The nurses note dated [DATE] at 11:12 a.m. indicates R26 had an elevated heart rate and the NP (nurse practitioner) was made aware and ordererd STAT (immediate) labs and IV (intravenous) fluids. The nurses note dated [DATE] at 11:46 a.m. indicates 20 gauge IV placed in R (right) arm. NS (normal saline) fluids running at 75ml/hr (milliliters/hour). The SBAR (situational, background, assessment, recommendation) dated [DATE] at 11:47 a.m. indicates BP ,d+[DATE], pulse 106, respiration rate 16, temperature 98.1 and pulse ox 92% on room air. There are no further assessments conducted after the SBAR note dated [DATE] at 11:47 a.m. There was no documented assessment of R26's lung sounds and no monitoring of vital signs for the rest of the day on [DATE]. Surveyor reviewed the lab results for R26. The lab report indicates the specimen was collected on [DATE] at 2:34 p.m. and the final report was generated on [DATE] at 11:28 p.m. The lab results indicate WBC (white blood cell) count was critically high at 20.1 (reference range: 4XXX, d+[DATE].8). Other note worthy lab results are platelet count 137 (reference range ,d+[DATE]), neutrophils percent 80.6 (reference range ,d+[DATE]), eosinophils percent 0 (reference ,d+[DATE]) and lymphocytes percent 4.2 (reference range ,d+[DATE]). On [DATE] at 12:31 a.m. R26 BP ,d+[DATE], pulse 85, temperature 97.7, respiration rate 18 and pulse ox 91% on room air. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Daily COVID assessment dated [DATE] at 2:18 a.m. indicates R26 did not exhibit any symptoms with a temperature of 97.7. No other assessment information is documented. There were no subsequent vital signs or assessment of R26. The nurses note dated [DATE] at 9:53 a.m. indicates writer went into resident's room today to give morning medications and take vitals. Writer noticed resident's chest was not moving and he appeared pale. Pulse ox was not able to get a reading. Management notified, DNR status confirmed. Management was not able to find a pulse or auscultate any heart sounds. Writer called resident's spouse, no answer. Waiting call back at this time. On [DATE] at 10:25 a.m. Surveyor interviewed RN H. RN H stated R26 was positive for Covid on [DATE] and on [DATE] R26 oxygen level dropped to 91%, had a pretty bad cough and a high pulse rate. RN H stated she notified the NP and received orders for 1 liter of NS at 75ml/hr and STAT lab work. RN H stated she started the IV fluids on her shift but it was at a slow rate so it didn't finish on her shift. RN H shift was from 7:00 a.m. until 7:00 p.m RN H stated the STAT labs were obtained on her shift but the results did not come back on her shift. RN H stated when she came back on [DATE] in the morning she noticed the lab results on the desk at the nurses station but did not look at it. RN H stated she did not look at it until after she noticed R26 deceased . RN H stated the night shift did not report any critical lab results to her and did not report any changes regarding R26. On [DATE] at 12:20 p.m. Surveyor called Lifescan Laboratory that provided the lab results. Lifescan representative indicated the critical lab result was called in to a nurse (LPN I) on [DATE] at 12:55 a.m They also indicate they attempted to call the facility on [DATE] at 11:56 p.m. and [DATE] at 12:12 a.m. and finally reached LPN I at 12:55 a.m. to report the critical lab result. On [DATE] at 6:25 a.m. Surveyor interviewed LPN I. LPN I stated she worked the 7:00 p.m. to 7:00 a.m. shift on [DATE] into [DATE]. LPN I stated RN 26 normally didn't sleep much at night. LPN I stated she saw R26 around 9:00p.m. for his evening medications. LPN I stated he was coughing at that time because of Covid. LPN I stated she then saw R26 about 4:00 a.m. or 4:30 a.m. and R26 was sitting up in bed alert and doing his word search puzzle. LPN I stated R26 was coughing but looked normal and seemed stable. Surveyor asked LPN I if she received a call from Lab with a critical lab for R26. LPN I stated she doesn't remember getting a call from lab. LPN I stated all calls come to her nurses station and then she forwards then to the appropriate unit if necessary but doesn't remember a call from lab. LPN I stated if she did receive a call with a critical lab result she would notify the physician on call. On [DATE] at 2:00 p.m. Surveyor interviewed MD J. MD J is the physician for R26. MD J stated her service did not get a call from the facility on [DATE] regarding a critical lab result for R26. MD J stated she would have expected the nursing staff to call her or whoever was on call that night with the critical lab. MD J stated she wouldn't have done or prescribed anything differently (although the nurse responsible for calling would not have known what the MD's response would be). MD J stated the lab results were indicative of COVID. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:00 p.m. during the daily exit meeting with DON B and NHA A, Surveyor explained the concerns R26 did not have regular comprehensive assessments while he was experiencing COVID symptoms and the critical lab result along with the other abnormal lab results were not communicated to the physician. Surveyor explained the concern R26 was found deceased without documentation indicating R26 health status prior to being found deceased . On [DATE] at 11:00 a.m. Surveyor asked DON B if the facility had a policy regarding the use of antiviral medications for residents experiencing COVID symptoms. DON B stated they do not have a policy regarding the use of antiviral medications for COVID. DON B stated no resident, positive with COVID in the facility, is prescribed an antiviral medication for COVID symptoms. According to a [DATE] memo put out by the Wisconsin Department of Public Health, Older adults are at highest risk of getting very sick from COVID-19. More than 81% of COVID-19 deaths occur in people over age 65. The number of deaths among people over age 65 is 97 times higher than the number of deaths among people ages ,d+[DATE] years. According to information from the Wisconsin Department of Health Services data through [DATE] shows, People who were unvaccinated died at a rate 6.4X the rate of people who had been vaccinated with a primary series only, and 3.5X the rate of those who had the primary series and booster dose. Similarly, failure to offer an antiviral medication increased the risk for hospitalization and death. In an analysis of over 40 clinical trials involving mostly unvaccinated individuals, [NAME] University in Ontario found: Molnupiravir and Paxlovid each lowered the risk of death beyond standard care or placebo with moderate certainty (10.9 fewer deaths per 1,000 patients; 95% confidence interval [CI], 12.6 to 4.5 fewer for molnupiravir and 11.7 fewer deaths per 1,000; 95% CI, 13.1 fewer to 2.6 more for Paxlovid). A total of 10 trials with 5,575 patients reported 252 hospitalization s over a median follow-up of 21 weeks. The researchers assumed a baseline risk of 54.4 hospitalization s per 1,000 patients. Paxlovid lowered the risk of hospitalization by 46.2 admissions per 1,000 (95% CI, 50.1 to 38.9 fewer) with high certainty, while molnupiravir likely reduced the risk of hospitalization s by 16.3 per 1,000 (95% CI, 27.2 to 0 fewer) with moderate certainty. The failure to assess R26, who was experiencing serious COVID-19 symptoms, the failure to not ask R26 if he wanted an antiviral medication for COVID, and the failure to notify the physician or a critical lab result, created a reasonable likelihood for serious harm given R26's age and vaccination status, thus creating a finding of immediate jeopardy. The facility removed the jeopardy on [DATE], when the facility completed the following: ~ The facility has provided re-education with all licensed nurses regarding notification of physician on policy and procedures regarding changes of condition, including timely reporting of abnormal lab results to the provider. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ Staff education with licensed nurses further has included education regarding the immediate notification and assessment by a designated RN in-house and/or on call. Staff education with licensed nurses has also included immediate notification of the provider in the event a critical lab result is received. Continuing staff re-education will occur for all licensed nurses prior to the start of shift until education is fully completed with all licensed nursing staff. ~ Changes of condition will be assessed immediately by a designated RN in-house and noted on the daily staffing sheet. Changes of condition will be discussed in verbal report each oncoming and off going shift by the licensed nurse, as well as reviewed during the daily clinical meeting by the DON and/or designee. Changes of condition, including assessment by the RN, provider notification, and any new orders or treatments received will be noted in the electronic medical record by the licensed nurse. ~ The DON and/or designee will review the 24 hour report board daily to ensure any changes of condition are reported to the provider in accordance with facility policy and procedure The Change of condition policy and procedure has also been added to the orientation and training agenda to be reviewed with all new licensed nurses. These updates occurred as of [DATE]. On [DATE] the facility policy regarding Changes of Condition was updated to specify timely notification of critical labs to the provider. Current standards of practice, as well as Medical Director review has occurred and will be reviewed on a monthly basis at the facility QAPI (Quality Assurance Program Improvement) committee meetings regarding the Changes of Condition policy and procedure. The Director of Nursing and/or designee will conduct audits daily x 2 weeks, weekly x 8 weeks, and monthly x 3 months to ensure resident changes of condition are timely reported to the provider, including abnormal and critical lab results. Audits will further ensure compliance with RN assessment of changes of condition, as well as ensuring shift to shift communication regarding changes of condition occurs in accordance with facility policy and procedure. Audits will be integrated into the quality assurance process and facility assessment. The deficient practice continues at a scope/severity of D (potential for more than minimal harm that is not immediate jeopardy) based on the following examples: 20483 2. R24 was admitted to the facility on [DATE] with diagnoses which includes diabetes mellitus, end stage renal disease, anxiety disorder, hypertension, and right below knee amputation. The admission MDS (minimum data set) with an assessment reference date of [DATE] documents a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. The nursing evaluation dated [DATE] under the skin integrity section documents yes for the question does the resident have skin integrity concerns. Under site documents Other (specify) and description BLE (bilateral lower extremity) weeping. Under site documents Other (specify) and description left lower leg diabetic ulcers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted there is no documentation of necrotic tissue on R24's great left toe or left 5th toe. The nurses note dated [DATE] documents New admit via ambulance transferred from [name of] hospital. DX (diagnosis) multifocal pneumonia. Edema present to LLE (left lower extremity) two open areas posterior of left calf. 7 sutures removed at hospital left outer knee. Dressing to be changed daily. HX (history) HTN (hypertension) DM2 (diabetes mellitus) hemodialysis in house. CPAP machine in evening. Resident full code alert orientated x (times) 4 VSS (vital signs stable) afebrile received all vaccines. Signed consents. On [DATE] at 10:35 a.m. Surveyor observed R24 in bed on his back. R24 is not wearing a gripper sock on his left foot today and Surveyor observed necrotic tissue on the top of R24's left great toe & left 5th toe. Surveyor inquired about these areas. R24 informed Surveyor developed these areas from new diabetic shoes. R24 informed Surveyor he hasn't worn the shoes at the Facility as his stump has edema and not able to wear his prosthetic leg. On [DATE] at 1:10 p.m. Surveyor reviewed R24's medical record and was unable to locate an assessment for the two necrotic areas on R24's left great & 5th toe. There is no treatment on R24's July or August TAR (treatment administration record). On [DATE] at 1:31 p.m. Surveyor asked ACNO (Assistant Chief Nursing Officer)-R what happens when a Resident is admitted with skin alterations. ACNO-R informed Surveyor the admission nurse takes pictures of the areas, measures the areas and makes sure there is a treatment. ACNO-R informed Surveyor the next day she or RN (Registered Nurse) Supervisor-K will assess the wounds and make sure everything is appropriate for that wound. Surveyor asked ACNO-R where would Surveyor be able to locate the assessment for R24's left great toe and 5th toe wound. ACNO-R informed Surveyor RN Supervisor-K took pictures today and R24 had left leg front surgical wound is what she saw. Surveyor asked ACNO-R if she observed R24's toes. ACNO-R informed Surveyor RN Supervisor-K has the list. Surveyor asked ACNO-R if R24's wound assessments has been completed. ACNO-R informed Surveyor she doesn't know if RN Supervisor-K has completed R24's wound assessments. Surveyor asked ACNO-R if she could get in contact with RN Supervisor-K for Surveyor. On [DATE] at 1:39 p.m. Surveyor asked RN Supervisor-K if she completed with R24's wound assessment. RN Supervisor-K replied all finished. Surveyor asked RN Supervisor-K where Surveyor would be able to locate the assessment for the necrotic areas on R24's left great & 5th toes. RN Supervisor-K informed Surveyor when R24 was admitted she was never informed of these areas on R24's toes. RN Supervisor-K informed Surveyor she looked at R24 on the 27th ([DATE]) for the surgical wound. RN Supervisor-K informed Surveyor she would look at R24's toes. Surveyor asked for a copy of the assessment when completed. The left 5th toe wound assessment dated [DATE] documents under wound information for type trauma, classification abrasion and source facility-acquired. Under tissue types documents Necrotic Hard, Firm, Adherent= 100%. Under measurements documents for size 0.50 x (times) 0.50 x Unknown. The R (right) great toe wound assessment dated [DATE] documents under wound information for type trauma, classification abrasion and source facility-acquired. Under tissue types documents Necrotic Hard, Firm, Adherent: 100%. Under measurements documents for size Length - 0.50 cm (centimeters) Width - 0. 50cm Depth - Unknown. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted this assessment is for the left great toe as R24 has a right below knee amputation. The SBAR (situation, background, assessment, recommendation) note dated [DATE] at 15:14 (3:14 p.m.) includes documentation of Nursing observations, evaluation, and recommendations are: scabbed over area to L (left) great toe and L 5th toe. Measuring 0.5x 0.5 for both. Will be followed in wound rounds. Betadine BID (twice daily). The nurses note dated [DATE] at 15:27 (3:27 p.m.) documents stated shoes did not fit right. Has been wearing slippers for months before admission to facility. Slippers observed at residents bedside. NP (nurse practitioner) updated, TX (treatment) in place. The necrotic areas on R24's left great and 5th toe were not assessed and a treatment was not ordered until Surveyor brought these areas to the attention of Facility staff. On [DATE] at 3:19 p.m. Administrator-A and DON (Director of Nursing)-B were informed of the above. 38146 3. The Facility Wound Policy and Procedure dated March, 2020 documents (in part) . .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. Procedure: Risk reduction measures such as use of heel protectors (designed for friction/shear reduction versus pressure reduction), elevation of lower extremities, etc. (etcetera) are initiated if determined appropriate. Discussion with the attending physician and resident/representative includes notification of any skin impairment identified upon admission. Orders are verified or obtained as needed. Comprehensive wound assessment documentation will be completed by the Wound Care Nurse and/or designee. R5 admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses included Acute Respiratory Failure, hyperkalemia, hypercapnia, Atrial Fibrillation, Diabetes Mellitus type 2, Hypertension and Acute Kidney Injury. R5's Hospital Discharge Summary dated [DATE] did not include any wound care orders. R5's Wound Assessment Details Report dated [DATE] documented: Left small toe venous stasis ulcer present on admission. An assessment and measurements was completed and documented. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Right great to venous stasis ulcer present on admission. An assessment and measurements was completed and documented. Right outer calf venous stasis ulcers present on admission. An assessment and measurements was completed and documented. R5's June, 2022 Treatment Administration Record (TAR) indicated no treatment was ordered or implemented for R5's right great toe ulcer upon admission. On [DATE] an order was obtained for Betadine to right great toe every day shift. Documentation revealed this treatment not signed out as having been completed on [DATE], [DATE] and [DATE]. On [DATE] orders were obtained for normal saline wash to the great toe, pat dry, followed by Santyl and dry dressing daily. Surveyor noted the Betadine treatment was not removed from the TAR. Documentation revealed this treatment not signed out as having been completed during the time R5 resided in the facility. R5's June, 2022 TAR indicated no treatment was implemented for R5's left small toe ulcer during the time R5 resided in the facility. R5's June, 2022 TAR indicated no treatment was ordered for R5's right outer calf ulcers upon admission. Orders were obtained on [DATE] for normal saline wash to bilateral lower extremities, pat dry followed by Unna Boots 2x (two times) a week, change every Tuesday and Friday AM. Documentation revealed this treatment not signed out as having been completed on [DATE] and [DATE]. Surveyor review of subsequent assessment and measurements indicated no decline in R5's wounds, ulcers were smaller in size according to last documented measurements on [DATE] (4 days before R5 discharged). On [DATE] at 9:45 AM Surveyor spoke with Licensed Practical Nurse (LPN)-Z who worked with R5 on [DATE], [DATE] and [DATE]. LPN-Z reported she did not remember doing Unna Boots for R5. Surveyor showed LPN-Z the 2 different treatment orders for R5's great toe. LPN-Z reported she did not remember which treatment she completed. On [DATE] at 9:00 AM, Surveyor spoke with Director of Nursing (DON)-B regarding R5's ulcer treatments. DON-B reported R5 did not have Unna Boot wraps on his lower extremities until she applied them on [DATE] after speaking to R5's daughter, who reported he wore them at home. Surveyor advised DON-B of concerns regarding delay in treatment, 2 different treatment orders for R5's great toe, and missing documentation of treatment having been completed for R5's venous stasis ulcers. DON-B reported ongoing education is provided to nurses to complete and sign out treatments. DON-B reported the facility has eliminated agency staff and has new department heads as of June, 2022. No additional information was provided.

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	525730	A. Building B. Wing	08/15/2022

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38937 Based on interview and record review the facility did not ensure the environment for 2 residents (R14 and R13) remained as free of accident hazards as possible and received adequate supervision and assistance devices to prevent accidents. * R14 had multiple falls at the facility. The facility did not thoroughly investigate the falls to determine a root cause or identify if previous fall interventions were in place at the time of the falls. On 6/30/22, R14 had a fall that resulted in a head laceration requiring sutures. R14 had a subsequent fall on 7/12/22 resulting in an identified altered mental status and transfer to the hospital. * R13 had falls while at the facility. The facility did not thoroughly investigate the falls to determine a root cause, nor implement fall prevention interventions to prevent future falls. Findings include: The facility policy, entitled Fall Prevention, dated November 2020, states: General: To ensure all residents have the necessary interventions in place to help prevent falls and promote safety in accordance with all state and federal regulations. Policy: Each resident residing at this facility will be provided services and care that ensures that the resident's environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility and after every fall in the facility. Interview the resident and/or responsible party to determine any factors that may predispose the resident for fall and/or activities that have helped prevent falls in the resident's previous environment. Ensure optimal communication regarding the resident's condition and potential for fall with other providers: during shift changes; including all disciplines; when sharing information about the resident; with the resident and family about the fall prevention issues and any fall prevention activities to be carried out for the resident. The interdisciplinary team will develop a plan of services to improve or maintain the resident's standing and sitting balance and other interventions to reduce the resident's risk for fall. The plan will include specific, individualized information about the resident's routine and personal habits that may place the resident at risk for fall such as night time voiding or night time wandering. The effectiveness of the fall reduction activities, including assessment, causal factors, interventions, and education will be evaluated by the Interdisciplinary Care Plan team at the time of each comprehensive assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. R14 was admitted to the facility on [DATE] with diagnoses that include: Encephalophy, Bell's palsy, other abnormalities of gait and mobility, dysarthria and anarthia, unspecified falls, cognitive communication deficit, lack of coordination, unspecified protein calorie malnutrition, congestive heart failure, type 2 diabetes with diabetic neuropathy, chronic obstructive pulmonary disease, and alcohol abuse. R14 was discharged to the community on 7/20/22. R14's Admission MDS (Minimum Data Set) assessment, dated 4/25/22, documents: a Brief Interview of Mental Status (BIMS) score of 10, indicating moderate cognitive impairment for daily decision making; Patient Health Questionnaire (PHQ-9) score of 15, indicating moderately severe depressive symptoms; requires limited assistance of one person for transfers, walking, dressing, toilet use and personal hygiene; balance is not steady and only able to stabilize with human assistance when moving from seated to standing, walking, turning around and facing opposite direction when walking, moving on and off the toilet and surface to surface transfers; occasionally incontinent of bladder and bowel; had a fall within 1 month of admission to the facility, had a fall within 2-6 months of admission to the facility, had a fall since admission to the facility without injury, and has received anticoagulant medication 7 times over the last 7 days and diuretic medication 6 times over the last 7 days. R14's care plan, dated 4/19/22, documents: The resident is at risk for falls r/t (related to) HX: (history) of CVA (cerebral vascular accident). Interventions dated 4/19/22: Anticipate and meet the resident's needs; Ensure bed brakes are locked; Ensure footwear fits properly; Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; Follow facility fall protocol. On 4/18/22, upon admission to the facility, R14 was assessed to be at high risk for falls. Fall 1 On 4/23/22, at 9:30 AM, R14's medical record documents the resident had an unwitnessed fall in the dining room. Nursing Description: resident stood up and w/c (wheelchair) brakes not locked and w/c rolled back and resident sat on floor. Resident Description: resident tried to stand and landed on the floor, w/c moved brakes not locked. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	No injuries noted; resident mental status: oriented to person, place and situation; no predisposing environmental factors; predisposing physiological factors section is left blank; predisposing situation factors: wheelchair unlocked; Post Fall Neurological Evaluation, dated 4/23/22, 09:00 (9:00 AM) documents: oriented to person, verbalizes appropriately, alert, confused, no baseline changes in grip strength; overall status: is left blank. Surveyor was unable to locate documentation the facility thoroughly investigated the fall to determine the root cause. There is no documentation of when R14 was last seen by staff, last assisted to the bathroom, last ate or why R14 was attempting to stand unassisted. On 4/23/22, R14 was assessed to be at a high risk for falls. On 4/23/22, at 14:31 (2:31 PM), R14's medical record documents: facts on falls education was not done due to resident cognitive status. Patient unaware to not stand up alone. On 4/24/22, R14's care plan was updated to include fall prevention intervention: W/C brakes locked when sitting in w/c auto lock brakes on w/c to prevent roll back. On 4/25/22 R14's medical record documents: MD (Medical Doctor) documents: resident is impulsive with ambulation and transfers, sometimes abandoning 2 WW (wheeled walker). Remind patient of need for assistance and during mobility tasks. Risk for falls, patient is a fall risk will continue gait, balance, and coordination in training with therapy team. Nursing unit fall protocols in place. Surveyor is unable to locate documentation of R14's impulsive behavior with ambulation and transfers and abandoning the 2 ww address in R14's care plan. Fall 2 On 5/2/22, at 19:00 (7:00 PM), R14's medical record documents, R14 had an unwitnessed fall in his room. Nursing Description: Resident stated that he had fallen asleep lying on his R (right) side and rolled out of bed. Abrasion x2 (two abrasions) noted to L (left) knee. Daughter updated. Resident Description: see above. Injury Type: Abrasion right front knee; Mental Status: oriented to person and place; Predisposing Environmental Factors: None is check marked; Predisposing Physiological Factors: gait imbalance, balance problems, incontinent; Predisposing Situation Factors: other equipment being used is checked; Other Info: rolled out of bed; Witnesses: no witnesses found. Post Fall Neurological Evaluation form, dated 5/2/22, 19:00 (7:00 PM), documents: oriented to person and place and not oriented x4; verbalizes appropriately; alert; evaluation grip strength for baseline changes: no baseline changes; over all status: evaluation indicates no changes from baseline. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor was unable to locate documentation the facility thoroughly investigated the fall to determine the root cause. There is no documentation of when R14 was last seen by staff, last assisted to the bathroom, if the call light was on or within R14's reach or when R14 was assisted to bed. On 5/3/22, R14's care plan was updated to include fall prevention intervention of: encourage body pillows while in bed. Fall 3 On 6/4/22, at 09:32 (9:32 AM), R14's medical record documents R14 had a witnessed fall in the dining room. Incident description documents: Nursing Description: Witnessed resident slide slowly from w/c onto floor near dining room table, softly landing on bottom. Resident fell asleep in w/c after eating b-fast (breakfast). Writer could not run to resident fast enough. Did not injure self. Did not hit head. Denied pain. Vitals stable. Neuro (Neurological) assessment at baseline and within normal limits. Resident able to stand up with assist of gait belt and assist of one back into w/c. ROM (Range of Motion) at baseline-within normal limits. Resident Description: Speech unclear, able to make out I fell asleep and slipped. Immediate Action Taken: Ran towards resident to try and avoid him from sliding/sitting on floor, unable to approach and prevent fast enough. Assessed range of motion, hand grasps, assesses pain. Neurological assessment completed. Vitals taken. Assessed skin and bony prominence's. Transferred back into w/c. Practitioner notified. RN (Registered Nurse) supervisor on call notified. Spouse [name of spouse] and brother of resident notified. Injuries observed at time of incident: No injuries observed at time of incident. Mental Status: oriented to: person, situation, place, time, x4; Predisposing Environmental Factors: None is check marked; Predisposing Physiological Factors: confused, gait imbalance, balance problems, behaviors, difficulty with communication, impaired memory, loss of leg or arm movement, weakness/fainted, incontinent; Predisposing Situation Factors: other, wheelchair locked, wheelchair used, other-fell asleep in w/c, slid to floor from low w/c seat onto bottom, gait belt used. Surveyor was unable to locate documentation the facility thoroughly investigated the fall to determine the root cause. There is no documentation of when R14 was last assisted to the bathroom, how R14 slept last evening or when R14 was assist out of bed that morning. On 6/6/22, R14's care plan was updated to include fall prevention interventions of: encourage to lay down after meals and sign in room to remind guest to call for assistance. These interventions were added to R14's care plan 2 days after his fall on 6/4/22, and on the same day R14 fell for the 4th time while in the facility. Fall 4 On 6/6/22 at 15:45 (3:45 PM), R14's medical record documents R14 had an unwitnessed fall in his room. Nursing Description: Writer was approached by CNA (Certified Nursing Assistant), found patient on the floor in sitting position. Upon writer's arrival, resident was found on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident Description: Pt (Patient) states I was trying to get up. Immediate Action Taken: Writer took vital signs and assessed alertness. The CNA and I got patient up in wheelchair, then CNA helped resident to the bed. No injuries observed at time of incident. Mental status: Oriented to person, situation, and place. Predisposing Environmental Factors: wet floor. Predisposing Physiological Factors: agitated, incontinent. Predisposing Situation Factors: ambulating without assistance. Witnesses: no witnesses found. Post Fall Neurological Evaluation, dated 6/6/22 at 15:45 (3:45 PM), documents: oriented to person place and situation; verbalizes appropriately; alert; evaluate grip strength for baseline changes: no baseline changes; overall status: this is left unchecked. Surveyor was unable to locate documentation the facility thoroughly investigated the fall to determine the root cause. There is no documentation of when R14 was last seen, last assisted to the bathroom, if R14 fell from his bed or his wheelchair and if R14 was encouraged to lay down after meals and if the floor was wet due to R14 being incontinent or for other reasons. On 6/6/22, R14's care plan was updated to include fall prevention interventions of: encourage to lay down after meals and sign in room to remind guest to call for assistance. Fall 5 On 6/24/22, at 03:25 (3:25 AM), R14's medical record documents the resident had an unwitnessed fall in his room. Incident Description Nurses Description: Called to pt (patient) room, CNA found pt on floor sleeping next to bed. Resident Description: Pt stated, He tired. Immediate Action Taken: Pt assessed then returned to bed, no injuries noted. Mental Status: Oriented to person, place, and time; Predisposing Environmental Factors: Interventions in place at time of fall, low bed; Predisposing Psychological Factors: incontinent; Predisposing Situation Factors: footwear in place, transferring independently; Witnesses: no witnesses found. Post Fall Neurological Evaluation, dated 6/24/22, at 03:25, documents: oriented: to person, place, and situation; verbalizes appropriately; alert; evaluate grip strength for baseline changes: no baseline changes; overall status: evaluation indicates no changes from baseline. Surveyor was unable to locate documentation the facility thoroughly investigated the fall to determine the root cause. There is no documentation of when R14 was last seen, last assisted to the bathroom, if R14 fell from his bed or his wheelchair, if the call light was within R14's reach or if it was on and, if R14 was in bed, were body pillows in the bed as per the 5/3/22 care planned intervention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/24/22, R14's care plan was updated to include fall prevention interventions of: low bed. Per the facility fall documentation on 6/24/22 at 3:25 AM, a low bed was documented as being in place at the time of the fall. No other fall prevention interventions were documented following this fall. Fall 6 On 6/30/22, at 15:55 (3:55 PM), R14's medical record documents R14 had an unwitnessed fall in the dining room. Incident Description Nursing Description: Writer notified resident had unwitnessed fall in dining room. Observed resident sitting on floor next to wc (wheelchair), RN performing assessment. Resident not able to verbalize how fall occurred. Able to answer yes/no questions. Laceration noted to L (left) eyebrow. No c/o (complaint of) pain or discomfort, able to move extremities freely. Resident transferred back to bed. POA (Power of Attorney), agrees for resident to be sent to [name of hospital] ER (emergency room), NP (Nurse Practitioner) updated. Resident Description: Resident unable to give description. Immediate Action Taken: sent to [name of hospital] ER. Injuries Observed at Time of Incident: Abrasion to left front of knee; laceration to face; and abrasion to other. Surveyor noted there was no description of location of the abrasion identified as other. Mental Status: oriented to person, situation; Predisposing Environmental Factors: none; Predisposing Physiological Factors: incontinent, calm; Predisposing Situation Factors: wheelchair used; Witnesses: no witnesses found. Post Fall Neurological Evaluation, dated 6/30/22 at 15:55 (3:55 PM) documents: oriented to person, not oriented x4, verbalizes appropriately, alert, evaluate grip strength for baseline changes: no baseline changes; Overall Status: Evaluation indicates no changes from baseline. Surveyor notes R14's orientation is documented as having declined from the Post Fall Neurological Evaluation completed on 6/24/22. This decline is not identified as an overall status decline for R14 by the facility. On 6/30/22, at 2300 (11:00 PM) R14's medical record documents: Res (resident) returned to facility 2300 6/30. Returned with new orders for stitches to left eyebrow laceration. Surveyor was unable to locate documentation the facility thoroughly investigated the fall to determine the root cause. There is no documentation of when R14 was last seen, last assisted to the bathroom, if the wheelchair brakes were locked and if auto lock brakes were on the wheelchair, if R14 agreed to lay down after meals and if so when was R14 assisted out of bed. Surveyor notes this is R14's 3rd fall in the dining room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/1/22, R14's care plan was updated to include fall prevention interventions of: wedge cushion in wheelchair. Fall 7 On 7/12/22, at 11:15 AM, R14's medical record documents R14 had a witnessed fall in the dining room. Incident Description Nursing Description: fell asleep in w/c and fell forward out of wheelchair. Did hit front of head with small indent observed. No active bleeding. Is on Eliquis and NP did order for resident to be transported to [name of hospital] for CT (Computed Tomography) scan of head. ROM (Range of Motion) WNL (Within Normal Limits), h/o (history of) stroke with hemiplegia. Falling asleep in w/c. Self-reported pain to area of head that hit floor. Vitals stable, Blood sugar reading read HI (high). Resident Description: Stated he fell asleep and fell out of wheelchair. Immediate Action Taken: Notified daughter [name of daughter], NP [name of NP], nurse manager of unit and report called into [name of ambulance company] for transport as well as ER charge nurse. Mental Status: oriented to person, situation, and place; Injuries reported post incident: no injuries observed post incident; Predisposing Environmental Factors: none; Predisposing Physiological Factors: drowsy, balance problem, incontinent; Predisposing Situation Factors: none; Witnesses: no witnesses found. Post Fall Neurological Evaluation, dated 7/12/22, at 11:16 AM documents: orientation to person and situation; right and left pupil equal and reactive to light; right pupil is brisk and left pupil is sluggish; verbalizes appropriately, alert; lethargic, drowsy; evaluate grip strength for baseline changes: no baseline changes; overall status: evaluation indicates no changes from baseline. Surveyor notes R14's left pupil is documented as being sluggish and R14 is describes as being lethargic and drowsy. R14 is assessed as having declined since the prior neurological assessment completed on 6/30/22. This decline is not identified as an overall status decline for R14 by the facility. On 7/12/22, at 15:29 (3:29 PM) R14's medical record documents: Res returned from [name of hospital] with no new orders received. [Name of transport company] transported, BMP (Basic Metabolic Panel) Electrocardigram, CT of cervical spine and head w/o (without) contrast completed with no new findings. VSS, neuro assessment at baseline. Dtr (daughter) [name of daughter] aware. Surveyor was unable to locate documentation the facility thoroughly investigated the fall to determine the root cause. There is no documentation of when R14 was last seen, last assisted to the bathroom, if the wheelchair brakes were locked and if auto lock brakes were on the wheelchair, if R14 agreed to lay down after meals and if so when was R14 assisted out of bed and if a wedge cushion was in the wheelchair at the time of the fall. Surveyor notes this is R14's 4th fall in the dining room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R14's care plan was not updated with new fall prevention interventions after this fall. On 8/3/22, at 1:15 PM, Surveyor interviewed Director of Nursing (DON)-B, who stated all information related to R14's fall investigations can be found in the electronic medical record (EMR). DON-B stated the fall investigation documentation in the ERM should indicate what fall prevention interventions were in place at the time of the fall. DON-B stated the fall investigation should document what fall prevention intervention was put in place to prevent future falls and the interventions should address the reason for the resident's fall. Surveyor informed DON-B of the concern R14's fall investigations do not document what fall prevention interventions were in place at the time of the fall, when R14 was last seen or assisted by staff or identify root cause of R14's falls. DON-B stated she would look into these concerns but would expect all information related to an investigation of a fall would be documented in the resident's medical record. On 8/4/22, surveyor informed Nursing Home Administrator-A and DON-B of the concern the facility did not thoroughly investigate R4's fall nor identify the root cause of the falls. 22692 2. R 13 was admitted to the facility on [DATE] with diagnosis that included Toxic Encephalopathy, and Muscle Weakness. An admission Minimum Data Set (MDS) was not completed as R13 discharged home against medical advice on 5/17/22, before 14 days at the facility. On 8/2/22 R13's fall risk evaluation dated 5/6/22 was reviewed and indicated R13 was at high risk for falls and had a recent fall before admission to the facility. On 8/2/22 R13's falls care plan dated 5/8/22 was reviewed and indicated risk for falls related to Gait/balance problems, Vision/hearing problems and R13 intentionally slides/falls to floor related to behaviors. On 8/2/22 R13's fall investigations were reviewed and read: 5/10/22: R13 found lying on the floor in his room. States he rolled out of bed. No other investigation was found as to when R13 was last seen or toileted or if falls interventions were in place at the time of the fall. 5/11/22: R13 found lying on the floor in supine position, next to his wheelchair. R13 indicated he slipped out. No other investigation was found as to when R13 was last seen or toileted or if falls interventions were in place at the time of the fall. 5/13/22: R13 on the floor next to his bed. R13 stated he was trying to sit up and slipped out of bed. No other investigation was found as to when R13 was last seen or toileted or if falls interventions were in place at the time of the fall. Interventions were added to R13's care plan after each fall to help prevent future falls but since the investigations were not through it is unclear if these interventions were appropriate as the reason for the fall was not fully investigated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/3/22 at 1:00m the Surveyor interviewed Director of Nursing (DON)-B and DON-B indicated she had no more information on R13's falls and there should be a through investigation with each fall. On 08/3/22 at 3:00 pm The Surveyor shared above findings with the Administrator and DON-B. Additional information was requested if available. None was provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, interview and record review the facility did not ensure 2 (R12) of 2 residents reviewed for weight received the necessary services to assist with nutritional maintenance. * R12 had a severe weight loss of 14.4 pounds or 9.09% in less than 30 days intervention was not taken until 5/4/22 (5 days later). *R1 had a severe weight loss of 19.2 pounds, or 12.9%, in eight weeks with no notification made to the physician or Registered Dietician. No interventions were put in place to prevent further weight loss. Findings include: On 8/3/22 the facility's policy titled, Weight Policy dated 11/18 was reviewed and read: Any resident with an unexplained significant weight loss will have a weight loss investigation completed. 1. R12 was admitted to the facility on [DATE] with diagnosis that included Diabetes type 2 and Muscle wasting. On 8/2/22 R12's weights were reviewed and were recorded as follows: 04/6/22 158.4 pounds (Lbs.) 04/29/22 144 Lbs. (a 14.4 Lbs. weight loss or 9.09% in less than 30 days) 05/18/22 153.5 Lbs. On 8/2/22 at 10:30 AM Dietician-S was interviewed and indicated that she reviews the weights weekly unless she is contacted. Dietician-S indicated she could not recall if she was notified on 4/29/22 of R12's 14-pound weight loss but should have been. Dietician-S indicated she did not put additional interventions due to R12's weight loss or assess it until 5/4/22 (5 days later). On 8/2/22 R12's nutrition note written by Dietician-S on 5/4/22 was reviewed and read: Weight: 4/29/22 144.0 lbs.; weight is down 24.8 lbs. x 1 month (17.2%). BMI 26.3. Hospital weights reviewed: 4/7/22: 77.1 kg/169.62 lbs., 4/26/22 65.5 kg/144.1 lbs. Intake 50% meals. Intake continues to be poor. Guest is independent with set-up. No chew/swallow issues noted. Nutrition Diagnosis: inadequate oral intake related to acute on chronic illness. Guest with increased nutrient needs related to wound healing. Evident protein calorie malnutrition related to Acute onset chronic disease AEB (as evidenced by) muscle wasting, edema, inadequate oral intake, functional decline. Significant weight loss. Nutrition Intervention: Registered Dietician recommendations: (continued on next page)

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	525730	A. Building B. Wing	08/15/2022

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Add 1500 cc (milliliters or cubic centimeter) Fluid Restriction due to ascites, End stage renal disease. 2. Nepro 1 carton po daily; provides 425 kcal (calories), 19 g (grams) protein 3. Prostat 30 cc daily for additional 100 kcal, 15 g protein. LCS, NAS diet as ordered due to low K+ per hospital recommendations. Staff continues to monitor and encourage intake, offer alternates as appropriate. Fluids pushed. Communication with Renal RD as needed. Nutrition Monitoring and Evaluation: Weight: Weight fluctuation anticipated with dialysis treatment. Intake: > (more then)50% meals, 100% supplement Labs: monitored per MD (Medical Doctor)/NP (Nurse Practitioner) orders Wounds: show signs/symptoms of healing. Resident referred to MD for diagnosis of malnutrition. Significant weight loss, inadequate oral intake, edema, Muscle wasting, functional decline. Although the above dietician notes indicate a 24.8-pound weight loss in one month that weight could not be verified in R12's medical record and the recorded weight with a 14.4-pound weight loss was used for these findings. No evidence could be found that R12's Physician was notified of her severe weight loss until 5/4/22. On 8/2/22 R12's nutritional care plan dated 3/24/22 was reviewed and included the intervention Evaluate any weight changes. Determine percentage changed and follow facility protocol for weight change. The intervention was added to the care plan on 3/28/22 and remained until R12 was discharged . On 08/3/22 at 1:00m the Surveyor interviewed Director of Nursing (DON)-B who indicated that the dietician and physician should have been notified right away for R12's 14.4 lb. weight loss on 4/29/22 and it appears they were not. On 08/3/22 at 3:00 pm Surveyor shared above findings with the Administrator and DON-B. Additional information was requested if available. None was provided. 38253 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R1 was admitted to the facility on [DATE] with diagnoses of acute posthemorrhagic anemia, gastrointestinal hemorrhage with chronic ulcer, acute kidney failure, diabetes, severe protein-calorie malnutrition, diverticulosis, and heart disease. R1's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and needed limited assistance with most activities of daily living. Hospital weights were reviewed and were documented as follows on the hospital discharge summary: -3/14/2022: 122 pounds, 125 pounds, 119 pounds. (Three separate weights were documented.) -3/16/2022: 125 pounds -3/17/2022: 126 pounds On 3/24/2022 in the facility, R1 weighed 133.0 pounds. On 3/25/2022 a Potential for Nutritional Deficit Care Plan was initiated with the following interventions: -Administer medications as ordered; monitor/document for side effects and effectiveness. -Allow R1 sufficient time to eat. -Obtain and document weights per physician orders and facility protocol. -Registered Dietician to evaluate and make diet change recommendations as needed. On 4/4/2022 on the Comprehensive Nutrition Assessment, the dietician documented this was the initial evaluation of R1. The assessment had the following information provided: Diet: no type of diet was indicated Texture: Regular Liquids: Thin Supplements: Spouse was bringing in Boost for R1 Current intake: 51-75% General appearance: Thin, muscle wasting noted Resident is well nourished: No Fat loss: Moderate Muscle loss: Moderate (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Condition of hair, nails, skin: mucous membranes moist Presence of edema: No Presence of skin alterations: Yes, skin tear to arm Able to use hands and arms: Yes Cognition: Able to understand and be understood Height: 66 inches (3/24/2022) Weight: 133.0 pounds (3/24/2022) BMI (Body Mass Index): 21.5 Usual body weight range: 125 pounds Ideal body weight: 154 pounds Adjusted body weight: 133 pounds 1 month, 3 month, 6 month weight gain/loss: Unknown Physician consulted for weight gain/loss: no answer indicated Nutrition Diagnosis: Evident protein calorie malnutrition related to inadequate oral intake, muscle/fat wasting, functional decline Nutrition Intervention: Continue with current diet as ordered. Boost provided by family per R1's preference. Staff continues to monitor and encourage intake, offer alternates as appropriate. Nutrition Monitoring and Evaluation: Maintain weight at 133 pounds plus or minus 3%, greater than 75% intake at meals, monitor labs per physician orders. Referred to physician for diagnosis of malnutrition: Yes due to diagnosis of malnutrition. R1 had an order on admission, 3/24/2022, for Vitamin D and Iron daily. On 4/4/2022, R1's Potential for Nutritional Deficit Care Plan had the following interventions added: -Evaluate any weight changes; determine percentage changed and follow facility protocol for weight change. -Family providing Boost supplement for R1 per R1's preference. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide LCS (low concentrated sweets) NAS (no added salt) regular consistency/thin liquid diet as ordered; monitor intake and record every meal. R1 did not have any weights recorded from 3/24/2022 until 5/20/2022. On 5/20/2022, R1 weighed 115.8 pounds, a 19.2-pound weight loss or 12.9%. On 5/24/2022, R1 weighed 114.4 pounds. On 6/5/2022, R1 weighed 113.8 pounds. No documentation was found indicating the Registered Dietician or the physician was notified of the significant weight loss. R1 discharged from the facility on 6/28/2022. In an interview on 8/2/2022 at 3:20 PM, Surveyor asked Registered Dietician (RD)-S what the facility protocol was for obtaining weights for a newly admitted resident. RD-S stated a weight is obtained on admission, weekly times four weeks, and then monthly if stable. In an interview on 8/3/2022 at 7:55 AM, Surveyor asked Dietary Manager (DM)-FF what the process was for staff recording meal intake and gathering food preferences. DM-FF stated R1 was not eating when first admitted to the facility and after DM-FF went to talk to R1, R1 started eating better. DM-FF stated R1 never complained about the food but had gotten a message to go and talk to R1 about the facility food. DM-FF stated the nursing staff enter the amount of food eaten after meals when they pick up the food tray following the meal. DM-FF stated the dietary staff will go into resident rooms an hour after meal service and collect trays that had not been picked up by the nursing staff. Surveyor asked DM-FF how the nursing staff would know the amount of food eaten if the dietary staff collected the meal tray. DM-FF stated he assumed the nurses noted how much was eaten. In an interview on 8/3/2022 at 8:35 AM, Surveyor asked RD-S if RD-S was aware of R1's weight loss from admission on 3/24/2022 of 133 pounds until the next weight of 115.8 pounds that was obtained on 5/20/2022. RD-S stated RD-S did not know of the weight loss until R1 discharged and was completing the discharge MDS assessment dated [DATE]. RD-S stated because no weights were entered into the computer charting system, the computer charting system did not trigger an alert of a significant weight loss. RD-S stated when the weight on 5/20/2022 was entered into the system, the computer system looks back 30 days, so the computer system did not capture any weight prior to the 30 days. Surveyor asked RD-S if RD-S was aware no weights had been obtained for eight weeks. RD-S was not aware R1 did not have any weights obtained for that time period. Surveyor asked RD-S if RD-S had been aware of the weight loss, what steps would RD-S have taken. RD-S stated RD-S would have assessed R1's intake, added nutritional supplements, and would have reviewed R1's medical record to see if any medical issues were affecting R1's weight such as a thyroid disorder or if R1 was taking any medications such as diuretics. On 8/3/2022 at 3:00 PM, Surveyor met with Nursing Home Administrator-A and Director of Nursing-B. Surveyor shared the concern R1 had a 19.2-pound weight loss with no physician or dietician notification and no supplements or interventions were implemented to prevent further weight loss. No further information was provided at that time.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, interview, and record review the facility did not provide appropriate treatment and services to prevent complications of enteral feeding, including potential for aspiration pneumonia for 1 (R16) of 1 sampled resident with a gastrostomy tube. R16 was observed in supine position (lying flat) in bed during Gastrostomy tube (G-tube) feeding. Findings include: The facility's policy entitled Tube Feeding dated 11/18 read: Pause or hold tube feeding when providing care that requires the resident's head of bed to be below 30-45 degrees. R16 was admitted to the facility on [DATE] with a medical diagnosis of Gastrostomy tube placement (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) and Dysphagia. On 8/2/22 R16's current tube feeding care plan dated on 05/24/21 was reviewed and read: R16 needs the HOB (head of the bed) elevated 30-45 degrees during and thirty minutes after tube feed. On 8/2/22 at 8:00 am the Surveyor observed Certified Nursing Assistant (CNA)-M and CNA-N providing care to R16 while he was in bed. R16's bed was flat, and his tube feeding was observed running at 75 milliliters an hour. The full observation was approximately 10 minutes and R16 remained flat in his bed with the tube feeding running the entire observation except for when CNA-M and CNA-N completed care with R16 then R16's head of his bed was elevated approximately 30 degrees. On 08/3/22 at 1:00pm the Surveyor interviewed Director of Nursing (DON)-B and DON-B indicated R16's head of the bed has to be elevated at least 30 degrees during tube feeding administration and should be paused for care needs that require the bed to be flat. On 08/3/22 at 3:00 pm Surveyor shared above findings with the Administrator and DON-B. Additional information was requested if available. None was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview, and record review the Facility did not ensure pharmaceutical services including accurate acquiring and administering of medications to meet the needs of each Resident for 3 (R11, R25 & R16) of 17 Residents reviewed. * On 5/25/22 R11 did not receive the evening dose of Aripiprazole, Buspirone HCL, & Lamotrigine. R11 did not receive the evening dose of Quetiapine Fumarate on 5/25/22 & 5/26/22. R11 did not receive the evening dose of Vortioxetine HBR on 5/25/22, 5/26/22, 5/27/22, & 5/28/22. R11 did not receive Vyvanse Capsule 70 mg on 5/25/22, 5/26/22, 5/27/22, & 5/28/22. R11 did not receive Ampicillin Sodium Solution Reconstituted 2 gm (grams) every six hours on 5/25/22 & 5/26/22. R11 did not receive these medications due to a delay in pharmacy. * On 7/6/22 R25 did not receive the evening dose of Lamotrigine 50 mg, Hydralazine 25 mg & 50 mg, and Protonix delayed release 40 mg due to a delay in pharmacy. * R16's May 2022 left leg and left toe treatments were not signed out for multiple days. Findings include: 1. R11 was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses includes sepsis, metabolic encephalopathy, bipolar disorder, hypertension, depressive disorder, and bacteremia. Surveyor reviewed R11's May & June 2022 MARs (medication administration record) and noted the following: Aripiprazole 10 mg (milligrams) with directions to give 1 tablet by mouth at bedtime for bipolar disorder. R11 did not receive this medication on 5/25/22 and received the medication on 5/26/22. Buspirone HCL tablet 10 mg with directions to give 3 tablets by mouth at bedtime for depression. R11 did not receive this medication on 5/25/22 and received the medication on 5/26/22. Lamotrigine tablet 200 mg with directions to give 2 mg by mouth at bedtime for seizure. R11 did not receive this medication on 5/25/22 and received the medication on 5/26/22. Quetiapine Fumarate table 200 mg with directions to give 3 tablet by mouth at bedtime for bipolar disorder. R11 did not receive this medication on 5/25/22 & 5/26/22 and started receiving the medication on 5/27/22. Vortioxetine HBR Tablet 20 mg with directions to give 1 tablet by mouth at bedtime for major depression. R11 did not receive this medication on 5/25/22, 5/26/22, 5/27/22, & 5/28/22 and started receiving the medication on 5/29/22. The emar note for Vortioxetine HBR Tablet 20 mg dated 5/26/22 documents NA, pharmacy is supplying, NP notified. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The emar note for Vortioxetine HBR Tablet 20 mg dated 5/28/22 documents has not yet been with pharmacy. The emar note for Vortioxetine HBR Tablet 20 mg dated 5/29/22 documents not available. Vyvanse Capsule 70 mg with directions to give 1 capsule by mouth one time a day for BD (bipolar disorder). R11 did not receive this medication on 5/25/22, 5/26/22, 5/27/22, & 5/28/22 and received the medication starting on 5/29/22. The emar note for Vyvanse capsule 70 mg dated 5/26/22 documents NP notified, na (not available) Pharmacy will send. Ampicillin Sodium Solution Reconstituted 2 gm (grams) with directions to use 2 gram intravenously every 6 hours for e faecalis bacteremia. R11 did not receive this medication on 5/25/22 & 5/26/22 and started receiving the medication starting on 5/27/22. The emar (electronic medication administration record) note dated 5/26/22 documents Ampicillin Sodium Solution N/A (not available) pending pharmacy delivery. Medication N/A to pull from Alixa. The emar note dated 5/26/22 documents Writer updated on call NP (nurse practitioner) on 5 potential missed ABT (antibiotic) IV (intravenous) doses until pharmacy delivers IV grenades. NOR (new order received) to extend end date to received missed doses. Writer updated order. The nurses note dated 5/26/22 at 07:53 (7:53 a.m.) documents call placed to pharmacy for ABT IV discharge paperwork faxed 3 x (times) to pharmacy for medication spoke with pharmacy who stated the IV ABT will be here soon they are working on filling it writer stated to pharmacy to stat meds and IV to facility. Pharmacy stated could be up to 6 hrs (hours) spoke with resident and family regarding meds writer explained that the med is on the way could be up to 6 hrs and the NP is aware and that we can send resident back to hospital for IV ABT resident stated no she will wait writer told resident and family that the NP stated we can extend the order for the IV to complete the order as needed resident asked if she could go out on pass writer stated yes just sigh (sic-sign) out with the nurse and sign back in when returning. The nurses note dated 5/26/22 at 12:11 p.m. documents Resident came to nurses station three times stating she has not received any medication. Resident received medication as scheduled per MD. Pharmacy was contacted multiple times in r/t (related to) STAT medication delivery. Pharmacy stated they will supply medications via local pharmacy and supply ABX in about 6 hrs (hours). Resident and family present and notified. NP notified. Resident was given the option to go back to hospital for care and resident and family refused. Resident requested medication times be changed, writer went through medications with resident. The nurses note dated 5/26/22 at 14:02 (2:02 p.m.) documents writer called pharmacy again regarding IV ABT pharmacy stated it is on the way. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 5/26/22 at 18:18 (6:18 p.m.) documents Pharmacy was contacted for ETA (estimated time arrival) on STAT ABX. Pharmacy was emailing carrier and would call back with ETA. Family members are updated and aware of there options to leave AMA (against medical advice) if they wish. Risks and benefits explained. Resident is choosing to stay and wait for IV ABX at this current time. Family has been updated. The nurses note dated 5/26/22 at 18:27 (6:27 p.m.) documents Carrier is about an hour away with medication. Family notified. The nurses note dated 5/27/22 at 03:39 (3:39 a.m.) documents ABT delivered and administered at HS (hour sleep), tolerated well, no c/o (complaints of) pain or discomfort at IV site, on schedule for next administration. The nurses note dated 5/27/22 at 14:25 (2:25 p.m.) documents NP aware of missed IV ABT and missed meds pharmacy called multiple times and order was for stat no new orders at this time. On 8/2/22 at 1:47 p.m. Surveyor asked ACNO (Assistant Chief Nursing Officer)-R if she has a list of medications available from the Alixa machine. ACNO-R informed Surveyor she doesn't have a list and then informed Surveyor there may be a list at the nurses station. ACNO-R went to the nurses station and returned a few minutes later informing Surveyor the list in the book is gone. Surveyor asked ACNO-R if the medication isn't available in the Alixa how do they ensure a Resident who is admitted receives their medication. ACNO-R informed Surveyor she can call the pharmacy and tell them she needs the medication stat but this takes four to six hours. ACNO-R explained the medications comes from out of state in Minnesota. Surveyor inquired if there is a local pharmacy. ACNO-R replied no not for them. At 1:57 p.m. ACNO-R was provided with a list of medications in the Alixa machine. ACNO-R informed Surveyor Aripiprazole 10 mg is not on the list, Buspirone is on the list, Lamotrigine there is 100 mg on the list. Surveyor informed ACNO-R R11's MAR indicates to give 2 mg and should be 200 mg as their is no dose for 2 mg of this medication. ACNO-R informed Surveyor there is Seroquel 25 & 50 mg in the machine and didn't know if there is enough of this medication in the machine for 200 mg. ACNO-R informed Surveyor the Alixa does not have Vortioxetine HBR Tablet 20 mg or Vyvanse Capsule 70 mg. ACNO-R informed Surveyor sometimes the pharmacy doesn't have access to the medication or they have to outsource the medication. ACNO-R informed Surveyor they had a hard time receiving R11's IV Ampicillin from the pharmacy and she had asked if they could outsource this medication but the pharmacy said they couldn't outsource it as they were mixing the medication there. ACNO-R informed Surveyor she did update the NP and the family had concerns with R11 not receiving her medication. Surveyor informed ACNO-R Surveyor has concerns regarding R11 not receiving multiple medications including the IV antibiotic after she was admitted . ACNO-R replied I agree with you and explained pharmacy they were mixing the medication and the medication was coming form Minnesota. ACNO-R informed Surveyor she told R11 they could send her back to the ER (emergency room) to get the dose or extend the dose longer. 2. R25 was admitted to the facility on [DATE] and discharged [DATE]. Surveyor reviewed R25's July MAR (medication administration record) and noted the following: Lamotrigine with directions to give 50 mg (milligrams) at bedtime for bipolar disorder. R25 did not receive this medication until 7/7/22. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The emar (electronic medication administration record) note dated 7/7/22 for Lamotrigine 50 mg documents PT (patient) meds (medications) were not in cart due to being a new admit. PT will receive morning medications as scheduled. Protonix Tablet delayed Release 40 mg with directions to give 1 tablet by mouth two times a day for GERD (gastroesophageal reflux disease). R25 did not received this medication on 7/6/22 with the first dose being administered on 7/7/22 at 8:00 a.m. The emar (electronic medication administration record) note for Protonix 40 mg delayed release dated 7/7/22 documents PT (patient) meds (medications) were not in cart due to being a new admit. PT will receive morning medications as scheduled. Hydralazine HCL 25 mg with directions to give one tablet by mouth three times a day for HTN (hypertension) Give with 50 mg. R25 did not receive this medication on 7/6/22 at 8:00 p.m. The emar (electronic medication administration record) note dated 7/7/22 for Hydralazine HCL 25 mg documents PT (patient) meds (medications) were not in cart due to being a new admit. PT will receive morning medications as scheduled. Hydralazine HCL 50 mg with directions to give one tablet by mouth three times a day for HTN (hypertension) Give with 25 mg. R25 did not receive this medication on 7/6/22 at 8:00 p.m. The emar (electronic medication administration record) note dated 7/7/22 for Hydralazine HCL 50 mg documents PT (patient) meds (medications) were not in cart due to being a new admit. PT will receive morning medications as scheduled. The nurses note dated 7/11/22 documents NP (nurse practitioner) aware of missed Lamotrigine, Hydralazine, and Protonix on 07/07/22. On 8/4/22 at 8:46 a.m. Surveyor spoke with ACNO (Assistant Chief Nursing Officer)-O regarding R25's Lamotrigine 50 mg, Hydralazine 25 mg & 50 mg, and Protonix delayed release 40 mg that was not administered on the evening of 7/6/22. ACNO-O informed Surveyor they can't order a Resident's medication until the Resident is physically in the building. ACNO-O informed Surveyor they try to keep frequently used medication in their Alixa Rx which is located on another unit. ACNO-O informed Surveyor if these medications aren't in their Alixa Rx they can partner with a twenty four hour pharmacy in the area. ACNO-O informed Surveyor he will look into these medications and get back to Surveyor. On 8/4/22 at 1:31 p.m. ACNO-O informed Surveyor all three medications (Lamotrigine 50 mg, Hydralazine 25 mg & 50 mg, and Protonix delayed release 40 mg) were all able to be pulled from the Alixa Rx system. ACNO-O informed Surveyor they weren't released until the next day. ACNO-O informed Surveyor it looks like pharmacy did delay release of these medications until the next day. ACNO-O indicated they can not pull the medication until pharmacy releases them. Surveyor noted the pharmacy delayed release of R25's medication resulted in a missed dose of Lamotrigine 50 mg, Hydralazine 25 mg & 50 mg, and Protonix delayed release 40 mg for R25. 22692 (continued on next page)

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	525730	A. Building B. Wing	08/15/2022

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R16 was admitted to the facility on [DATE] with a medical diagnosis of Dementia and Traumatic Brain injury. R16 had pressure injuries to the left toe, heel and leg that required amputation on 6/2/22 due to infection that would not resolve. On 8/2/22 R16's treatment records were reviewed for 5/22 and several days the treatments to R16's left leg, toes and heel were not signed out as completed. The following dates were blank: Left leg: (order for Santyl ointment and foam dressing every day) 5/2/22, 5/3/22, 5/5/22, 5/10/22, 5/24/22, 5/15/22, 5/23/22, 5/28/22, 5/29/22 and 5/30/22. Left toes: (order for betadine twice a day) 5/2/22 days, 5/3/22 days, 5/5/22, days, 5/20/22 days, 5/14/22 days, 5/19/22 days, 5/23/22 days, 5/29/22 days, 5/30/22 days. On 08/3/22 at 1:00m the Surveyor interviewed Director of Nursing (DON)-B and DON-B indicated she did the treatment several times for R16 on days in May and forgot to sign them out. DON-B indicated she would look and sign out the days she completed it. DON-B indicated treatments should be signed out right after they are completed. On 8/3/22 DON-B provided a revised treatment record for R16 5/22. All but 3 days were times that DON-B completed the treatment. On 08/3/22 at 3:00 pm The Surveyor shared above findings with the Administrator and DON-B. Additional information was requested if available. None was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview and record review the Facility did not ensure 1 (R11) of 17 Residents were free of significant medication errors. R11's hospital discharge summary dated 5/25/22 indicated R11 was to receive BusPIRone 45 mg by mouth nightly. R11's BusPIRone was incorrectly transcribed to 30 mg by mouth nightly. R11 received the incorrect dosage of BusPIRone 9 times which resulted in a significant medication error for R11. Findings include: The Facility's Transcription of Orders policy & procedure dated July 2020 under policy documents Orders will be verified only by a Licensed Nurse or designee. If orders are transcribed by other than a licensed nurse, a licensed nurse will verify the order transcription and will sign off the orders per policy and procedure to ensure the order has been correctly transcribed and/or implemented including reviewing actions completed for scheduling or ordering medications, laboratory testing, radiology orders, referrals,diets, etc. Under Procedure documents Transcribing orders is a competency-based task, obtained through on-the-job training and augmented with the completion of a medical terminology and ICD (International Classification of Diseases)-10 coding training course. Transcribing and verifying orders are a responsibility of a licensed nurse and are considered part of the process of administering medication/medication dispensing. In this facility, a Licensed Practical Nurse may verify any medication within the State's professional scope of practice. It is the responsibility of the person transcribing the order to bring all STAT orders to the immediate attention of the primary care nurse responsible for completion of the order. An RN (Registered Nurse)/LPN (Licensed Practical Nurse) must verify the transcriptions' accuracy and completeness prior to the end of the RN/LPN's shift and PRIOR TO administration of the orders including medication administration. R11 was admitted to the facility on [DATE] and discharged on [DATE]. R11 was reviewed as a closed record. R11's diagnosis includes depressive disorder. The hospital discharge summary dated 5/25/22 under Discharge Medications includes documentation of busPIRone 15 mg (milligrams) tablet Commonly known as Buspar. Take 45 mg by mouth nightly. Dose=3 tabs (45mg). R11's physician orders includes busPIRone HCl Tablet 10 mg Give 3 tablet by mouth at bedtime for depression. The order date is 5/25/2022 and D/C (discontinue) date is 6/4/22. This order was incorrectly transcribed as the Facility's order is for BusPIRone 30 mg and should have been for 45 mg. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R11's May MAR (medication administration record) and noted R11 received BusPIRone 30 mg on 5/26/22, 5/27/22, 5/28/22, 5/29/22, 5/30/22, & 5/31/22. R11 should have received 45 mg daily. Surveyor reviewed R11's June MAR and noted R11 received BusPIRone 30 mg on 6/1/22, 6/2/22, & 6/3/22. R11 received the incorrect dose of BusPIRone 9 times. On 8/2/22 at 1:57 p.m. Surveyor informed ACNO (Assistant Chief Nursing Officer)-R R11's hospital discharge summary documents BusPIRone 15 mg with directions to take 45 mg at bedtime and the Facility's physician's orders and May/June MAR's document R11 was 30 mg not 45 mg. Surveyor informed ACNO-R R11 received the incorrect dose of BusPIRone the entire time (9 times) R11 was at the Facility. ACNO-R informed Surveyor this is a medication error for R11. On 8/3/22 at 3:19 p.m. Administrator-A and DON (Director of Nursing)-B were informed of the above.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03357 Based on observation, interview and record review the facility did not ensure its infection control program was implemented regarding a COVID-19 outbreak. On [DATE] R3, who resides on the 200 unit and who has a history of pneumonia, acute and chronic respiratory failure, idiopathic pulmonary fibrosis, history of tuberclosis and is on oxygen, became more congested and developed a cough. Nursing suspected he might have COVID-19 but did not test him and did not implement isolation precautions. Two days later, on [DATE] using a Rapid test, R3 tested positive for COVID-19. The facility did not implement their outbreak procedures/testing on [DATE], waiting to conduct staff and resident testing on [DATE]. This gave COVID a four-day head start. On [DATE] R3's PCR (polymerase chain reaction) test came back on [DATE] with the results inconclusive and said no swab-test not performed. Over the next week, additional PCR tests came back with no results because staff had incorrectly performed the test. On [DATE], three staff who worked the 200 unit tested positive for COVID-19. R3 was not on the facility Infection control line listing even though R3 tested positive for COVID-19 on [DATE]. Staff were not clear as to when R3 was placed in isolation and when R3 was taken off of isolation. The facility was not routinely testing staff based on the transmission rate for the county. During staff interviews, staff were unaware of proper isolation for residents with COVID or suspected COVID. Facility staff working on the 200 unit with residents who were suspected and/or positive with COVID were not wearing N95's, but instead were wearing KN 95's. Staff were not always wearing PPE appropriately. On [DATE] the facility had ten residents on 200 unit and five staff positive for COVID 19. This deficient practice has the potential to affect all units with census of 103 at the time of the survey. The Facility's failure to implement their outbreak procedure at the start of the COVID outbreak created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA (Nursing Home Administrator) A of the immediate jeopardy on [DATE] at 12:30 p.m. The immediate jeopardy was removed on [DATE], however the deficient practice continues at a scope/severity of F (potential for more than minimal harm that is not immediate jeopardy/widespread) as the facility continues to implement and monitor the effectiveness of its removal plan. Finding include: Policy and Procedures: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Covid 19 Policy with revision date of [DATE] CDC guidelines will be reviewed on an ongoing basis by the Chief Clinical Officer and policy revisions completed as needed. Process: To prevent the introduction of respiratory illness in the facility the following steps should be taken: -Post signs at the entrance instructing visitors not to visit -Ensure employees who are sick stay home; make sure to track call ins and symptoms on facility log. -Instruct all employees to clean their hands before and after contact with residents after contact with contaminated surfaces or equipment and after removing Personal Protective Equipment (PPE). -All staff are required to wear face masks upon entering the building and at all times while in the facility 1. The guest will remain on precautions until they are free of signs and symptoms per Centers for Disease Control and Prevention (CDC) guidelines (cough, fever, periorbital redness, etc) 2. If a guest develops signs or symptoms of COVID-19 including acute fever >100.4 F, cough, sore throat, shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills, muscle pain, headache, new loss of taste or smell, please refer to policy item number #5. 3. Documentation of signs and symptoms of COVID-19 will be documented in the electronic medical record by exception. Signs and symptoms of COVID-19 may include cough, sore throat, shortness of breath or difficulty breathing, vomiting and/or diarrhea, chills, muscle pain, headache, new loss of taste or smell. 4. If a guest becomes symptomatic for COVID-19: place a mask on the resident, place them in a room by themselves, shut the door, place them on droplet and contact precautions with eye protection and notify the DON (Director of Nursing) and physician. Request orders from the physician for: a. influenza swab b. respiratory pathogen panel and/or COVID-19 testing c. Bloodwork to include WBC count d. Chest X- ray 5. Place the appropriate signage on the door. The staff assigned to the guest will be the only individuals allowed in the room until the guest is asymptomatic and deemed appropriate by the provider for isolation precautions to be discontinued. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. Keep guest in strict droplet and contact precautions until asymptomatic and provider deems appropriate to remove isolation precautions. Monitor oral temperature and SpO2 frequently per provider order 9. PPE for droplet precautions will include face masks, eye protection, gloves and gowns. Place a trash can near the exit inside any resident room on isolation to make it easy for employees to discard PPE. 14. All COVID-19 positive guest will remain in isolation for 10 days from the date of the initial positive test. In accordance with CDC guidelines a time-based stragety will be followed. At the end of the 10 day period, isolation precautions may be discontinued and the guest transferred out of the COVID unit if the guest has been asymptomatic for signs and symptoms of COVID-19 for 24 hours at the end of the 10 day period. Guest continuing to exhibit symptoms of COVID-19 at the end of the 10 day period will continue to remain in contact and droplet precautions on the COVID unit until guest is no longer symptomatic. The decision to discontinue isolation precautions will be determined by the Medical Director and/or CNO. 19. If not providing direct resident care and/or completing an aerolized generating procedure, Ignite staff may wear a mask only for residents and guests in their 14 day observation period. The facility's Federal COVID-19 Vaccine Mandate Policy dated [DATE] indicate: Face coverings: Face coverings must be worn by all individuals regardless of vaccination status. Ignite medical resorts will require the use of those face coverings that comply with federal mandate/guidance at the time said Mandate/guidance is implemented. Covered individuals who are not fully vaccinated as defined by the state(s) in which they practice, are required to wear all federally and state specific mandated PPE, including but not limited to an N95 face mask while working in resident care areas. 1. On [DATE] Surveyor reviewed R3's medical record. R3 was admitted into the facility on [DATE] with diagnoses that included but were not limited to; Sepsis, unspecified organism, pneumonia, unspecified organism, acute and chronic respiratory failure with hypoxia, idiopathic pulmonary fibrosis, pneumothorax, unspecified, personal history of tuberculosis, dilated cardiomyopathy, primary pulmonary hypertesnion, abnormal weight loss, interstitial pulmonary disease, unspecified, etc. R3's record documents R3 refused the COVID-19 vaccination dose 1. The facility utilizes a computer based Daily COVID Assessment listing signs and symptoms (s/sx) of COVID -19 which the assessor is able to check mark. The available signs and symptoms included: fever, cough, (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	headache, muscle pain, vomiting, diarrhea, new loss of taste, sore throat, none of the above present R3's progress notes document and medical record reflects: On [DATE] (Friday) at 1:50 pm the Daily COVID Assessment indicates: Category: No positive response. None of the above are present (referring to fever, cough, headache, muscle pain, vomiting, diarrhea, new loss of taste, sore throat) Temperature: 97.5 - date [DATE] 11:36 am [DATE] 15:15 (3:15 pm) Daily COVID Assessment: Category: No positive response. None of above present. Temperature: 97.7 - date [DATE] 10:26 am [DATE] 13:20 Physician/PA/PN progress note: . History of Present Illness: . Patient complains of upper respiratory congestion X 2 weeks, which is intermittent, increased in the morning, occurs daily, and resolves as the day goes on negative issues with appetite, negative fevers, swelling, weakness, nausea,/vomiting .Pt opted for Mucinex 400 mg q 8 h PRN congestion. On [DATE] at approximately 8:30 am, Surveyor interviewed Director of Nursing (DON) B as to when R3 was placed in isolation and when R3 was removed from isolation. Surveyor asked DON B when R3 was taken off of isolation. DON B stated she went back to [DATE] (two days prior to when R3 tested positive for COVID-19) because that is when she thought R3's symptoms began. DON B stated [R3] came in with pneumonia, TB other respiratory systems and thought this was an exacerbation of pneumonia. Despite suspecting that R3 might have symptoms of COVID, the facility did not test R3 on this date. Lack of such testing prevented staff from immediately implementing precautions to prevent COVID from spreading if R3 had tested positive. [DATE] (Saturday 4:05 am) Daily COVID Assessment: Category: No positive response. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	None of above present. Temperature: 97.7 - date [DATE] [DATE] (Sunday 3:48 am) Daily COVID Assessment: Category: No positive response. None of above present. Temperature: 98.4 - date [DATE] Although no signs and symptoms of COVID were noted on the [DATE] Daily COVID Assessment, Surveyor noted the following on [DATE]. [DATE] 20:37 (8:37 pm) eINTERACT SBAR (situation, background, assessment, recommendations) Summary for Providers. The change in condition (CIC) reported on this CIC Evaluation are/were: Respiratory infection other change in condition. At time of evaluation resident/patient vital signs, weight and blood sugar were: Blood pressure: BP ,d+[DATE]-[DATE] 23:09 position: sitting/arm, Pulse: P95 . Temp: T 97.3, Pulse Oximetry: O2 95.0% Oxygen via nasal cannula . Positive findings reported on the resident/patient evaluation for this change in condition were: .Respiratory Status Evaluation: Cough other respiratory changes . [DATE] 23:48 (11:48 pm) Resident tested positive for COVID via rapid test at 2037 (8:37pm). Resident complaint (sic) of sore throat, productive cough with yellow sputum, and a slight headache. VSS stable. Resident expressed he does not want any medication for COVID Tx (Treatment). MD notified. NNO (No new order). Unit Manager notified. [DATE] (Monday 11:01 am) Daily COVID Assessment: Category: One positive response. Does the resident have any of the following? Cough Temperature: 98.1 - date [DATE] 10:32 am Highlighted in red, the computerized Daily COVID Assessment states, Notify Nursing Administration immediately of the above answers. [DATE] 16:18 (4:18pm) Physician/PA/NP Progress Note: Chief complaint: Mobility and ADL impairment due to sepsis, PNA, Acute on chronic respiratory failure, PTX, severe protein calorie malnutrition, and dysphagia, now with cough ,d+[DATE] COVID-19 History of present illness: Pt complains of continued cough, which is constant, increased in the morning, productive of mucus, and not associated with other sx. Has been diagnosed with COVID-19 since last visit. Denies SOB (shortness of breath) . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Assessment: .COVID-19 .Plan/Recommendations: Discussed plan of care with patient. Patient opted for scheduled Mucinex 400 mg TID X5days for congestion. Will continue current medications and rehabilitation services per orders. He has deferred specific treatment for COVID -19 at this time. The first charting indicating that R3 had been placed in isolation was on [DATE], although the Director of Nurses stated on [DATE] at 8:30 am that this had occurred on [DATE]. [DATE] (Tuesday) Daily COVID Assessment: No daily COVID Assessment noted on this date. [DATE] 05:42 notification note: Primary Chief Complaint: Respiratory: COVID-19 rule out . Summary: noted pt with positive COVID test refusing medications vitals stable pt on isolation . [DATE] 8:52 am Physician/PA/NP progress note: .Chief complaint: Mobility and ADL dysfunction due to sepsis . now with COVID-19 [DATE] (Wednesday) Daily COVID Assessment: No daily COVID Assessment was noted on this date. [DATE] 16:57 (Thursday 4:57pm) Daily COVID Assessment: Category: One positive response. Does the resident have any of the following: Cough. Temperature: 99.2 - date [DATE] 08:23 am Highlighted in red, the computerized Daily COVID Assessment states, Notify Nursing Administration immediately of the above answers. [DATE] 21:34 (9:34pm) Daily COVID Assessment: Category: No positive response. None of above present. Temperature: 97.7 - date [DATE] 21:45 [DATE] 17:08 Reason for skilled services: Primary Dx: COVID + [DATE] (strict isolation, all services are being provided to resident in his room .Special precautions: blank [DATE] (Friday) 4:18 am The pt is COVID pos. Pt is on strict isolation and in a single room. Pt is asymptomatic. [DATE] 12:38 pm . Chief Complaint .now with fatigue . History of illness: . positive for congestion, cough . Assessment: COVID-19 [DATE] (Saturday) 10:22 Daily COVID Assessment: Category: No positive response. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	None of above present. Temperature: 97.0 - date [DATE] 9:15 am [DATE] (Sunday) 11:13 am Daily COVID Assessment: Category: No positive response. None of above present. Temperature: 97.5 - date [DATE] 10:12 am [DATE] 6:35 am. Isolation remains-afebrile. VSS. Denies pain, SOB. [DATE] 10:53 am, Reason for skilled services: Primary Dx. COVID = [DATE] (Strict isolation, all services are being provided to resident in his room) . special precautions: blank [DATE] 3:30 am (Monday) Daily COVID Assessment: Category: No positive response. None of above present. Temperature: 98.2 - date [DATE] 3:30 am [DATE] 13:50 (1:50 pm) Chief Complaint: Mobility and ADL impairment due to sepsis, PNA, acute on chronic respiratory failure, PTX, PCM, COVID-19 and dysphagia, now with fatigue .positive for cough .Assessment: . COVID-19. [DATE] 3:23 am Daily COVID Assessment: Category: One positive response. Does the resident have any of the following? Cough Temperature: 97.6 - date [DATE] 2:30 am [DATE] 10:08 am Daily COVID Assessment: Category: No positive response. None of above present. Temperature: 97.4 - date [DATE] 10:08 am The line list did not indicate when R3 came off precautions. Surveyor noted according to the CDC (Centers for Disease Control and Prevention) guidelines, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated [DATE], states; Patients with mild to moderate illness who are not moderately to severely immunocompromised: At least 10 days have passed since symptoms first appeared and At least 24 hours have passed since last fever without the use of fever-reducing medications and Symptoms (e.g. cough, shortness of breath) have improved. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Surveyor noted according to the facility's eInteract SBAR summary dated [DATE] 20:38 (8:37 pm) R3 experienced a change in condition in regards to R3's respiratory status with cough other respiratory changes . and with R3 testing positive for COVID via rapid test at 2037 (8:37pm). The facility's documentation indicates R3 complained of sore throat, productive cough with yellow sputum, and a slight headache and at which time the MD was notified. Surveyor noted R3 had a confirmed COVID -19 test on [DATE]. R3 should have been in isolation for 10 days until [DATE]. Surveyor noted R3 had not been in isolation as of [DATE] at 10:29 am. On [DATE] at 1:30 pm, Surveyor spoke with LPN AA who was working on the [NAME] (200) unit. LPN AA reported there is a cart outside a resident's room door and a sign on the door if a resident is on isolation. LPN AA reported she has worked this unit for the last week and a half. LPN AA stated [R3] was not on her group however he should have had a cart in front of his door and a sign indicating isolation when he had COVID. LPN AA stated residents stay in isolation for 7 days if they are COVID positive. LPN AA stated she has had training and they had us sign a paper. On [DATE] at approximately 1:35 pm, Surveyor spoke with Housekeeper E who reported there is always a sign on the door and a cart outside the door for a resident who is in isolation. Housekeeper E reported she has worked the [NAME] (200) unit in the last week and a half. Housekeep E stated she wears a KN95, gown, gloves, and goggles when going into the rooms with a sign on the door. Surveyor observed Housekeeper E presently wearing a KN95 with goggles. Housekeeper E stated the last time she worked was last Sunday ([DATE]) and there was a cart outside of [R3]'s room and a sign on [R3]'s door. Housekeeper E stated she works first shift from 7:00 am until 3:30 pm. Housekeeper E stated this (200 unit) is where most of the residents who are in isolation are. Housekeeper E stated sometimes there are carts outside of a resident's room for storage but the resident is not on isolation, you always have to look for the sign taped to the outside of the door. On [DATE] at 1:45 pm, Surveyor interviewed CMA BB who was working on the [NAME] (200) unit. CMA BB stated she believed [R3] was in isolation on Monday [DATE]. On [DATE] at 1:46 pm, Surveyor interviewed CNA F who works the [NAME] (200) unit from 7:00 am until 7:00 pm who stated there would be a note on a resident's door and a cart outside the room if a resident was on isolation. CNA F stated [R3] was in isolation and may have gone off on Monday ([DATE]) however CNA F was off on Monday ([DATE]). CNA F reported receiving training and wears goggles and a KN95 for this unit. On [DATE] at 7:20 am, Surveyor asked Assistant Chief Nursing Officer (ACNO)/RN Unit Manager for the [NAME] (200) unit- R if she recalled when R3 was taken off isolation. RN R stated on Monday ([DATE]) she asked who could come off as she was off the week before. Surveyor asked RN R if she removed the sign on R3's door and the cart from outside of R3's room. RN R stated, probably, it had to be in the am was playing catch up. RN R reported that off the top of her head she could not say when [R3] was placed in isolation and saying she could have sworn he was placed in isolation right before RN R went out on Tuesday ([DATE]). On [DATE] at approximately 8:30 am, Surveyor interviewed Director of Nursing (DON) B as to when R3 was placed in isolation and when R3 was removed from isolation. (continued on next page)

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	525730	A. Building B. Wing	08/15/2022

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Surveyor informed DON B R3 tested positive for COVID-19 on [DATE]. Surveyor observed the first note of R3 being in isolation was on [DATE] and as of [DATE] at 10:29 am, R3 was no longer in transmission based precautions/isolation. Surveyor also informed DON B that it was noted R3 was not on the facility's COVID-19 Infection control line listing. DON B informed Surveyor she had forgotten to put R3 onto the line listing. DON B stated she placed R3 into isolation on [DATE] when he was positive for COVID-19. DON B indicated they conducted a rapid COVID test on R3 on [DATE] in which he was positive however it was faint. They followed this up with a PCR (polymerase chain reaction) lab test with the results sent back on [DATE] with the test resulting in an error as it could not be processed. DON B stated the facility started testing everyone (staff and other residents) on [DATE]. Surveyor noted on [DATE], the facility should have considered R3's positive COVID-19 status as a facility outbreak and should have started the COVID-19 testing for staff and residents on [DATE] and not wait until [DATE]. Surveyor also noted 3 staff (Staff R, Staff DD, and Staff EE) who worked on the 200 unit tested positive for COVID-19 on [DATE]. Surveyor noted if R3 has symptoms starting on [DATE] the 10 days of transmission based precautions/isolation would have continued to have been implemented until [DATE]. Surveyor also noted if the symptoms were first noted on [DATE], R3 should have been placed in isolation on [DATE] and not on [DATE] as indicated by DON B. Surveyor also noted R3 was not placed into isolation until the Rapid COVID 19 test resulted in a positive finding on [DATE] and 10 days of isolation would have been implemented until [DATE], which was not the case for R3. On [DATE] DON B provided Surveyor with the Laboratory Report dated [DATE] for the PCR test which had documented that the test was not performed and No swab in Vial. On [DATE] at 9:30 am, Surveyor interviewed Infection Preventionist C who reported starting in May of 2022. Infection Preventionist- C stated if we believe a resident may have COVID, we do a test and put the resident in precautions. Infection Preventionist-C indicated the facility policy indicates the duration of isolation would then be 7 days as long as they have no symptoms. Infection Preventionist-C stated she thought [R3]'s COVID symptoms started on [DATE] so that the 7-day isolation time frame would have ended on [DATE]. Surveyor noted the duration of a 7-day isolation for a resident who has been tested positive for COVID-19 is not consistent with the CDC recommendations. Surveyor also reviewed the facility's Coronavirus (COVID-19) policy dated February 2020 and revised on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] which states in part; (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Guest will remain on precautions until they are free of signs and symptoms per CDC guidelines (cough, fever, periorbital redness, etc.) All COVID-19 positive guests will remain in isolation for 10 days from the date of the initial positive test. In accordance with CDC guidelines a time-based strategy will be followed. At the end of the 10-day period, isolation precautions may be discontinued and the guest transferred out of the COVID unit if the guest has been asymptomtic for signs and symptoms of COVID-19 for 24 hours at the end of the 10 day period The facility could not identify when R3 was initially placed in isolation and when R3 was removed from isolation. R3 was not placed in isolation on [DATE] if this is the date identified by DON B as R3 having COVID-19 symptoms. When R3 had a confirmed COVID-19 test on [DATE] the facility did not conduct resident and staff testing until [DATE]. Staff R, Staff DD, and Staff EE who worked on the 200 unit tested positive for COVID-19 on [DATE]. Surveyors noted the lab could not always process resident COVID-19 tests due to not having a swab in the vial. Surveyors also noted staff not to be wearing Personal Protective Equipment (PPE) correctly and/or not wearing the CDC recommended PPE, such as wearing N95's. On [DATE] at 12:05 pm, Administrator A informed Surveyors, we have been using KN95's since the building opened and we don't do fit testing. Administrator A showed Surveyors the Central Supply room where Surveyors observed the following: 17 boxes @ 20 in each box Particulate Respirator (total 680)- Central Supply G stated these are KN95's. 1 box Niosh N95 @ 25 in each box (total 25). ,d+[DATE] box Niosh N95 in Administrator's office. Central Supply G stated they had 10 boxes of N95's coming in and when she checked her computer Central Supply G stated, Oh they are here. We go by what's going on in the building. Had 7 boxes of N95's coming and they were delivered yesterday ([DATE]), will go find them. Will be putting them on the [NAME] (200) unit. All units presently have KN95. I could put some out to the other units but think other units do not have a COVID outbreak. According to the CDC Heath Care Professionals (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e. goggles or a face shield that covers the front and side of the face.) 20025 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observations: 2. On [DATE] Surveyor received a list of residents who were COVID-19 positive. The list consisted of R43, R44, R45, R46, R2, R33, R47, R48 and R49. All residents resided on the 200 unit. On [DATE] at 11:00 a.m. Surveyor observed all the COVID positive residents listed in rooms with PPE and a droplet and contact sign on the door or on the PPE cart, except for R46 and R2. R46 and R2 did not have any signage or PPE outside of their rooms. During the survey, Surveyor observed facility staff on the COVID unit ([NAME]/200 unit) with KN95 masks on and goggles. Surveyor reviewed the outbreak line list and a total of 5 staff and 10 residents tested positive for COVID on [DATE]. R26 tested positive for COVID 19 and died on [DATE] (Cross reference F684.) During record review, Surveyor noticed R3 tested positive for COVID-19 on [DATE]. On [DATE] it was observed R3 did not have any PPE outside the room and no droplet or/and contact precaution sign outside the door. R3 is not listed on the infection line list. Interviews: On [DATE] at 1:30 p.m. Surveyor interviewed Director of Nursing (DON) B regarding the COVID outbreak and infection control. DON B stated two staff tested positive on [DATE], so the facility tested every resident and staff for COVID-19. DON B stated they implemented their outbreak policy on [DATE]. DON B stated they are testing staff and residents every Monday and Thursday. DON B stated prior to the outbreak on [DATE] they were testing staff weekly. DON B stated the infection control nurse was on vacation during this outbreak and returned to the facility on [DATE]. DON B stated she has been in charge of the outbreak. Surveyor asked DON B about R3 testing positive for COVID [DATE] and that R3 is not on the infection line list. DON B stated she must have missed that one. Surveyor asked DON B why staff were wearing KN95s instead of N95s. DON B stated they were told by public health that they can wear KN95s during an outbreak and with COVID-19 positive residents. On [DATE] at 8:00 a.m. Surveyor interviewed IP (infection preventionist) C. IP C stated she was on vacation from [DATE] and back to work on [DATE]. IP C stated DON B took charge of the Covid outbreak. IP C stated staff not fully vaccinated (which includes the booster) are tested weekly but with the outbreak all staff are tested twice a week. IP C stated when she spoke with public health department, she was told KN95 masks are sufficient for outbreaks. IP C stated new admission residents that are not fully vaccinated (including boosters) are placed in isolation and tested on admission and day 5 for COVID-19. After testing negative on day 5 and with no symptoms, the new admission residents are taken off isolation on day 7. IP C stated fully vaccinated new admissions are not put in isolation but still tested on admission and day 5 for COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 12:30 p.m. Surveyor interviewed IP C. Surveyor asked IP C how often does she test staff not fully vaccinated (prior to the [DATE] outbreak). IP C stated weekly and it's based on the county infection rates. Surveyor asked IP C how does she keep track of the county infection rates. IP C stated DON B gets the data and forwards the data to IP C per email. Surveyor asked to see the emails from [DATE] to current. IP C printed the rates out for Surveyor. Surveyor asked IP C, based on the data the county was high on [DATE]th and continued to stay high, how did she know to test the staff not fully vaccinated only once a week. IP C stated she's not sure, she would have to look at the grid and decided how often to test. IP C stated it changes so often. According to Centers for Medicare and Medicaid Services (CMS) QSO-,d+[DATE] NH revised [DATE], staff who are not up-to-date should be tested twice a week when the level of COVID-19 Community Transmission is substantial and high. The facility should have ensured routine staff testing was conducted twice a week for those staff who are not-up to date with their COVID-19 vaccinations and when the Community Transmission of COVID-19 was substantial and high. On [DATE] at 11:00 a.m. Surveyor asked DON B if the facility had a policy regarding the use of antiviral medications for residents experiencing COVID symptoms. DON B stated they do not have a policy regarding the use of antiviral medications for COVID. DON B stated no resident, positive with COVID in the facility, is prescribed an antiviral medication for COVID symptoms. On [DATE] Surveyor called, the public health nurse, whom the facility communicates with, and the public health nurse did not call back during the survey. According to a [DATE] memo put out by the Wisconsin Department of Public Health, Older adults are at highest risk of getting very sick from COVID-19. More than 81% of COVID-19 deaths occur in people over age 65. The number of deaths among people over age 65 is 97 times higher than the number of deaths among people ages ,d+[DATE] years. According to information from the Wisconsin Department of Health Services data through [DATE] shows, People who were unvaccinated died at a rate 6.4X the rate of people who had been vaccinated with a primary series only, and 3.5X the rate of those who had the primary series and booster dose. Similarly, failure to offer an antiviral medication increased the risk for hospitalization and death. In an analysis of over 40 clinical trials involving mostly unvaccinated individuals, [NAME] University in Ontario found: Molnupiravir and Paxlovid each lowered the risk of death beyond standard care or placebo with moderate certainty (10.9 fewer deaths per 1,000 patients; 95% confidence interval [CI], 12.6 to 4.5 fewer for molnupiravir and 11.7 fewer deaths per 1,000; 95% CI, 13.1 fewer to 2.6 more for Paxlovid). A total of 10 trials with 5,575 patients reported 252 hospitalization s over a median follow-up of 21 weeks. The researchers assumed a baseline risk of 54.4 hospitalization s per 1,000 patients. Paxlovid lowered the risk of hospitalization by 46.2 admissions per 1,000 (95% CI, 50.1 to 38.9 fewer) with high certainty, while molnupiravir likely reduced the risk of hospitalization s by 16.3 per 1,000 (95% CI, 27.2 to 0 fewer) with moderate certainty. Lab Results (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Surveyor reviewed R43's COVID lab results. R43 COVID swab results collected on [DATE] indicate a positive result for COVID 19. Surveyor reviewed R44 COVID lab results. R44 COVID swab results collected on [DATE] indicate test not performed due to no swab and another swab was collected on [DATE] which indicate test not performed due to invalid media. No other COVID swab tests were done. Surveyor reviewed R45 COVID Lab results. R45 COVID swab results collected on [DATE] indicate test not performed due to no swab and another swab was collected on [DATE] which indicates test not performed due to invalid media. No other COVID swab tests were done. Surveyor asked DON B if staff were trained and are knowledgeable to collect COVID swabs accurately. DON B stated she's not sure what happened but did ask the staff that collected the swab and was told they followed the instructions. DON B states she thinks it was a lab mistake. DON B was unable to provide Surveyors with a sampled swab and instructions for the collection of the sample. 38253 3. On [DATE] at 12:25 PM, Surveyor observed Licensed Practical Nurse (LPN)-CC on the 200 unit with positive COVID-19 residents with no eye protection on. On [DATE] at 12:20 PM, Surveyor observed LPN-Z on the 100 unit at the nurses' station with other staff members present. LPN-Z had a surgical mask hanging down on one ear and eye protection glasses on top of the head. LPN-Z put the mask on when Surveyor approached but pulled the mask down when talking. On [DATE] at 1:30 PM, Surveyor [TRUNCATED]