| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 525730 | A. Building<br>B. Wing | 12/14/2022 |

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

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>The grievance documents do not identify how the grievances were investigated, if interviews with staff/residents were completed, or the outcome of the investigation. Resident Council Minutes did not include actions taken regarding the concerns voiced by residents.<br><br>Findings include:<br><br>The policy addressed Resident Council stating, All grievances identified during the Resident Council meeting will be submitted immediately to the Grievance Official for investigation and resolution. Reporting of resolution outcomes will be provided to the Resident Council .The Grievance Official will initiate the appropriate notification and investigation processes per individual circumstance and facility guidelines . Resolution: The Grievance Official will complete a response to the resident and/or resident representative which includes: Date of grievance, Summary of Grievance. Investigation steps. Findings. Resolution outcome and actions taken with date decision was determined.<br><br>On [DATE] at 9:43 a.m. ADON-C (Assistant Director of Nursing) informed Surveyor the facility had not held resident council meetings prior to September and provided resident council minutes for September, October, and November.<br><br>[DATE] resident council minutes state, Nursing Cares: Guests reported they have experienced long call wait times. Waiting to get put to bed. All guests could not identify a date or date time/ratios that long call lights occurred. Concern reported during managers meeting on [DATE].<br><br>[DATE] resident council minutes state, Nursing Concerns/Cares: (Residents) asked that staff members . introduce themselves at the start of the shift. Concern was presented during managers meeting on [DATE].<br><br>[DATE] resident council minutes state, Nursing Cares: #1. All guests reported that staff members will not introduce themselves . #2. (3 residents) reported experiencing long call light wait times between 7pm and 7am. All guests were unable to provide a date and time of the occurrences. Kitchen/Dietary: All residents expressed concerns with receiving cold food. No consistency was reported for days or meals. F/U (follow-up) tracking: Kitchen: All residents were asked if they would like to file a grievance, all denied. Informed dietary manager of the concerns on [DATE]. Nursing: #1. All guests were asked if they would like to file a grievance. All residents denied. Concerns were reported to all managers on [DATE].<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | No additional information was provided to show that action was taken related to the resident concerns voiced at the Resident Council meetings that occurred from September to December. No resolution was documented.<br><br>On [DATE] at 9:43 a.m. ADON-C stated she had provided all the information she had to present to the Surveyors, meaning other than the Resident Council Minutes, there was no further information that demonstrated the grievances were reviewed and remedied . |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview and record review the facility did not take all appropriate steps to thoroughly investigate allegations for 1 of 2 residents (R1).<br><br>R1's family member filed a complaint that staff would not take R1 to the bathroom. Review of the facility's investigation found that it was not thorough as there were no resident interviews completed and no other staff interviews completed to determine the extent of the concern with a particular staff member.<br><br>Findings include:<br><br>On 12/05/22 at 1:45 p.m., ADON-C (Assistant Director of Nursing) provided the facility's Abuse Policy updated on 11/2018. The policy included the following: .Investigation: The facility Administrator will initiate and complete a thorough investigation of the allegations and will gather and document all relevant information .Two facility management staff members will conduct an interview with the resident. The responsible party will be contacted and notified of the allegation. Interviews will be conducted and documented with any witnesses, staff, other residents, or visitors who potentially have any knowledge or information regarding the allegation. Interviews will be conducted with a sample of other residents residing on the same unit as the resident. Every staff member working on the specific unit that the resident resides who was working or present during the period of time of the allegation will be interviewed<br><br>R1 was admitted to the facility on [DATE] and discharged on [DATE]. R1's diagnoses included immune disorder, gastrointestinal disorder with abdominal pain, and weakness with difficulty walking.<br><br>According to the MDS (Minimum Data Set) assessment, completed on 10/25/22, R1's BIMS (Brief Interview for Mental Status) score was 14 suggesting the resident's cognition was intact.<br><br>R1's care plan was initiated on 10/19/22 indicating the resident requires physical assistance of 1 staff and a 2 wheeled walker for transfers and the assistance of 1 staff for toileting.<br><br>On 10/24/22, R1's family reported that on 10/22/22, CNA-E (Certified Nursing Assistant), did not assist R1 to the bathroom and told R1 urinate in her brief and she would clean her up afterward. DON-B (Director of Nursing) and NHA-A (Nursing Home Administrator) were notified of the concern on 10/24/22<br><br>According to the Investigation Report, the facility investigation did not include an interview with R1, other residents who may have received care from CNA-E or staff who may have worked with CNA-E or other potential witnesses.<br><br>On 12/13/22, NHA-A told Surveyor that interviews with other residents had been done, but no evidence of those interviews were provided |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview and record review, the facility did not ensure that 6 of 21 residents (R4, R11, R2, R3, R25, R39) reviewed for ADLs (activities of daily living) were provided with necessary services.<br><br>R4, R11, R2, R3, R25, and R39 were not provided with bathing assistance.<br><br>Findings include:<br><br>On 12/14/22 at 2:15 p.m. DON-B stated that if a resident is diagnosed with COVID-19, those residents do not receive a bath or shower for 14 days. Instead, the staff should wash the resident up at bedside and record that a bed bath was provided. Upon review of Tasks section of the documentation and nurses notes, bed baths were not addressed as being given in the place of a shower or full bath. DON-B confirmed that the dates for when baths/showers were provided to residents was inclusive; no other dates were located in the residents' records.<br><br>Example 1:<br><br>R4 was admitted to the facility on [DATE].<br><br>The most recent MDS (Minimum Data Set) dated 10/23/22 indicated R4 required total assistance for bathing.<br><br>R4's care plan initiated 10/17/22 identified a focus area for ADL (activities of daily living) self-care performance deficit and limited physical mobility . Interventions indicated that R4 required assistance of 1 staff for personal hygiene and for bathing.<br><br>According to R4's Bathing Task documentation for the past 30 days indicates R4 had not received a shower or bath. The documentation indicated either the resident refused or it was not applicable without further explanation.<br><br>Surveyor observed R4's hair appeared oily and was combed back away from her face. The resident's fingernails were long (approximately 1/2 inch beyond her fingertips) and discolored brown.<br><br>Example 2:<br><br>R11 was admitted to the facility on [DATE].<br><br>R11's MDS dated [DATE] indicated R11 required extensive assistance or was totally dependent on staff for all activities of daily living. The most recent quarterly MDS dated [DATE] indicated R11 required limited assistance for toilet use and personal hygiene, and bathing did not occur during the assessment period.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R11's care plan initiated 08/19/22 indicated, ADL self-care performance deficit and limited physical mobility . The care plan indicated R11 required physical assistance of 1 for bathing and personal hygiene.<br><br>According to the December 2022 shower schedule, R11 was to receive a shower on 12/03/22, 12/07/22 and 12/10/22; there was no documentation indicating specifically why a shower or bath was not provided. Either the resident refused or it was not applicable without further explanation.<br><br>Surveyor spoke with R11 and asked if she was assisted with showers on Saturdays and Wednesdays, but R11 could not recall if the showers occurred. During review of December 2022 documentation for bathing it could not be determined if twice a week bathing/showers occurred.<br><br>R11's hair appeared oily and combed back away from her face. The resident's skin on her face appeared oily.<br><br>R2 was admitted to the facility on [DATE]. The resident's quarterly MDS on 10/07/22 indicated that bathing did not occur during the reporting period.<br><br>R2's Care Kardex indicated Bathing: A-1 (assist of 1).<br><br>According to R2's bath sheet, R2 is to receive a bath every Thursday and Sunday night and as needed. Task Section for Baths indicated R2 did not receive a bath on 11/13/22 (documented as not applicable) and 12/5/22 (documented as refused)<br><br>On 12/06/22 at 2:20 p.m. R2 was interviewed related to bathing. R2 stated, I can't remember the last time I bathed. I would like a good bath to clean up.<br><br>Example 3:<br><br>R3 was readmitted to the facility on [DATE]. R3's 09/15/22 admission MDS identified a BIMS score of 11, suggesting moderately impaired cognition. He required extensive assistance of 1 with bathing.<br><br>Care Kardex: 12/06/22 indicated Bathing: Physical Assist.<br><br>According to R3's bath sheet, R3 is to receive a shower every Thursday and Sunday night and as needed. Review of the Task Section for Baths identified R3 had a bath on 11/27/22 (Sunday) with no evidence of bathing after that date.<br><br>Example 4:<br><br>R25 was admitted to the facility on [DATE]. R25's admission MDS dated [DATE] indicates she required extensive assist with bathing.<br><br>R25's undated Care Kardex identified she was to receive a bath on Monday and Friday mornings and as needed. The care Kardex included a Bathing section:<br><br>Review of the Task Section for Baths identified R25 had not received a bath or shower since admission to the facility.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/06/22 at 9:30 a.m., R25 indicated that she was being discharged today (12/06/22) and confirmed she had not received a bath or shower since coming to the facility. R25 stated she washed herself up. R25 stated she wished she could have a shower before she left that morning but did not receive one. She said at home she washed her hair a couple times a week. Surveyor noted R25's hair appeared greasy and unkept.<br><br>Example 5:<br><br>R39 was admitted to the facility on [DATE]. R39's undated Care Kardex identified she was to receive a shower on Mondays and Thursdays and as needed.<br><br>Review of the Task Section for Baths did not indicate any showers had been received.<br><br>On 12/13/22 at 2:15 p.m. DON-B confirmed there was no documentation indicating R39 received any showers stating, Maybe her showers didn't get scheduled. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview and record review, the facility did not provide an activity program that met the needs of 4 of 12 sampled residents.<br><br>R26, R14, R7, and R44 all expressed that they had little to do and would like to have more things to do while residing in the facility.<br><br>Findings include:<br><br>Review of the November and December 2022 activity calendars revealed that each week there were three to four planned activities and there were activity packets available in the dining areas of each unit.<br><br>Example 1:<br><br>R26 was admitted to the facility on [DATE]. R26's MDS dated ,d+[DATE] was coded to indicate the resident scored 8 on the BIMS suggesting moderately impaired cognition. The section regarding activity preferences was not completed.<br><br>R26's care plan initiated 08/28/22 included a focus area for activities and stated, The resident has little or no activity involvement r/t (related to) disinterest, resident wishes not to participate. The goal read, Resident will participate in leisure activities as desired through the review date .11/03/2022. Interventions included: Invite/encourage the resident to attend activities .Provide activities with family and staff. Provide resident with 1:1 activity. R26's Leisure Preferences listed on the care plan included committees/clubs, discussion groups, having visitors, hobbies, learning/education.<br><br>On 12/05/22 at 1:19 p.m. and 3:23 p.m., R26 was observed in the dining hall reading a book.<br><br>On 12/06/22 at 3:15 p.m., R26 was sitting in the dining hall. The resident said to LPN-V (Licensed Practical Nurse) that she was running out of books to read. The LPN brought the resident a board game and played the game with the resident.<br><br>On 12/07/22 at 11:30 a.m., R26 was sitting in the dining hall. During interview with the Surveyor, R26 stated, I want to know how long I've been here and when I can go home. I hate it here, there is nothing here to stimulate my brain.<br><br>R26 did participated in one group activity on 12/06/22.<br><br>Example 2:<br><br>R14 was initially admitted to the facility on [DATE]<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The resident's comprehensive MDS, dated [DATE], included a BIMS score of 10 suggesting moderately impaired cognition. The MDS included the following preferred activities of R14: having books, newspapers, and magazines to read, listening to preferred music, being around animals/pets, keeping up with the news, doing things with groups of people, doing favorite activities, and going outside to get fresh air.<br><br>R14's care plan dated 10/17/22 indicated Leisure Preferences of card/games, computer/video games, exercise/ports, having visitors, and outdoor activities.<br><br>On 12/06/22 at 9:12 a.m., R14 was observed sitting in a wheelchair in her room. R14 stated, I want to talk to somebody. I wish I could do some of the things other ladies are doing. I want to talk to my sister. Why can't I go out?<br><br>On 12/12/22 at 2:57 p.m., the Surveyor observed R14 with a visitor. Surveyor asked R14 how she was feeling today. R14 replied I am feeling better. Surveyor did not observe the facility offering any of the other activities provided for R14.<br><br>Example 3:<br><br>R7 was admitted to the facility on [DATE].<br><br>The most recent comprehensive (admission) MDS dated [DATE] included a BIMS score of 5, suggesting severely impaired cognition. The MDS included the following activity preferences as very important to the resident having books, newspapers, and magazines to read, participating in religious services; activity preferences that are somewhat important included being around animals, keeping up with the news, doing things with groups of people, doing favorite activities, and going outside to get fresh air.<br><br>The care plan dated 11/01/22 included the following: The resident has little or no activity involvement r/t resident wishes not to participate. R7 will participate in their leisure activities as desired through the review date. Explain to the resident the importance of social interaction, leisure activity time. Encourage the resident's participation by asking them to attend group activities weekly. Invite/encourage the resident's family members to attend activities with resident in order to support participation. Provide resident in room activities.<br><br>On 12/05/22 from 1:00 p.m. to 3:50 p.m., R7 was observed sitting in his chair in his room looking out the window or out his room door. No activities or items for leisure activity were present in his room.<br><br>On 12/06/22 at 12:00 p.m. R7 was observed seated in his chair in his room, with the overbed table in the high position; the resident was looking under the table. The television was on. R7 indicated he didn't watch TV. No other activity items were observed in R7's room. R7 stated, There is nothing to do. I can't leave.<br><br>At 3:20 p.m. R7 was looking out the window. When asked how he was doing he said, I need something to do. I like talking to you. No leisure activity items were present in his room except the television that was on.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Example 4:<br><br>R44 was admitted to the facility on [DATE]. The resident's MDS, dated [DATE], included a BIMS score of 15 suggesting intact cognition.<br><br>R44's care plan included leisure preferences of cards/games, committees/clubs, computer/video games, creative arts, discussion group, having visitors, hobbies, activities, and puzzles/trivia.<br><br>On 12/12/22 at 3:10 p.m. R44 was observed seated in the main lounge while drinking a cup of coffee. R44 stated she tries to find things to do so that she can leave her room. R44 stated that she tries to visit with staff but they are busy and cannot visit for long. She prefers to socialize and stay busy. She expressed she was happy to have physical therapy start up again because it would get her out of her room and keep her busy. R44 indicated that she cannot read because her vision is not good. She used to like to read and do puzzles and crafts but does not do so any longer. R44 stated she had been to a couple of activities such as bingo. No one had ever brought any activity packet to her room or offered her one.<br><br>On 12/13/22 beginning at 8:30 a.m., when asked if the resident attended activities, R44 said she had been here since October 2022 and had attended two activities.<br><br>When interviewed on 12/13/22 at approximately 3:00 p.m. the Director of Hospitality, (DH-U) stated that she oversees the activity department but now she has been filling in for the activities department providing 1:1 and group activities for residents and scheduling/organizing of activities since the beginning of November. The previous activity employee left early November. DH-U explained that she develops the activity calendar, including four activities a week and she also provides 10-15 activity packet to each unit; activity packets include items such as sudoku, crossword puzzles and coloring. Surveyors did not observe any packets in resident rooms during survey. When interviewed on 12/14/22 at 11:00 a.m. DH-U confirmed that she was currently the only staff member in both the hospitality department and activity department for 105 residents at the facility; her goal was to hire someone to work Sundays through Thursdays and DH-U would cover Fridays and Saturdays.<br><br>During the daily meeting with leadership staff on 12/13/22 and 12/14/22 at 4:00 p.m., leadership staff were informed about concerns with no activities offered to residents. No additional information was provided. |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview, and record review, the facility did not ensure that 3 of 4 residents (R22, R28, R46) reviewed for pressure injuries received appropriate care to prevent the development of and/or promote the healing of pressure injuries.<br><br>R22 was admitted with a pressure injury to his left buttock which subsequently healed. R22 was assessed by the facility to be high risk for pressure injury development. The facility did not implement interventions to prevent recurrence of the pressure injury. After 3 days of observations of staff not offering or assisting R22 with repositioning, a recurrent Stage 2 pressure injury was identified on R22's left buttock. In addition, R22 developed unstageable pressure injuries on both heels after admission to the facility. Facility documentation indicates R22 chooses not to follow interventions, however observations and interviews found R22 is not offered or assisted with implementing those interventions.<br><br>R28 was admitted to the facility with a right tibia fracture for which an immobilizer is worn. R28 developed 7 pressure injuries, 6 of which were on his left leg, foot, and toes. The facility indicated the injuries were related to rubbing on the immobilizer but did not implement any measures to promote healing or prevent new pressure injuries from occurring. Observations of the areas found they were on bony prominences prone to pressure injury development.<br><br>R46 was admitted to the facility following a below the knee amputation related to osteomyelitis in the left foot, peripheral vascular disease, and diabetes. The facility did not implement interventions to prevent the development of pressure injuries such as protecting R46's right foot from pressure. R46 subsequently developed a pressure injury to the right heel and was sent to the hospital for wound healing. An orthopedic consult recommended the use of a pressure relief boot for the right foot. The facility indicated R46 refused to wear it, however, the intervention was never added to the care plan and no physician's order was obtained.<br><br>Findings include:<br><br>Example 1:<br><br>R22 was admitted to the facility on [DATE] with diagnoses including injury at the C5 (Cervical Spine 5), paraplegia, fusion of spine - cervical region, spastic quadriplegia,, protein calorie malnutrition, spinal stenosis of cervical region, and clinical depression.<br><br>R22's admission Minimum Data Set (MDS) dated [DATE] was coded to indicate R22 had clear speech, understood and was understood by others, scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition, and did not experience behavioral symptoms or refusal of care. R22 required total assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing; had functional limitations in the bilateral upper and lower extremities; had an indwelling urinary catheter and was always incontinent of bowel. The MDS indicated R22 was at risk for developing pressure ulcers and was admitted with two Stage 3 pressure ulcers. Skin and wound treatments coded on the MDS included pressure reducing devices for the bed and chair, pressure ulcer and surgical wound care, and applications of dressings (with or without topical medications) other than to the feet.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R22's Significant Change in Status MDS dated [DATE] was coded similarly; however, the MDS indicated the resident had a facility acquired Stage 2 pressure ulcer that was not present on the previous assessment. Skin and wound treatments include the items listed above and nutrition or hydration interventions to manage skin problems.<br><br>R22's care plan included the following entry initiated 08/15/22, The resident has potential for impairment to skin integrity r/t (related to) impaired mobility . Interventions dated 08/15/22 included: Apply barrier cream per facility protocol to help protect skin from excess moisture, Encourage/Assist with turning and repositioning every 2-3 hours .Ensure that heels are elevated while resident is laying in bed.<br><br>Additional interventions were added on the following dates:<br><br>~08/25/22: Assist resident in adjusting water temperature to prevent scalding/burns, remind resident when providing warm drinks. Encourage/assist resident to reposition when in wheelchair every 2 hours.<br><br>~09/19/22: Encourage good nutrition and hydration in order to promote healthier skin.<br><br>~09/20/22: Monitor skin when providing cares (care), notify nurse of any changes in skin appearance.<br><br>A care plan entry was initiated on 09/19/22 and read, The resident has actual impairment to skin integrity r/t bilateral heels PU (pressure ulcer). Interventions dated 09/19/22 included: Educate resident/family/caregivers of causative factors and measures to prevent skin injury .Ensure that heels are elevated while resident is lying in bed .Evaluate and treat per physician orders .Evaluate resident for s/sx (signs/symptoms) of possible infections .Identify/document potential causative factors and eliminate/resolve where possible Nurse to assess/record/monitor wound healing with dressing changes .Assess and document status of wound perimeter, wound bed and healing progress. Report improvements or declines to the MD (Medical Doctor).<br><br>A Pressure Ulcer Unavoidability document noted:<br><br>1. Site: 49) Right heel, Pressure: Length 3.5 (centimeters) Width: 5.0 (cm) Unstageable.<br><br>2. Site: 50) Left heel. Pressure: Length: 3.0 Width 2.5 Unstageable.<br><br>Date noted: 9/19/22.<br><br>~Risk Factors: Other. Limited movement in BUE (bilateral upper extremities) and no movement in BLE (bilateral lower extremities) with foot drop. Two or more Diagnoses/Conditions: Quadreplegia [sic], continuous or chronic urinary incontinence, chronic bowel incontinence. Education given on importance of floating heels at all times. Also the importance of eating well balanced meals and how good nutrition aids in wound healing.<br><br>~Current and Prior Interventions: Floating heels, wound care, nutritional supplements, monitoring percentage of intake.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | ~Describe non-compliance with interventions: When up in chair and wheelchair he refuses elevating legs and using a pillow so his heals [sic] are not resting on a hard surface and limiting blood flow to the area.<br><br>~Summary: Patient in general has not been interested in being part of recovery. He tends to stay in bed and refuses going into recliner, etc. Guest is allowing us now (to) float heels, wound care nurse seeing weekly and nurse manager is changing dressing daily. Daily reminder of importance of nutritional intake.<br><br>On 12/05/22 at 11:30 a.m., R22 was interviewed and indicated he had pressure ulcers on both of his heels that had developed since admission and were first identified on 09/19/22. At the time of interview the resident was in bed with his heels floated. R22 stated, The staff float my heels on pillows so my heels don't touch the mattress. They are supposed to come in every 2 hours and reposition me and adjust my pillows. Last time anyone came in to reposition me was around 8:00 a.m. today. No one has been back since then except to serve me my breakfast tray and give me my medications. R22 was subsequently observed in bed lying on his back, with his heels floated from 11:30 a.m. to 3:10 p.m. During the observation he was not repositioned. R22 verified he had not been repositioned during that time.<br><br>On 12/06/22 at 8:30 a.m., R22 was observed in bed on his back with the head of the bed raised eating his breakfast with his heels floated. R22 indicated he had last been turned by the night shift around 6:30 a.m. and had not seen any day shift CNAs (Certified Nursing Assistant) yet. R22 was observed from 8:30 a.m. to 12:15 p.m.<br><br>At 11:32 a.m., CNA-I was observed exiting R22's room. During interview, CNA-I indicated she was assigned to take care of R22 that day and said she had stopped in to see if R22 needed anything. CNA-I stated she had not repositioned R22 since she came on duty and said that R22, Asks when he wants to be repositioned. At 12:15 p.m., R22 verified he had not been repositioned or had his pillows adjusted since the day shift staff came on duty.<br><br>R22's Care Kardex as of 12/06/22 included: Bed mobility. Patient requires physical assist x1-2 (of one to two staff) for repositioning (from) side to side every 2 hours. Physical assist x2 for bed positioning. Skin: Ensure that heels are elevated while resident is lying in bed. Monitor skin when providing cares (care), notify nurse of any changes in skin appearance. Tubi-grips on BLE (bilateral lower extremities) on AM off HS (on in the morning and off at night. Transfers: Resident requires physical assist x1 with sit to stand mechanical lift.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 12/07/22 at 8:15 a.m., R22 was observed on his back with the head of the bed elevated. The resident indicated he was ready for breakfast. The night shift had repositioned him and given him something to eat to tide him over until breakfast. Breakfast was delivered at approximately 8:40 a.m. During observation from 8:15 a.m. to 11:10 a.m., R22 remained in the same position, on his back with the head of the bed raised. At 11:10 a.m., R22 was interviewed and indicated the night staff told him he was getting a bedsore on his buttocks so he had better start getting up out of bed more. R22 said, They offered me Tubigrips to wear on my legs but they are not always put on. Once in a great while they put them on me. After I was here for a month and a half, I got sores on both my heels. The only thing I have done to keep my feet off the bed is have pillows placed under my legs. I have never been offered any types of boots to wear in bed or when up. A nurse talked about some type of cushion that could be placed between my legs so my feet would stay off the mattress. Nothing was ever brought to my room to try and no one ever mentioned it again. I don't wear any footwear except gripper socks which I wear all the time. R22 stated he had last been repositioned by the night shift about 6:00 a.m. R22 stated it was much easier to reposition when two staff assisted as he can't help at all with repositioning. R22 indicated no day shift staff had repositioned him on 12/07/22.<br><br>R22's care plan was updated on 12/8/22 to indicate R22 had a pressure injury to the left buttock. Interventions dated 12/08/22 included, Apply barrier cream per facility protocol to help protect skin from excess moisture .Avoid scratching and keep hands and body parts from excessive moisture .Keep fingernails short .Encourage good nutrition and hydration in order to promote healthier skin .Use a draw sheet or lifting device to move resident .Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, by wound nurse or provider.<br><br>Surveyor requested to review Wound Round notes or other information related to R22's skin assessments/pressure injuries since admission. The following information was provided by DON-B (Director of Nursing) on 12/13/22:<br><br>8/27/22 Admission: Does the resident have any skin issues observed (including new and old)? No. No skin issues described. Wound team notified of new areas? No.<br><br>9/3/22 Other: Does the resident have any skin issues observed (including new and old)? No. No skin issues described. Wound team notified of new areas? No.<br><br>9/10/22 Weekly: Does the resident have any skin issues observed (including new and old)? No. No skin issues described. Wound team notified of new areas? No.<br><br>10/01/22 Weekly: Does the resident have any skin issues observed (including new and old)? No. No skin issues described. Wound team notified of new areas? No.<br><br>10/22/22 Admission: Does the resident have any skin issues observed (including new and old)? Yes. Document and Describe All skin issues: 50) Left Heel Description: PU (pressure ulcer). 49) Right Heel. Description: PU. Wound team notified of new areas? Yes.<br><br>11/05/22 Admission: Does the resident have any skin issues observed (including new and old)? Yes. Document and Describe All skin issues: Other. Description: Bilateral heels pressure. Wound team notified of new areas? No.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 11/12/22 Admission: Does the resident have any skin issues observed (including new and old)? Yes. Document and Describe All skin issues: Other Bilateral heels PU healing well. Wound team notified of new areas? No.<br><br>12/08/22: Does the resident have any skin issues observed (including new and old)? Yes. Document and Describe All skin issues: 32) Left buttock. Description: open area. 31) Right buttock. Description: open area. Wound team notified of new areas? Yes.<br><br>Wound Round Notes:<br><br>12/08/22: Braden Score (Scale for Predicting Pressure Ulcer Risk): 10 (High Risk). Active Wounds (Active/Closed)<br><br>Active Wounds:<br><br>Wound Site: L buttocks. Date Identified: 12/8/22. Type: Pressure. Classification: Ulceration. Status: Active. Clinical Stage: Stage 2.<br><br>Wound Site: L Heel. Date Identified: 9/19/22. Type: Pressure. Classification: Ulceration. Status: Active. Clinical Stage: Unstageable.<br><br>Wound Site: R heel. Date Identified: 9/19/22. Type: Pressure. Classification: Ulceration. Status: Active. Clinical Stage: Unstageable.<br><br>Inactive Wounds (healed):<br><br>.Wound Site: L buttocks: Date Identified: 8/16/22. Type: Pressure. Classification: Ulceration. Status: Healed.<br><br>.Wound Site: R heel. Date Identified: 9/19/22. Type: Pressure. Classification: Ulceration. Status: Healed. Clinical Stage: Unstageable<br><br>R22's progress Health Status notes entered on 12/08/22 by RN-H (Registered Nurse) indicated, .left buttocks. Measurements recorded. Peri wound: WNL (within normal limits), wound bed light pink/red, nongratulating (non-granulating) tissue. No c/o (complaints of) pain or discomfort to area. L buttocks cleansed, barrier cream applied. Resident and NP updated.<br><br>A Wound Assessment Detail Report dated 12/08/22 and written by RN-H stated, Assessment Date: 12/8/2022 10:29 a.m. Wound: L buttocks. Status: Active. Type: Pressure. Classification: Ulceration. Source: Facility acquired. Date identified: 12/8/2022. Clinical Stage: Stage 2. Tissue Type: pink or red non-granulating = 100%. Exudate: None/ Periwound Criteria: normal. Wound Edge: Distinct and attached. Pain Scale: 0. Outcome; Probable improvement. Size: 0.50 x 0.50 x 0.10 (L x W X D)<br><br>On 12/8/22 at 11:46 a.m., R22 indicated he was told by the night staff that he had a new pressure ulcer on his buttocks. The nurses looked at it this morning and told me it was a new pressure ulcer.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 12/08/22 at 12:10 p.m., RN-H was interviewed and stated, R22 does have a pressure ulcer on his left buttocks. It is a Stage 2. He has a standing order for preventative barrier cream. All residents get this ordered on admission to the facility. I took a picture with a measurement. This new pressure ulcer is facility acquired. I don't know why R22 no longer gets out of bed. When he worked with therapy he was out of bed in his chair. If he wants to get up or be repositioned, he can ask us. Residents should be repositioned every 2 hours or as requested.<br><br>On 12/13/22 at 10:00 a.m., RN-L was interviewed and indicated R22 was alert and oriented times 4 and was able to make his needs known. RN L indicated she felt R22 was reliable with what he told staff. RN-L said, He is very particular about how he wants his care provided. Every 2 hours he is to be repositioned and his pillows adjusted. It really takes two staff to reposition him as he is unable to assist. He has very limited movement of his arms. He has never refused to be repositioned for me. I have not heard other staff say he refuses cares. He used to get up when he went to therapy. I do not know why they stopped getting him up.<br><br>He developed pressure ulcers on his bilateral heels in September. We were floating his heels since he was admitted . He is high risk to develop pressure ulcers. We are now using 3 pillows under his legs to float his heels. He likes a towel placed between his legs also. I don't remember him ever refusing to have the pillows placed under his lower extremities in bed. He was admitted with pressure ulcers on his buttocks that have healed.<br><br>RN-L stated R22 developed a pressure ulcer last week (12/08/22) on his buttocks. The pressure ulcer was facility acquired. RN-L stated she had not seen R22's pressure injury as he transferred to a different neighborhood last week.<br><br>Example 2:<br><br>Resident #28 (R28) was admitted to the facility on [DATE] with diagnoses including right fractured tibia with right lower leg immobilizer, renal failure, history of falls, diabetes, and heart disease.<br><br>The resident's MDS dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15. R28 was non-ambulatory due to a leg fracture and required extensive assistance with bathing and personal hygiene. The MDS indicated the resident was at risk for pressure ulcer development but did not have a pressure ulcer at the time of the assessment.<br><br>The resident's care plan initiated 10/28/22 indicated the resident had the potential for impairment to skin integrity related to impaired mobility. Interventions included, Apply barrier cream per facility protocol to help protect skin from excess moisture .Encourage activity as tolerated .Encourage good nutrition and hydration in order to promote healthier skin .Ensure proper fitting footwear Monitor skin when providing cares, notify nurse of any changes in skin appearance .Encourage/assist with turning and repositioning every 2-3 hours . Ensure that heels are elevated while resident is lying in bed .Identify/document potential causative factors and eliminate/resolve where possible .<br><br>R28's physician orders included:<br><br>~10/28/22: Braden (skin assessment) to be completed in Point Click Care one time a day every 7 day(s) for 4 weeks<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | ~11/05/22: Knee immobilizer to RLE (right lower extremities) at all times. May loosen while in bed. Every shift.<br><br>~11/05/22: Wound consult as needed This was ordered again on 12/08/22.<br><br>~11/05/22: Skin checks weekly. Every day shift every Wed, Sat (Wednesday, Saturday) -Must open and document skin evaluation for each assessment. This was ordered again on 12/08/22.<br><br>~12/06/22: Tubigrip (tubular support bandage) every shift.<br><br>On 11/23/22 a podiatry consult was ordered with a scheduled date for 01/24/2023.<br><br>During interview with R28 on 12/09/22 at 2:00 p.m., the resident reported he had several open areas on his left front leg, left ankle, left toes and a toe on his right foot. The resident stated he didn't know how they occurred but staff told him, it must be from rubbing up against the immobilizer. R28 stated that he was supposed to have Tubigrip to wear but he never received it. The resident was observed wearing white ankle socks on both feet. No dressings were observed covering the wounds. He stated he just got an order to remove the knee immobilizer today, 12/09/22. He also started physical therapy. The resident stated, I wear my shoes when I go out from the facility and when I'm working with physical therapy.<br><br>R28 had a Braden Scale for Predicting Pressure Ulcer Risk score of 15 indicating moderate risk was documented on 12/08/22. The resident's record indicated the resident developed the following open areas after admission to the facility and described as trauma and abrasions as indicated below. Active wounds at that time included:<br><br>Active wounds at the time of survey included<br><br>1. 12/06/22 the fourth right toe Trauma / abrasion was measured at 2 cm x 1 cm x blank (not entered by staff);<br><br>2. 12/13/22 the left lower leg measurements were 2 cm x 0.50 cm x 0 cm;<br><br>3. 12/13/22 the left ankle lower (heel) measurements were 0.5 cm x 0.5 cm x 0 cm;<br><br>4. On 12/13/22 the left fifth toe measurements were Sm. Area;<br><br>5. On 12/13/22 the left fourth toe measurements were 1 cm x 0.5 cm x blank;<br><br>6. On 12/13/22 the left third toe measurements were 2 cm x 1 cm x blank; and<br><br>7. On 12/13/22 the left second toe measurements were 1 cm x 1 cm x 0 cm.<br><br>The wounds on the right fourth toe, left fifth toe, left fourth toe, left third toe, left second toe wound, and left lower leg were first identified on 11/25/22 as a trauma/abrasion with necrotic soft adherent tissue 100%. Observation of a photo indicated the open area was over a bony prominence. The left ankle medial wound was first identified on 12/06/22 as a trauma/abrasion with bright pink or red tissue-100%. Observation of a photo indicated the open area was over a bony prominence.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Example 3:<br><br>R46 was admitted to the facility on [DATE] with diagnoses that included left foot osteomyelitis, status post left below the knee amputation, peripheral vascular disease, sepsis, COVID-19, end stage renal disease, and diabetes.<br><br>The comprehensive MDS dated [DATE] and quarterly MDS dated [DATE] indicated a BIMS score of 13 and 14, which indicated intact cognition, and that R46 required extensive to total assistance of one with ADLs. The MDS comprehensive and quarterly MDSs indicated R46 was at risk for skin breakdown; did not have a pressure ulcer or diabetic foot ulcer; had surgical wound (identified in comprehensive MDS); and used pressure reducing device in bed and chair, surgical wound care, and application of ointments/medications to other than feet.<br><br>R46's care plan initiated on 05/06/22 included the following statement: Focus: The resident has potential for impairment to skin integrity r/t impaired mobility. Interventions included:<br><br>~Apply barrier cream per facility protocol to help protect skin from excess moisture. Date Initiated: 05/08/2022<br><br>~Change bedding/clothing if moist. Date Initiated: 05/10/2022<br><br>~Dietary Consult as needed. Date Initiated: 05/10/2022<br><br>~Do not allow linens to be creased/folded under resident, keep bedding as smooth as possible. Date Initiated: 05/10/2022<br><br>~Encourage activity as tolerated. Date Initiated: 05/06/2022<br><br>~Encourage good nutrition and hydration in order to promote healthier skin. Date Initiated: 05/06/2022<br><br>~Encourage/assist with turning and repositioning every 2-3 hours. Date Initiated: 05/10/2022<br><br>~Ensure proper fitting footwear. Date Initiated: 05/08/2022<br><br>~Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date Initiated: 05/08/2022<br><br>~PT/OT Consultation. Date Initiated: 05/10/2022<br><br>~Use draw sheet when turning/repositioning Date Initiated: 05/06/2022<br><br>A second care plan focus area initiated on 05/08/22 stated, The resident has actual impairment to skin integrity. 1. Right heel. Interventions dated 05/08/22 included the following:<br><br>~Encourage good nutrition and hydration in order to promote healthier skin<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | ~Nurse to assess/record/monitor wound healing with dressing changes. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements or declines to the MD<br><br>~Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, by wound nurse or provider<br><br>Provider orders were as follows:<br><br>~05/06/22: Podiatrist Consult as Needed.<br><br>~05/06/22: Diabetic foot checks at bedtime.<br><br>~05/06/22: LLE (left lower extremity) amputation site- cleanse with NS, pat dry. Cover incision with ABD FB kerlix daily, prn (as needed) every day shift AND as needed for wound care.<br><br>~05/6/22: Wound Consult as needed<br><br>~06/10/22: Wound Consult as needed.<br><br>~08/23/22: Santyl Ointment 250 UNIT/GM (Collagenase) Apply to R heel topically every day shift for wound care.<br><br>~09/10/22: Wound Consult as needed.<br><br>~09/10/22: Collagenase Ointment 250 UNIT/GM Apply to right foot 1,2 toe topically one time a day for infection.<br><br>~09/10/22: Podiatrist Consult as Needed.<br><br>~09/12/22: Santyl Ointment 250 UNIT/GM (Collagenase) Apply to R heel topically every day shift for wound care santyl FB foam dressing.<br><br>~09/27/22: Betadine R 2nd and 3rd toe BID every shift for wound care.<br><br>Skin observation notes were reviewed the time period R46 was at the facility (05/08/22 to 11/02/22) in PCC and showed two entries:<br><br>*07/24/22 that indicated R46 had No new skin lesions.<br><br>*08/20/22 indicated New Skin Issue: Right Heel PU (pressure ulcer) and PU (pressure ulcer) 2nd and 3rd toe on R foot.<br><br>According to document review, the identification and status of R46's right heel wound included the following:<br><br>08/20/22 eINTERACT SBAR Summary for Providers Late Entry by RN-FF stated, .Skin wound or ulcer started 08/20/22 . Pressure ulcer/injury Right heel PU, Date of clinical notification: 08/20/22(.)<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The right heel wound was identified as a pressure ulcer/injury however a description including measurements was not included in the document.<br><br>08/22/22 Orthopedic Consult to Evaluate Prosthesis recommended R46 wear pressure relief boot on R foot when in bed.<br><br>Surveyor did not find an order for pressure relief boots in the electronic health record on or after this date. The boots were not added to the care plan and there was no documentation provided indicating the resident used pressure relief boots.<br><br>An evaluation of R46's right heel wound was conducted on 10/29/22 through Telehealth Evaluation. The visit summary note described the wound to have Purulent Drainage a left [sic] heal [sic] wound. Pt (patient) reports redness of the heal [sic] starting about 4 weeks ago. He hasn't noticed much change since that time though. He hadn't noticed wheezing [sic] from the wound (though it is present on my exam). He denies fever or other complaint such as dysuria or abdominal pain. He has not been on abx (antibiotics) recently for the foot and is awaiting a vascular surgeon consult per the RN.<br><br>Three days after the telehealth evaluation, on 11/01/22, a Physician-Progress Note states, R46 reports pain in the right foot, intensity 3/10, duration chronic, frequency intermittent, described as dull and non-radiating. Functional gains limited by pain and weakness. Pain right foot pain. There were no recommendations regarding intervention for the pain.<br><br>One week after the telehealth evaluation was conducted, R46 was discharged to the hospital. According to an eINTERACT Transfer Form dated 11/02/22, resident was discharge(d) to Hospital for Wound to heel.<br><br>During interview on 12/13/22 at 3:18 p.m. DON-B indicated R46's right heel wound was a diabetic ulcer of the heel; a WOUND ASSESSMENT DETAILS REPORT was provided, with assessment date of 08/22/22.<br><br>According to the assessment, the wound was described as Vascular Diabetic/Ulcer Facility-acquired 08/22/2022, Superficial 2.50 x 1.50 x Unknown (L x W x D) 3.75 cm 2. The form indicated R46 had a Braden Score of 15 on 10/02/22 with risk factors that included:<br><br>Braden Score 15 - high risk;<br><br>Sensory = 2 very limited;<br><br>Moisture = 3 occasionally moist;<br><br>Activity = 2 chairfast;<br><br>Mobility = 3 slightly limited;<br><br>Nutrition = 3 - adequate; and<br><br>Friction and Shear = 2 - potential problem.<br><br>(continued on next page) |

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|---|---|---|---|
| | 525730 | A. Building<br>B. Wing | 12/14/2022 |

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| Medical Suites at Oak Creek (the) | 2700 Honadel Boulevard<br>Oak Creek, WI 53154 |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | DON-B indicated R46 was followed by the vascular surgeon beginning toward the end of October 2022. R46 was not assessed by the wound care nurse until 11/01/22.<br><br>During the exit meeting on 12/14/22, DON-B indicated R46 refused to wear a pressure relief boot. There was no indication R46 refused to wear a pressure relief boot. There was no evidence the facility implemented an alternative such as using a pillow to float the heel off the mattress. There was no evidence the recommendation was shared with the physician to obtain an order and the intervention was not added to the care plan. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview, and record review, the facility did not provide care and services to maintain 1 of 21 residents reviewed for declines in mobility.<br><br>R2 was discharged from therapy on 10/11/22 indicating that R2 should be transferred and ambulated with moderate assistance of 1 staff, using a gait belt and a 2 wheeled walker. As of 12/12/22, staff were using a mechanical lift to transfer R2 and were not assisting him to ambulate. There was no referral to therapy related to the decline until Surveyor began investigating.<br><br>Findings include:<br><br>R2 was admitted to the facility on [DATE] with diagnoses to include difficulty walking and unsteadiness, and cognitive communication deficit.<br><br>The admission MDS (Minimum Data Set) assessment dated [DATE] indicated R2 required extensive assistance of two persons for bed mobility and transfers, had no functional limitations in range of motion, and used a wheelchair for mobility; R2 received physical and occupational therapy with a start date of 07/13/22.<br><br>The quarterly MDS dated [DATE] demonstrated improvement as R2 required limited assistance of one person for bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, had no functional limitations in range of motion and used a walker for a mobility device.<br><br>R2's care plan initiated on 07/13/22 stated, The resident has an ADL (activity of daily living) self-care performance deficit and limited physical mobility r/t (related to) generalized weakness. Interventions included: Bed Mobility: Physical Assist .Transfers: Resident requires physical assistance of 1 staff, gait belt and FWW (front wheeled walker).<br><br>R2's care plan was updated on 09/29/22 to indicate: Ambulation x1 (one staff), Physical Assist use gait belt . Bed Mobility: Physical Assist with HOB [head of bed] bars.<br><br>R2's current care plan that was reviewed on 12/12/22 stated, .Ambulation: Assist x2 with hoyer lift sic Bed Mobility: Physical Assist x2 with HOB bars .Transfers: Assist x2 with hoyer lift sic.<br><br>R2's Care Kardex that was dated 12/06/22 included: Transfers: Resident requires physical assistance of 1 staff assist, gait belt and FWW (front wheeled walker). Mobility: Ambulation: X1 staff Physical Assist (use gait belt).<br><br>R2's Care Kardex was updated on 12/12/22 to include, Ambulation: Assist x2 with hoyer lift, Bed Mobility: Physical Assist x2 with HOB bars, Transfers: Assist x2 with hoyer lift.<br><br>R2's Daily Skilled progress notes written by nursing staff describing the resident's abilities to transfer and ambulate included:<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10/07/22 Resident is receiving skilled services for: Physical Therapy, Occupational Therapy. ADL Function: The resident walks. The resident requires partial/moderate assistance while ambulating. The resident requires partial/moderate while transferring. The resident requires partial/moderate assistance for bed mobility. The resident requires partial/moderate assistance for wheelchair mobility.<br><br>10/08/22 Resident is receiving skilled services for: Physical Therapy, Occupational Therapy. ADL Function: The resident does not walk. The resident requires substantial/max assistance while ambulating. The resident requires substantial/max while transferring. The resident requires substantial/max assistance for bed mobility. The resident requires substantial/max assistance for wheelchair mobility.<br><br>11/01/22 - Resident is receiving skilled services for: Physical Therapy, Occupational Therapy. ADL Function: The resident does not walk. The resident requires substantial/max assistance while transferring. The resident requires substantial/max assistance for bed mobility. The resident requires substantial/max assistance for w/c (wheelchair) mobility. The exact same note was written on 11/08/22, 11/11/22,11/13/22, 11/14/22, and 11/20/22.<br><br>11/10/22 - Resident is receiving skilled services for: Physical Therapy, Occupational Therapy. ADL Function: The resident does not walk. The resident is 100% dependent while walking. The resident is 100% dependent while transferring. The resident is 100% dependent for bed mobility. The resident is 100% dependent for wheelchair mobility.<br><br>12/03/22 - Resident is receiving skilled services for: Physical Therapy, Occupational Therapy. ADL Function: The resident does not walk. The resident is 100% dependent while walking. The resident is 100% dependent while transferring. The resident is 100% dependent for bed mobility. The resident is 100% dependent for wheelchair mobility.<br><br>On 12/06/22 at 2:45 p.m., Surveyor spoke with CNA-J (Certified Nursing Assistant) related to R2's transfer and ambulation status. CNA-J stated she would have to check the Care Kardex for R2 to determine if R2 had the ability to ambulate. CNA-J said R2 was, Transferred with a sit-to-stand lift.<br><br>At 3:30 p.m., Surveyor spoke again to CNA-J who indicated R2 no longer transfers or ambulates as indicated on the Care Kardex. CNA-J said, R2 now uses a sit-to-stand lift with assistance of one staff but he could really use a Hoyer lift. He is not standing well in the sit-to-stand. R2 is no longer ambulatory. He's kind of stiff all over. R2 is no longer walked.<br><br>On 12/06/22 at 3:40 p.m., Surveyor spoke with CNA-I who stated she was assigned to provide care for R2 on that day. CNA-I stated she had transferred R2 with the sit-to-stand lift but did not ambulate him. She indicated she did not feel it would be safe to transfer him by herself using a gait belt and walker as indicated in the care plan.<br><br>On 12/06/22 at 3:45 p.m., Surveyor spoke with RN-L (Registered Nurse) who indicated she did not know if R2 ambulated or still transferred with assistance of one staff. RN-L stated she would submit a referral to physical therapy to re-evaluate the resident for rehabilitative services.<br><br>On 12/07/22 at 9:40 a.m., RN-L informed the Surveyor that physical therapy had reassessed R2 and he now required a Hoyer mechanical lift for transfers and was no longer ambulatory. R2 was going to receive physical therapy services again as a result of the decline in physical functioning.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/7/22 at 12:23 p.m., PTA-EE (Physical Therapy Aide) was interviewed. PTA-EE stated, There is a restorative program where the rehab tech goes around and sees certain residents. If therapy staff are notified of any resident who has become weaker, has a change in transfer or ambulation ability, we would go see the resident and work to get the resident back to his/her baseline.<br><br>On 12/13/22 at 2:25 p.m., the DOR-Z (Director of Rehab) was interviewed related to R2's ambulation and transfer status. DOR-Z said R2 was discharged from therapy on 10/11/22. Recommendations at the time of discharge were for assist of 1 with bed mobility, assist of 1 with a gait belt and 2 wheeled walker for transfers and ambulation. DOR-Z indicated she received a call from the nurses on Unit 1 (Kindle) last week (the week of 12/5/22) asking for an evaluation of R2's transfer and ambulation status. DOR-Z stated, R2 has had declines in ambulation and transfer ability. He is stiff all over but does not have contractures. DOR-Z indicated that after assessing R2, she determined R2 needs to be transferred with a Hoyer lift and is not to be ambulated by nursing staff.<br><br>DOR-Z said, the nurses on the floor are to notify therapy staff when a resident has declines in ambulation, transfers, or range of motion. DOR-Z indicated she had not been contacted by nursing related to R2's decline until last week following inquiry by Surveyor. DOR-Z stated, I screen each resident quarterly. Nursing can downgrade a resident from transfers with assist of one (staff), gait belt and walker to a sit-to-stand lift. Nursing should not wait for therapy to do a screen if the downgrade is necessary. When they change the transfer or ambulation status of the resident they should notified therapy for a re-evaluation.<br><br>DOR-Z indicated R2 was placed back on physical therapy last week with his wife's consent. DOR-Z clarified that the facility has never had a restorative nursing program, but there was a restorative technician in the therapy department with a list of residents she performs exercises for and ambulation. At 3:00 p.m., DOR-Z provided a list of 7 residents the restorative technician assisted to ambulate or perform exercises. R2 was not receiving services provided by the restorative technician.<br><br>On 12/13/22 at 4:00 p.m., Surveyor spoke with DON-B and NHA-A (Nursing Home Administrator) about R2. NHA-A confirmed that the facility does not have a restorative program. DON-B indicated restorative care was incorporated into the direct care provided by CNAs for activities of daily living, stating, It's just the movement with dressing. We do not have anyone in charge of a restorative program. DON-B stated that when declines are observed, nursing brings it up at the morning meetings which DOR-Z attends and then therapy screens the residents who have functional declines. There was no evidence that R2's declines were discussed with therapy at any time until Surveyor inquired about R2's status. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview, and record review, the facility did not ensure 8 of 11 sampled residents (R5, R3, R6, R17, R4, R12, R2, and R17) reviewed for falls/accidents received appropriate care and supervision to prevent incidents.<br><br>R5 experienced 3 falls while at the facility. The second fall resulted in a fractured nose and a fractured wrist. The third fall resulted in a subdural hematoma. The facility implemented new interventions after the falls, but did not conduct a thorough investigation to determine the cause of the falls.<br><br>Upon admission, R3 was to have anti-roll back brakes installed on their wheelchair. This was not done. On 10/18/22, R3 had a fall which the facility indicated the wheelchair rolled back on R3 causing a fall. The facility identified anti-roll back brakes as a new intervention following the fall. R3 was diagnosed with a hip fracture following this fall. Following return from hospitalization for the hip fracture, R3 had another fall where the wheelchair rolled back. The facility again identified anti-roll back brakes as a new intervention for R3. R3 had an additional 4 falls where the facility did not thoroughly investigate the falls in order to identify the root cause and did not implement interventions that addressed the causes of the falls.<br><br>R46 had multiple falls at the facility. Following each fall, the facility implemented new interventions, but did not conduct a thorough investigation to determine the root cause of R46's attempts at self transfer.<br><br>R17 had 6 falls with 5 of those being from bed. Although the facility implemented interventions after each fall, they did not address the root cause of the falls from bed and did not implement interventions to limit falls from bed.<br><br>R4 had 3 falls while at the facility. The fall assessments did not address if all care planned interventions were in place at the time of each fall. Following those falls, there was no reassessment and/or modifications to the care plan interventions. There was no investigation to determine the root cause of R4's falls.<br><br>R12 experienced 5 falls. There was no evidence that orders for an x-ray and for resident to be sent to the emergency room were followed through for 2 falls. There was also no evidence of the findings and treatment required. There was no investigation to determine the root cause of R12's falls and no new interventions added to the care plan despite being identified in the fall assessment.<br><br>R2 had 6 falls in the last 2 months. Although R2 was able to tell staff what he was trying to do at the time of the falls, these statements were not taken into consideration while identifying the root cause and to develop care plan approaches to reduce the risk of falls. Observations made by Surveyor found that care planned interventions were not consistently implemented related to falls.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R2 had an intervention that he was to be served hot beverages in a cup with a lid following an incident where he spilled hot coffee on himself while using a foam cup. If R2 refused to use a cup with a lid, staff were to stay with R2 while he drank the hot beverage. These interventions, which were verbalized by the NHA (Nursing Home Administrator) and DON (Director of Nursing) were not added to the care plan and were not know by staff. Multiple observations of R2 using a foam cup found that the cup would bend/fold while R2 was trying to drink from it. There were no staff supervising R2 while he drank hot beverages from the foam cup.<br><br>R17 had a Speech Therapy intervention to eat in the dining hall for all meals related to an episode of aspiration. R17 was observed on multiple occasions to be eating in the TV area and her room without any supervision.<br><br>Findings include:<br><br>On 12/05/22, ADON-C (Assistance Director of Nursing) provided the facility policy and procedure that addressed Fall Prevention that was dated 11/2020. The policy stated, .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 .<br><br>Surveyor reviewed the facility's fall documentation and noted there had been 351 falls at the facility since 04/01/22. NHA-A (Nursing Home Administrator) and DON-B (Director of Nursing) shared that a new process for managing falls was implemented approximately three months prior to the survey. Falls for the past 3.5 months (09/15/22-12/05/22) were reviewed and 172 falls were documented.<br><br>Example 1:<br><br>R5 was admitted to the facility on [DATE] and had diagnoses including mental health disorders, dementia, unsteadiness on feet, and diabetes; R5 had a recent injury of the head and fracture of the lower end of right radius on 11/06/22.<br><br>R5's admission Minimum Data Set (MDS) completed on 09/22/22 included a BIMS (Brief Interview for Mental Status) score of 3 suggesting the resident had severely impaired cognition. According to the MDS, the resident required limited assistance with bed mobility and transfers. The resident was non-ambulatory with a wheelchair and was totally dependent on staff for locomotion.<br><br>The resident's care plan dated 09/17/22 indicated the resident was at risk for falls related to weakness. The goal was to keep the resident free of minor injury through the review date. Interventions included: ask visitors to inform staff when leaving, ensure footwear fits properly, and encourage resident to stay properly hydrated, educate that dehydration increases risk of falls.<br><br>The resident's Kardex was not available for review because the resident was no longer in the facility.<br><br>According to facility documentation, R5 experienced 3 falls since admission. Facility documentation related to the resident's falls, provided by ADON-C was reviewed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | ~10/21/22 - R5 experienced a non-injury fall on 10/21/22 at 10:18 p.m.: Resident was observed by CNA (Certified Nursing Assistant) sliding out of wheel chair onto the dining hall floor .Guest stated she was trying to remove herself from the dining area back to her room.<br><br>A note added to the incident report on 10/24/22 included, Resident is alert with confusion and needs moderate assist with ADLs (activities of daily living) and transfers . MD and family made aware of the above incident and in agreement to the current POC (plan of care) with the addition to putting Dycem under the w/c (wheelchair) cushion to prevention of falls. All interventions were in place at the time of the fall .IDT (Interdisciplinary Team) reviewed and revised the POC to meet her needs.<br><br>On 10/21/22, a Fall Risk Evaluation was conducted post fall. The [NAME] II Fall Risk Model documented score was 17 indicating the resident was at high risk for falls.<br><br>R5's care plan was updated to include approaches of Dycem under the cushion, do not leave resident unattended in the bathroom, educate resident/family/visitors on need to call for assistance when transferring in/out chair.<br><br>~10/30/22 - R5 experienced a fall with subsequent injury on 10/30/22 at 8:15 p.m.: CNA reports pt (patient) is on the floor in hallway outside of room while conducting rounds Resident Unable to give Description. No witnesses found. Fall interventions in place at time of incident. The report indicated the resident was transferred to the emergency room . According to the ED (emergency department) report, Guest is an [AGE] year old female with history of dementia .Assist of 1 with ADLs and transfers .abrasion to top of right hand with c/o (complaints of) pain, hematoma above left eye and bruising to bridge of nose .Guest returned with fracture to nose and right wrist. Interventions in place at time of fall. IDT (Interdisciplinary Team) reviewed with new intervention to offer a walk when notice guest becoming agitated or restless.<br><br>On 10/30/22 a Fall Risk Evaluation was conducted post fall. The [NAME] II Fall Risk Model documented score was 17 indicating the resident was at high risk for falls.<br><br>R5's care plan was updated to include interventions of evaluate gait and ambulation capabilities, identify abnormalities, physical therapy to evaluate, and when restless and agitated offer a walk.<br><br>~11/06/22 - According to an incident report R5 experienced a fall with subsequent injury on 11/06/22 at 2:30 a.m.: Guest was observed on the floor of bedroom laying on her left side bleeding from head and nose .guest very confused and doesn't remember getting out of bed or the reason she got out of bed. No witnesses found. Fall safety interventions in place at time of incident. A note added to the report, dated 11/07/22 stated, .guest was observed on the floor in front of her bathroom lying on her left side with apparent injury to her head. First aid was administered, and resident was sent out immediately to r/o (rule out) an acute head injury .Resident was observed about an hour prior to incident sleeping in the bed and toileted at 12:30 a.m. and was last observed at 1:00 a.m.<br><br>According to the Incident report, Resident did return with a subdural hematoma. Hospice was ordered. All interventions will remain in place for preventatives along with encouraging hipsters because resident has poor safety awareness of her impaired cognition r/t dementia. The IDT reviewed and revised the POC to meet her needs.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 11/06/22, a Fall Risk Evaluation was conducted post fall. The [NAME] II Fall Risk Model documented score was 17 indicating the resident was at high risk for falls. On 11/06/22 at 7:58 a.m., an entry in the progress notes indicated the resident returned to the facility from the Emergency Department. The resident was alert and awake.<br><br>On a 11/12/22 at 4:05 p.m., the resident was found Nonresponsive, no vital signs, no sign of life, apical pulse absent. Resident was a DNR (do not resuscitate) awaiting hospice on Monday.<br><br>The incident reports for falls on 10/21/22, 10/30/22, and 11/06/22 did not address whether all care planned interventions were in place including whether the resident was kept hydrated, whether the resident was wearing the appropriate footwear (gripper socks), etc Although the facility added interventions following each fall, the facility did not conduct a root cause analysis to identify or investigate the reason for the falls.<br><br>Example 2:<br><br>R3 was admitted on [DATE] with readmitted s of 09/09/22 and 11/02/22. The resident's diagnoses included metabolic encephalopathy, chronic obstructive pulmonary disease (COPD), protein-calorie malnutrition, muscle weakness, lack of coordination, muscle wasting and atrophy, chronic kidney disease Stage 4, and dementia.<br><br>On 10/21/22, R3 had a closed left hip fracture.<br><br>R3's MDS dated [DATE] was coded to indicate R3 scored 13 on the BIMS indicating intact cognition; required limited assistance with bed mobility, transfers, walking in room, and personal hygiene; and required extensive assistance with dressing and toilet use. When ambulating, R3 was not steady but he was able to stabilize without staff assistance; when moving from seated-to-standing position and during surface-to-surface transfers, the resident was not steady but he was able to stabilize with assistance. Moving on and off the toilet and turning around did not occur. According to the MDS, R3 had functional limitations in range of motion in one lower extremity and used a walker for mobility. The MDS indicated the resident had falls within the last month and within the last 2-6 months. No MDS was completed following the resident's 11/02/22 re-admission.<br><br>R3's current care plan indicated the resident was at risk for falls r/t weakness. Interventions included the items listed below. All interventions were initiated on 09/09/22 unless otherwise noted.<br><br>Anti-roll backs<br><br>Anticipate and meet the resident's needs<br><br>Ensure bed brakes are locked<br><br>Ensure footwear fit properly<br><br>Ensure that resident's call light is within reach and encourage the resident to use it for assistance as needed.<br><br>Follow facility fall protocol<br><br>(continued on next page) |

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| Medical Suites at Oak Creek (the) | 2700 Honadel Boulevard<br>Oak Creek, WI 53154 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Re-education for assistance (added on 09/17/22)<br><br>Assist resident into wheelchair before all meals (added on 09/19/22)<br><br>No plastic/paper draw sheets to be used in bed (added on 09/19/22)<br><br>PT to evaluate and treat as ordered or PRN (added on 10/10/22)<br><br>Med review (added on 11/13/22)<br><br>Body pillows to L, R (Left, Right) sides while in bed (added on 12/08/22 following inquiry by Surveyor)<br><br>Bed in low position (added on 12/09/22 following inquiry by Surveyor)<br><br>Stop sign in place to remind resident to call for assistance when needing assistant (added on 12/09/22 following inquiry by Surveyor)<br><br>Room change (added on 12/14/22; was related to the resident being positive for COVID-19)<br><br>Scoop mattress (added on 12/13/22 following inquiry by Surveyor)<br><br>The resident's current care plan included a statement dated 09/09/22 indicating the resident had an ADL self-care performance deficit and limited physical mobility r/t weakness. Interventions included:<br><br>09/09/22: Bed mobility assist x1<br><br>09/09/22: Toileting: Resident requires A-1 (assist of one) with toileting<br><br>09/09/22: Uses wheelchair: Self propels wheelchair (Does not use foot pedals, ask resident to lift feet if pushing w/c)<br><br>09/12/22: Ambulation: x1 staff physical assist (use gait belt) and 2 ww (wheeled walker) in room.<br><br>09/12/22: Transfers: Resident requires assist A-1 with 2 ww and gait belt for transfers<br><br>A care plan problem dated 09/12/22 stated, The resident has impaired cognitive function or impaired thought process r/t primary DX (diagnosis): acute toxic encephalopathy, r/t (related to) UTI, dementia, weakness. Interventions included: Ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed. Use task segmentation to support short term memory deficits. Break tasks into one step at a time.<br><br>Fall Risk Evaluations completed on 07/13/22, 07/29/22, 09/09/22, 09/17/22, 09/19/22, 10/08/22, 11/01/22, 11/07/22, 11/08/22, 11/13/22, and 12/13/22 indicated the resident was at high risk for falls.<br><br>R3 had orders for psychotropic medication including Seroquel, an antipsychotic medication, which increased the resident's risk for falls.<br><br>(continued on next page) |

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| | 525730 | A. Building<br>B. Wing | 12/14/2022 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A Behavioral and Psychotropic Medication Evaluation dated 11/16/22 stated, Guest has had a GDR (gradual dose reduction) on ordered Seroquel. Guest is impulsive leading to falls, verbally aggressive to spouse, confusion. Evaluation: Appears controlled.<br><br>Review of Incident Reports provided by AC-C indicated that since October 22 the resident experienced six falls.<br><br>~10/08/22 - R3 fell on [DATE] at 7:31 a.m. The report stated, CNAs observed resident on the floor next to bed with his pillow and blanket sleeping during rounds. R: (Resident) Stated around 0230 (2:30 a.m.) he attempted to get into bed but didn't make it and didn't want to yell for help so he pulled a pillow and blanket on the floor to sleep. Resident stated no pain. Immediate action: Wife and MD updated. DON and weekend manager notified. VSS no visual injuries noted. Neuro checks negative. No c/o pain. NNO (No New Orders). ROM WNL .Other info: Fall safety interventions in place at time of incident. Notes included in the incident report dated 10/17/22 indicated, On [DATE] around 0731 he was observed lying on the floor with his pillow and sheet. Resident stated he fell around 0230 and fell asleep there. Statements show he was not on the floor around that time. All interventions were in place at the time of the incident. The MD and family were made aware of the above incident and in agreement to the current POC with the addition of therapy working on strengthening. The IDT reviewed and revised his POC to meet his needs .<br><br>On 12/15/22, NHA-A provided additional information including a Fall Risk Check List, Fall Scene Investigation Report and Interview/Statement Records related to the fall that occurred on 10/18/22. The Fall Risk Check List indicated an Immediate Intervention was put in place on the care plan. Therapy was to follow up. The Fall Scene Investigation Report stated, (R3) stated he was trying to get into bed. Mental Status: Unknown. Usual mental status: Alert and oriented x3. Re-creation of Last 3 hours before fall: Patient was in bed around 4:30 a.m. to 5:00 a.m. Re-enactment of Falls: Resident self transferred. Fall Huddle: No new changes. Root cause of fall: (symbol for no was entered). Initial root cause: Poor judgement. Initial intervention: Call don't fall sign. Fall Team Meeting Notes: Summary of meeting: No systemic issues. Conclusion: Will have therapy P/U (pick up) for strengthening. An interview statement from the CNA who was responsible for R3's care at the time of the fall indicated the last time he had observed R3 was between 4-5:30 a.m.<br><br>The intervention of therapy evaluation does not immediately reduce the risk of falls or injuries from falls.<br><br>~10/18/22 - An incident report indicated that R3 fell on [DATE] at 2:57 p.m. The report stated, .heard thumping coming from resident's room. noted bathroom door locked, after opening door resident was laying on his back on the floor with his pants at his ankle. Resident statement: Stood up after using the bathroom and pants got stuck under shoe and I slipped. Immediate action: Vitals, neuro check, ROM, skin assessment, md and family updated. No injuries observed at time of incident. Oriented x4. No injuries observed post incident. Situation Factors: transferring independently, ambulating without assistance. Other Info: Fall safety interventions in place at time of incident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 12/15/22 NHA-A provided additional information including a Fall Risk Check List, Fall Scene Investigation Report, and Interview/Statement Records related to the fall that occurred on 10/18/22. The Fall Risk Check List indicated an Immediate Intervention was put in place on the care plan. Anti-roll brakes were added. According to the care plan, this was an intervention put in place in September. The Fall Scene Investigation Report stated, Resident was attempting a self transfer. Mental Status: Alert and Oriented x4. Usual mental status: Wearing shoes and socks. Baseline. Re-creation of Last 3 hours before fall: Resident sitting in wheelchair watching TV drinking water. Call light not on resident didn't need anything. Re-enactment of Falls: Resident self transferred to the bathroom .Root cause of fall: Amount of assistance in effect, footwear. Initial root cause: Self transferring in bathroom. Initial intervention: Anti roll back w/c .Conclusion: Resident took self to the bathroom and when he attempted to get back into w/c it rolled back. Additional care plan/nurse aide assignment updates: Will add anti roll backs. One CNA interview/statement indicated the CNA had last seen R3 in his chair in hallway at 10:30 a.m. Two other staff members interviewed indicated they had not seen the resident that day.<br><br>The facility did not consider the resident's statement (pants got stuck on shoe causing resident to slip) when indicating anti-roll back brakes as an intervention. In addition, anti-roll back brakes were an intervention that was to be in place as of 9/9/22.<br><br>On 12/13/22 at 10:00 a.m., Surveyor interviewed RN-L about the anti-roll back brakes. RN-L could not recall if the anti-roll backs were on R3's wheelchair at the time of the fall. If the anti-roll backs were on the chair at the time of the fall this would not be a new intervention. RN L did not know if R3 had anti-roll backs on his wheelchair currently.<br><br>On 12/7/22 at 10:20 a.m., CNA K was interviewed. She did not know if R3 had anti-roll backs on his wheelchair.<br><br>On 12/13/22 at approx. 2:00 p.m., Surveyor spoke with NHA-A and DON-B. No additional information was received indicating when the anti-roll back brakes were applied.<br><br>Although no injury was apparent at the time of the fall, R3 began to experience an increase in pain beginning on 10/21/22:<br><br>~10/21/22 at 9:41 p.m. - a nurse added the following: Evaluation: Pain (uncontrolled). Outcome of Physical Assessment: Pain Status Evaluation: Does the resident/patient have pain? Yes.<br><br>~10/21/22 at 10:46 p.m. - Daily Skilled Note: .Most recent pain level: 9 on 10/21/22 at 8:53 p.m.<br><br>~10/22/22 at 2:15 a.m. - a nurse added the following: Resident sent to ER via Bell Ambulance at the request of POA and family due to bruising and swelling of the left hip, resident admitted to St. Luke's Medical Center for closed left hip fx. (fracture). The resident remained at the hospital until readmission on 11/02/22.<br><br>Fall documentation continues:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | ~11/07/22 - According to an incident report, R3 had a fall on 11/7/22 at 2:10 a.m. The report stated, Guest was observed lying on the floor next to bed. Call light in reach but not activated. And guest is barefoot . Stated he was trying to get himself up to look for (sic) and rolled onto the floor .VS stable, ROM WNL, denies pain, assisted back to bed, no SKIN alteration noted neuro checks WNL. Pain: 0 Oriented to person and time. Psychological Factors: confused. Situation: improper footwear and none. Call light in reach. Transferring independently. Other Info: Fall safety interventions in place at time of incident. Education/non skid footwear applied. POA called 0222 (2:22 a.m.). Notes dated 11/07/22 and included in the report indicated, Guest found lying on the floor next to bed. Call light within reach but was not sounding. Guest was barefoot at time of fall. Staff checked on guest approximately 10-15 minutes prior to fall and guest was not soiled and stated he did not need anything. Urostomy in place. Nursing assessment completed with no injury noted. ROM WNL .Interventions in place at time of fall. IDT reviewed with new intervention to encourage use of gripper socks Summary: Encourage use of gripper socks .<br><br>On 12/15/22, NHA-A provided additional information including a Fall Risk Check List, Fall Scene Investigation Report, and Interview/Statement Records related to the fall that occurred on 11/07/22. The Fall Risk Check List indicated the Immediate Intervention put in place on the care plan was gripper socks. The Fall Scene Investigation Report indicates the fall was on 11/07/22 at 2:10 a.m. The report read, Fall summary: found on floor .Resident was attempting a self transfer. Mental Status: Alert and Oriented x2. Normal mental status. Footwear: barefoot. Re-creation of Last 3 hours before fall: Guest in bed sleeping. Aide checked on him about 15 minutes prior to fall, guest dry and stated he did not need anything. Re-enactment of Fall: Resident was up looking for significant other .Initial root cause: Self transferring/confusion. Initial intervention: Encourage gripper socks .Conclusion: Resident continues to self transfer. Additional care plan/nurse aide assignment updates: Will encourage gripper socks to help prevent falls. Two CNA interview statements indicated they had last seen R3 laying down watching tv at 2:00 a.m.<br><br>~11/13/22 - R3 had a fall on 11/13/22 at 3:53 p.m. The report stated, Pt was observed on the floor sitting up next to the wheelchair .reports he slipped out of his wheelchair reaching for his shoe under the bed. Immediate Action Assisted patient with gait belt back into his wheelchair after assessment. Skin assessment, ROM, Neuro assessment completed and all baseline. No injuries noted. Oriented to person and place. Physiological: confused. Situation factors: call light in reach and transferring independently. Other information: Fall safety interventions in place at time of incident. Family notified at 1558 (3:58 p.m.). Notes dated 11/14/22 included the following: On 11/13/22 around 1400 (2:00 p.m.) guest was found on the floor next to bed stated he was looking for his shoes. Resident was last seen around 12:30 (p.m.) sitting in his wheelchair watching tv. All interventions were in placed at the time of the incident .The MD and family were made aware of the above incident and in agreement to the current POC with the addition to doing a med review. The med review consists of a GDR of his Seroquel. The IDT reviewed and revised the POC to meet his needs .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 12/15/22 NHA-A provided additional information including a Fall Risk Check List, Fall Scene Investigation Report, and Interview/Statement Records related to the fall that occurred on 11/13/22. The Fall Check Risk Check List indicated the Immediate Intervention that was put in place on the care plan was shoes on. The Fall Scene Investigation Report included: Fall summary: found on floor .Reaching for something - reaching for shoe. Mental Status: Alert and Oriented x2. Mental status: unchanged. Footwear: slippers. Re-creation of Last 3 hours before fall: Prior to fall resident was in wheelchair watching tv. Re-enactment of Falls: Resident has had increased confusion. Fall Huddle: Nothing Different. Root cause of fall: (symbol indicating no was documented). Initial root cause: Resident did not ask for assistance. Initial intervention: Anti roll backs, gripper socks, low bed, see C.P. (care plan).<br><br>Fall Team Meeting Notes .Will do medication review to GDR Seroquel to r/o (rule out) possible increased fall risk from S/E (side effects). Conclusion: Resident continues to self transfer. Additional care plan/nurse aide assignment updates: Med review add for intervention.<br><br>Anti-roll back brakes were to be in place on 9/9/22 per the care plan and were also identified as an intervention following the 10/18/22 fall.<br><br>~12/09/22 - According to an incident report, R3 had a fall on 12/09/22 at 4:27 a.m. The report stated, (R3) was found laying on his back on his left side of his bed. He was wrapped in his bedding. Resident alert, responding clearly. Vitals WNL. No apparent injuries Movement in upper and lower extremities. Continent of bowel. Urine leaking from urostomy bag. Resident states he rolled out of bed while sleeping, denies hitting head or pain. Immediate action: neuro checks completed, Vital signs assessed, transferred resident back to bed with assistance from CNA. No injuries observed at the time of the incident. Mental status: Oriented to person, situation and time. Mobility: Bedridden. Interventions in place at time of fall: low bed.<br><br>On 12/13/22 at 10:00 a.m., DON-B provided the Fall Scene Investigation Report which did not identify if the bed was in the low position. Additional care plan/nurse aide assignments updates were: Low bed and stop sign. The statements from staff do not identify if the bed was in the low position. DON-B indicated this was the completed investigation. No additional information was available.<br><br>On 12/13/22 at 10:00 a.m., DON-B provided the Fall Risk Check List which identified immediate interventions put in place and added to the care plan, the Fall Scene Investigation Report, and Interview/Statement Records related to the fall that occurred on 12/09/22. The Fall Scene Investigation Report incorrectly identified the date of the fall as 11/13/22 at 2:10 p.m. rather than 12/09/22 at 4:27 a.m. The report documented, Fall summary: found on floor unwitnessed .rolling/sliding out of bed. Mental Status: Alert and Oriented. Mental status: Baseline. Footwear: slippers. Re-creation of Last 3 hours before fall: resident was in bed watching tv. Re-enactment of Falls: Patient confused, unable to say what he was trying to do. Root cause of fall: None. Initial root cause: Resident rolled out of bed while sleeping. Initial intervention: proper bed positioning, bed linen straightened out, so resident doesn't tangle and slip out .Summary of meeting: No systemic condition. According to the conclusion: Resident is confused at times, had body pillows in place . Additional care plan/nurse aide assignment updates: Low bed and stop signs.<br><br>On 12/05/22 at approximately 10:00 a.m. during the initial tour, R3's room door was observed closed. A sign on the door indicated Contact/Droplet Precautions were implemented for the resident. A Personal Protective Equipment (PPE) cart was observed outside of the resident's room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R3's door remained closed from 11:20 a.m. to 12:39 on 12/05/22 when CNA-I was observed donning PPE and delivering R3's noon meal tray. CNA-I indicated R3 was eating the meal while in bed. CNA-I stated, (R3) requires assistance with ambulation and transfers. (R3) had quite a few falls while trying to transfer himself. CNA-I said that nursing staff had been instructed to keep all resident room doors closed due to the COVID-19 outbreak and indicated that R3 was checked every 2 hours to see if he needs anything. According to CNA-I, R3 did not use his call light. CNA-I stated, We have not been instructed to check on the residents any more often than every 2 hours.<br><br>R3's room door remained closed from 1:00 p.m. to 4:00 p.m. No staff were observed donning PPE to enter the room.<br><br>On 12/05/22 at 4:02 p.m., CNA-K indicated during interview that she had not provided any care for R3 that day. At 4:05 p.m., CNA-I indicated she had not done anything for R3 since delivering his lunch tray. At 4:10 p. m. CNA-J stated she had not checked on R3 since that morning.<br><br>On 12/06/22 at 8:15 a.m., CNA-J stated she had not been in R3's room that morning and indicated that she had been busy assisting her other assigned residents. At 8:20 a.m. CNA-J donned PPE and delivered R3's breakfast tray. Upon exiting R3's room, CNA-J verified that R3 was eating breakfast in bed that morning. CNA-J said, R3 tries to get up by himself and has had falls. He tries to take himself to the bathroom. The facility does not use any type of alarms.<br><br>On 12/06/22 at 9:35 a.m., RN-L exited R3's room after administering his medication and discarding his breakfast containers. RN-L said that R3 was in bed watching television. From 9:35 a.m. until 12:25 p.m., when CNA-I donned PPE and delivered R3's noon meal tray, no staff was entering or exiting R3's room. CNA-I indicated she helped R3 transfer into his wheelchair for lunch and placed the call light within reach.<br><br>During periodic observations on 12/07/22, R3's room door was closed whenever the Surveyor walked past the resident's room.<br><br>On 12/13/22 at 10:00 a.m., RN-L was interviewed and indicated R3 had a cognitive deficit and was very impulsive. RN-L stated, In the late afternoon he gets really agitated especially when his wife comes in and he sun downs. (R3) requires assistance of one staff, with a gait belt and wheeled walker to transfer and ambulate. After his hip fracture he required assistance of two staff. He tries to transfer himself all the time. I don't think he could remember how to use the call light even if told how to. I don't know if he would read a stop sign instructing him to ring for assistance prior to transferring. He maybe could understand the sign if it was read to him. Not sure how long he would remember it. I don't believe he has ever had a low bed. The facility does not use any type of alarms or floor mats. Nursing staff are instructed to monitor residents every 2 hours and provide toileting and repositioning. Nursing has never been instructed to increase the frequency of checking on (R3). No change in how often to check on him since administration instructed us to keep the room doors closed due to the COVID outbreak. R3 was a high fall risk - when he was on his previous unit and on this unit, he is in a room close to the nurses' station for closer monitoring. I've never been here when he had a fall. I don't ever remember R3 having body pillows, any different type mattress than what all the residents routinely have, a toileting schedule, a wider bed or a stop sign in his room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 12/13/22 at 11:40 a.m., CNA-Q was interviewed. CNA-Q indicated R3 was very confused and was often trying to get out of his bed or wheelchair. He takes himself to the bathroom even though he is not supposed to. We have to keep his room door along with all the other resident's room doors on the unit closed due to the COVID outbreak. I don't ever remember being told to increase the monitoring of R3. He is checked on every 2 hours or when we have time. I don't remember any different type of mattress (scoop or wider), body pillows, low bed, or a stop s [TRUNCATED] |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview, and record review, the facility did not ensure 1 of 2 residents (R27) reviewed for bowel and bladder incontinence received care and assistance to admitted to the facility continent of bowel and bladder, or occasionally incontinent of bladder, received services and assistance to maintain continence<br><br>Upon admission, R27 was continent of bowel and occasionally incontinent of urine. Since admission R27 has increased bowel and bladder incontinence. R27 indicated staff do not respond to the call light and that the urinal is not placed within reach. The facility has not implemented a plan for R27 to improve his bowel and bladder continence or to identify the reasons for the decline in bowel and bladder function.<br><br>Findings include:<br><br>On 12/13/22 beginning at 4:00 p.m. the Surveyor asked DON-B for a policy and procedure for bowel and bladder training; a policy and procedure was not provided.<br><br>R27 was admitted to the facility on [DATE] with diagnoses including cerebral palsy, peripheral vascular disease, and Type 2 diabetes.<br><br>R27's admission MDS dated [DATE] included a BIMS score of 14 suggesting intact cognition. R27 was occasionally incontinent of bladder and was always continent of bowel. According to the MDS, the resident was not on a urinary toileting program.<br><br>R27's care plan contained the following:<br><br>11/25/22 The resident has an ADL self-care performance deficit and limited physical mobility. The interventions include: Toileting: Resident requires physical assistance of 1 with bedpan urinal at bedside with toileting .<br><br>12/01/22 The resident has bladder incontinence r/t (related to) impaired mobility. The interventions included Brief Use: The resident use disposable briefs. Change as needed. Clean peri-area with each incontinence episode. Ensure the resident has unobstructed path to the bathroom.<br><br>R27's Bowel and Bladder Tool/Eval Dated 11/25/22 Admission identified R27 did not have new or worsening bladder incontinence. No further information was provided within this tool.<br><br>Daily Skilled Note[s] dated 11/26/22 and 12/05/22 stated, the resident requires partial/moderate assistance while toileting.<br><br>Review of R27's Task: Bowel Continence record identified R27 was incontinent of stool on 11/30/22 and 12/08/22.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 27's Task: Bladder Incontinence record identified R27 was incontinent of bladder on 11/27/22, 11/30/22, 12/05/22 and 12/08/22.<br><br>On 12/06/22 at 12:01 p.m. CNA-K (Certified Nursing Assistant) exited R27's room and informed the Surveyor that R27 would be unavailable until the CNA was finished assisting the resident with incontinence care stating, He (R27) was incontinent of bowel.<br><br>On 12/06/22 at 1:00 p.m. R27 stated, Yes, I was incontinent of BM this morning. Never was incontinent of BM until I came here. They don't answer my call light so I end up having accidents. I don't like being incontinent but what am I going to do? That is the way it is around this place. I'm incontinent of urine more now since I came here. I can't even reach the urinal. Surveyor noted that they urinal was on the bedside stand and out of R27's reach. R27 continued, I can't use it if I can't reach it. This happens more often than I like. Never seems to be any staff around when you need them.<br><br>On 12/07/22 at 1:30 p.m. CNA-I stated, We check on all the residents every 2 hours. R27 is usually incontinent of urine and sometimes of bowel. He uses a bedpan, transfers with using a Hoyer lift and assist or 2 CNAs. His urinal and call light should be in reach.<br><br>On 12/13/22 at 4:00 p.m. DON-B stated she did not have a list of residents on a bowel and bladder program, and no one was responsible for a bowel and bladder program. DON-B stated the unit managers on each unit review the residents and will put a program in place to prompt the resident with toileting. DON-B informed Surveyor the nurses document the bowel and bladder assessments in the residents' progress notes. Surveyor requested a copy of the bowel and bladder training program, the program was not provided to the Surveyor. No list of residents who were on a bowel and bladder program was provided. Of all the record reviews completed there were no resident MDSs that identified the resident was on a program, and no reviewed care plans identified a bowel and bladder program. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview and record review the facility did not ensure 2 of 2 residents (R17 and R10) reviewed for weight loss maintained acceptable parameters of nutritional status, such as usual body weight.<br><br>R17 was to have weight monitored per physician order daily for 3 days, once a week for 3 weeks, and then once a month thereafter. R17 was weighed on 10/24/22 and 11/1/22. When R17's weight was obtained on 12/6/22 after inquiry from Surveyor, it was found R17 had a 15.4 pound weight loss in 1 month. R17 did not consistently receive a supplement with all meals, and did not consistently receive a snack. Amount of supplement and snacks consumed were not documented.<br><br>R10 had an over 100 weight gain in 3 days. This was significant weight change was not identified and a reweigh was not completed.<br><br>Findings include:<br><br>On 12/05/22 at 1:45 p.m., ADON-C (Assistant Director of Nursing) provided a facility policy and procedure for managing weights that was last revised November 2018 that stated:<br><br>All residents will be weighed on admission, readmission, weekly for the first 4 weeks and then at least monthly. Weekly weights will also be done with a significant change of condition, food intake decline that has persisted for more than one week, or with a physician order .All weights, upon completion, will be given to the DON or designee to determine a list of reweighs. Once the reweighs have occurred any resident with an unexplained significant to insidious weight loss will have a weight loss investigation completed. Dietary recommendations will be forwarded to the physician or NP by the DON or designee.<br><br>Example 1:<br><br>R17 was admitted on [DATE] with multiple medical conditions including Parkinson's Disease, encephalopathy, tremors, diabetes, and failure to thrive.<br><br>R17's admission MDS completed on 10/24/22 indicated the resident scored 9 on the BIMS suggesting the resident had moderately impaired cognition. The resident had clear speech and was usually understood by others, and required limited assistance for eating. R17's admission weight was 148 pounds at 5 feet 4 inches and the resident had no problems with eating and was on a mechanical soft diet.<br><br>A lab result dated 10/20/22 indicated R17 had an albumin of 3.4 grams per deciliter (gm/dL); normal range is from 3.4 to 4.8 gm/dL.<br><br>R17 had an order dated 11/04/22 for Magic Cup Dessert with meals for Nutritional Supplementation 1 cup with meals TID (three times a day) . which was to be provided by dietary).<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 12/06/22 at approximately 9:00 a.m. R17 was observed sitting in her wheelchair in the common area where the TV was located with a meal tray in front of her. The resident was not eating her breakfast and no Magic Cup nutritional supplement was on the tray. LPN-V (Licensed Practical Nurse) was asked if the resident received a supplement. LPN-V stated, Yes, she gets a Magic Cup. LPN-V was asked if the Magic Cup was provided by nursing. LPN-V said, No, dietary brings that up from the kitchen.<br><br>On 12/06/22 during the noon meal, R17 was observed refusing to eat. The staff offered R17 several options which she refused. There was no Magic Cup or other supplement on the tray or offered to the resident.<br><br>Review of documented weights indicated the resident was weighed on admission and then on 11/01/22 and weighed 148 pounds. A current weight could not be located in the record. On 12/06/22 at 10:00 a.m. the Surveyor asked ADON-C about R17's current weight. The resident was weighed on 12/06/22 at 2:32 p.m. following inquiry by Surveyor and weighed 132.6 pounds, a 15.4-pound or 10.4% weight loss in 1 month.<br><br>There was no documentation found to support the resident was weighed according to provider orders: One time only for 1 Day AND one time a day for 3 Days AND one time a day every 7 day(s) for 3 Weeks AND one time a day starting on the 1st and ending on the 5th every month.<br><br>R17's meal intake was to be documented by staff. Review of meal intake records indicated the resident's intake was not consistently documented. Meal intake was only recorded on 13 days and did not include meal intake for all three meals.<br><br>R17 had an order for a bedtime snack dated 10/24/22; documentation indicated the snacks were provided on 14 days of the past 30 days that included: 11/13/22, 11/15/22, 11/19/22, 11/20/22, 11/24/22, 11/26/22, 11/27/22, 11/28/22 to 12/01/22, 12/05/22, 12/09/22, and 12/10/22. The type of snack was not documented and there was no information that indicated the amount of the snack consumed by R17. There was also no documentation in the medical record was found to indicate if R17 had consumed the Magic Cup supplement that is to be provided at each meal.<br><br>On 12/07/2022 at 8:52 a.m. R17 was refusing breakfast. A supplement drink was on the resident's tray. A Dietary Note dated 12/07/22 at 1:08 p.m. stated, Weight 12/06/22 132.4 lbs (pounds) weight is down 15.6 lbs. x 2 months (10.5%) . Surveyor was told the weight change was 15.4 pounds as calculated above. Doetary note continues, .Guest declines meals at times, declining Magic cup supplement. Nutrition Diagnosis: Significant weight loss related to inadequate oral intake intervention: Boost supplement trialed with guest, states she would drink supplement RD (Registered Dietitian) recommendation. Intervention: House supplement/Boost/Ensure 1 carton/bottle po TID for nutrition supplement .Discontinue Magic cup TID. Staff continues to monitor and encourage intake. Monitoring and Evaluation: Weight: maintain at 132 lbs. +/- 3%. Intake: >50% meals. 100% supplement. Labs: monitored per MD/NP.<br><br>Example 2:<br><br>R10 was admitted to the facility on [DATE] MDS completed on 11/24/22 was coded to indicate the R10 scored 11 on the BIMS suggesting moderately impaired cognition, required limited assistance with eating, and weighed 215 pounds.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The care plan initiated on 08/19/22 indicated R10 had the potential for nutritional deficit related to heart disease, diabetes, and obesity. The goal was to maintain adequate nutritional status as evidenced by maintaining weight without any unplanned significant changes. The interventions included:<br><br>Allow resident sufficient time to eat. Date Initiated: 08/19/2022<br><br>Diabetic diet as ordered. Date Initiated: 08/19/2022<br><br>Evaluate any weight changes. Determine percentage changed and follow facility protocol for weight change. Date Initiated: 08/25/2022<br><br>Obtain and document weights per MD orders and facility protocol. Date Initiated: 08/19/2022<br><br>Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 08/25/2022 Nursing<br><br>Provide LCS [low concentrated sweets], REGULAR/THIN diet as ordered. Monitor intake and record every meal. Date Initiated: 08/25/2022<br><br>RD to evaluate and make diet change recommendations PRN. Date Initiated: 08/19/2022<br><br>The resident's Kardex (undated) included direction to staff related to the resident's eating/nutrition as follows: Diabetic diet as ordered. Provide LCS, Regular/Thin diet as ordered. Monitor intake and record every meal.<br><br>R10 had a physician's order dated that read, Weights - one time only for 1 Day AND one time a day for 3 Days AND one time a day every 7 day(s) for 3 weeks AND one time a day starting on the 1st and ending on the 5th every month.<br><br>A comprehensive nutrition assessment dated [DATE] and completed by a Registered Dietitian stated, Assessment: Guest .RD recommendations: 1. Change diet to LCS, regular/thin. Intake adequate to meet estimated nutritional needs. Staff continues to monitor and encourage intake. Offer alternates as appropriate. Weight: fluctuation anticipated with diuretic therapy intake: 75% meals. Labs: monitored per MD/NP orders. There were no subsequent nutrition notes.<br><br>The resident's weight record indicated the resident weighed the following in pounds:<br><br>11/05/22 - 225.0 (standing)<br><br>11/29/22 - 218.6 (standing)<br><br>12/02/22 - 332 pounds (standing); A weight gain of 113.4 pounds. The resident was not reweighed on this date.<br><br>Although the record documented other weight fluctuations, the 113.4 pound recorded weight gain was not identified or addressed.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R10 was interviewed on 12/06/22 at 12:15 p.m. while eating the noon meal. The resident denied having problems with care and services and stated the food quality was Alright. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview, and record review the facility did not ensure 1 of 1 resident reviewed for respiratory services received recommended treatments.<br><br>R15 has disagnoses of Chronic Obsructive Pulmonary Diease, and Congestive Heart Failure. R15's care plan includes an intervention for sustained deep breaths and order from Respiratory Therapy to do deep breathing exercies, 10 repetitions 4 times a day. There is no evidence R15 completed the exercises and no evidence that staff were instructing or monitoring R15 for completion. There was no monitoring of her blood oxygen levels. R15 was diagnosed with bronchitis, and complained of chest congestion that she could not clear.<br><br>Evidence includes:<br><br>R15 was admitted on [DATE] with diagnoses that included CHF and COPD.<br><br>The resident was legally blind. The comprehensive MDS 07/08/22 and quarterly MDS dated [DATE] were coded to indicate the resident scored 15 on the BIMS and had intact cognition. Both assessments indicated the resident experienced shortness of breath when lying flat.<br><br>The care plan dated 06/10/22 indicated: The resident has altered respiratory status/difficulty breathing r/t COPD, CHF. Interventions dated 06/10/22 included in part, Encourage sustained deep breaths by: Using demonstration (emphasizing slow inhalation, holding end inspiration for a few seconds, and passive exhalation); Using incentive spirometer (place close for convenient resident use); Asking resident to yawn<br><br>R15's current provider orders included in part, Respiratory therapy evaluation and treatment if indicated.<br><br>RT Porgress Note from 6/13/22 states, Resident is Tolerating room air well. Breathing exercises done with resident 10x (times). Encouraged to do them QID (four time a day) for 10x. Take weights and vitals daily . R15 was seen by RT an addition 4 times through June and July 2022.<br><br>On 11/10/22 at 9:09 a.m. an eINTERACT SBAR Summary for Providers was documented and stated, The Change In Condition/s reported on this CIC Evaluation are/were: Functional decline (worsening function and/or mobility).<br><br>A nurse practitioner note dated 11/11/22 read, Pneumonia-stable on Levaquin (antibiotic), incentive spirometry encouraged.<br><br>Medical Doctor/Nurse Practitioner noted dated 11/25/22 stated: f/u (follow/up) for pneumonia, hyperkalemia, CHF, atrial fibrillation .Patient is stable in no acute distress. Patient continues to decline in condition, patient reports little to no appetite, and congestion and cough .lung sounds diminished, lung sounds coarse throughout .pneumonia-stable on Levaquin, incentive spirometry encouraged, neb tx (nebulizer treatment) CHF-stable monitor weights, on lasix, referral to hospice.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor spoke with R15 on 12/7/22 at 9:30 a.m. During this interview, R15 stated that she had chest congestion and can't seem to expectorate wishing she could bring it up. Surveyor heard R15's congestion when she coughed.<br><br>On 12/9/22 at 9:56 a.m., Surveyor informed the AC-AA (Assistant Chief) that R15 indicated she had chest congestion that she can't seem to expectorate and wished she could bring it up. Surveyor also communicated that congestion was audible to the Surveyor when the resident coughed. Surveyor asked if RT had been consulted. AC-AA stated the nurse practiotioner had diagnosed R15 with bronchitis a week or week and a half ago and the resident was started on an antibiotic. AC-AA indicated there is a standing order for all residents. AC-AA stated RT was at the facility yesterday. Surveyor asked AC-AA if there was a note as the last RT note in R15's record was from July 2022. AC-AA stated, RT is a contracted service and RT is supposed to document when they come in for visits.<br><br>A review of the Vital Signs section of the electronic health record showed the last oxygen saturation level (pulse oximetry) was performed on 11/24/22 and was 96%. Following Surveyor inquiry and staff interview about the resident's chest congestion, the resident's oxygen saturation level was obtained on 12/08/22 with pulse oximetry and was 95%.<br><br>An RT progress note from 12/8/22 was entered on 12/9/22 and stated, 94% on room air. HR (heart rate) 82, RR (respiratory rate) 19. Slightly coarse bilaterally. Breathing exercises done with resident. Demonstrated understanding. Continue breathing exercises qid for 10 reps each .<br><br>On 12/14/22 at 9:14 a.m., Surveyor asked R15 about breathing exercises Respiratory Therapy did with her. R15 stated, I'm not sure what exercises you mean. Maybe they will send the nurse to help me. I have not done that (breathing exercises). I still have congestion once in a while.<br><br>During the exit conference on 12/14/22 at 4:00 pm., DON-B indicated that R15 performed breathing exercises independently. DON-B was informed that R15 was not aware of what the breathing exercised were. Surveyor asked how staff were monitoring and ensuring R15 was completing the breathing exercises correctly, with the correct number of repetitions, 4 times a day. DON-B indicated the breathing exercises will be added to the medication administration recrod. NHA-A (Nursing Home Administrator) indicated the breathing exercises would be placed on the treatment administration record. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation, interview and record review, the facility did not ensure 1 of 4 residents (R22) reviewed for pain.<br><br>R22 has a number of diagnoses that are reasonably likely to cause pain. R22's pain assessment identified R22's pain had gone from occasional to severe and constant. Review of the medication records found R22 received as needed pain medication in November and December 2022. Staff indicated R22 no longer gets out of bed, but did not know why. The facility did not comprehensively assess R22's pain management regime to determine if the current as needed pain medication regime was effective in managing R22's pain.<br><br>Findings include:<br><br>The facility's policy titled, Pain Management, dated 10/2022 stated, It is the responsibility of all clinical staff to assess and periodically reassess the resident for pain and relief from pain. The resident will have routine reassessments performed per policy weekly. Should reassessment activities identify presence of pain as a new condition for the resident the comprehensive initial pain assessment form will be completed at that time .<br><br>R22 was admitted to the facility on [DATE] with diagnoses including injury at the C5 (cervical 5) level of the cervical spinal, paraplegia, fusion of spine - cervical region, spastic quadriplegia, arthrodesis, protein calorie malnutrition, spinal stenosis of cervical region, and clinical depression.<br><br>R22's admission Minimum Data Set (MDS) dated [DATE] was coded to indicate scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition and did not experience behavioral symptoms or refusal of care. R22's pain assessment in the 08/18/22 MDS indicated R22 received PRN (as needed) pain medication, or was offered and declined, for occasional pain rated a 3 (on a scale of 0 to 10, with 10 being the worst pain possible).<br><br>R22's MDS dated [DATE] also included a pain assessment indicating R22 received PRN pain medication, or was offered and declined, for almost constant, severe pain. The pain made it hard for the resident to sleep at night.<br><br>R22's care plan initiated on 08/14/22 has a problem area of potential for pain. Interventions initiated on 08/14/22 included: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.<br><br>Additional approaches were initiated on 09/02/22, Identify and record previous pain history and management of that pain and impact on function, Identify previous response to analgesia including pain relief, side effects and impact on function, and Monitor/document for probable cause of each pain episode. Remove/limit causes where possible.<br><br>R22's provider orders for pain management included:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ~08/12/22: Oxycodone HCL Tablet 10mg. (milligrams) Give 1 tablet every 4 hours as needed for pain<br><br>~08/12/22: Oxycodone HCL Tablet 10mg. Give 0.5 tablet by mouth (For pain)<br><br>~08/12/22: Acetaminophen Tablet 325mg. Give 2 tablets by mouth every 6 hours as needed for pain or elevated temperature. Do not exceed 3 grams of Tylenol in 24 hours.<br><br>~08/13/22: Pain - Evaluate pain every shift for pain evaluation<br><br>~10/24/22: Icy Hot Patch - Menthol Apply to bilateral shoulders<br><br>~12/06/22: Referral to pain management for spastic quadriplegia, arthrodesis, chronic pain<br><br>~Tizanidine HCL Tablet 2mg Give one tablet by mouth every 8 hours as needed for muscle spasms.<br><br>R22's pain assessment in the 08/18/22 MDS indicated R22 received PRN (as needed) pain medication, or was offered and declined, for occasional pain rated a 3 (on a scale of 0 to 10, with 10 being the worst pain possible).<br><br>R22's pain assessment in the 10/03/22 MDS indicated R2 received PRN pain medication, or was offered and declined, for almost constant, severe pain. The pain made it hard for the resident to sleep at night<br><br>R22's Pain Evaluations were:<br><br>~08/12/22 - Admission: Pain score: 0 out of 10. Acceptable level of pain: 2 out of 10.<br><br>~09/20/22 - Other: Pain score: 2 out of 10. Location: neck. Pain does not radiate. Characteristic of current pain: constant. Description: Dull. Acceptable level of pain 2 out of 10. Manner of expressing pain: restlessness, facial expressions, moaning. Onset of pain: recent-within the last 3 months. Type/frequency of pain: occasionally. The intensity/change in description has not changed in the past 7 days. Worst pain in the past 24 hours: 9. Current pain medication regime: narcotics. Frequency: prn. Additional comments: Resident denies any pain or discomfort, states he does not have much feeling d/t (due to) paraplegia. Current pain regime is effective. Goal is met and PRN's are effective at this time. NP (Nurse Practitioner) aware of current pain ratings.<br><br>~12/08/22 - Other: Pain score 0 out of 10. The intensity/change in description has not changed in the past 7 days. Worst pain in the last 24 hours was 0. Frequency type(s) for medication administration: PRN.<br><br>A Health Status Note dated 08/18/22 and written by a Registered Nurse stated, Met with family regarding pain control and 1:1 feeding. Scribing RN placed orders for TID (three times a day) scheduled pain assessments on the MAR (medication administration record) This was in response to concerns with pain control.<br><br>Nursing progress documented from 11/01/22 through 11/25/22 indicated the resident's pain intensity level was 0 except on 11/09/22 at 10:22 p.m. when the resident rated his pain intensity as 5.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | There were no pain scores entered in the progress notes from 11/26/22 to 12/06/22. On 12/06/22 an order was placed for a pain management consult.<br><br>R22's progress notes, evaluation notes, or physician/nurse practitioner notes did not contain documentation as to why a referral to pain management for spastic quadriplegia, arthrodesis and chronic pain was obtained.<br><br>Provider notes from 10/27/22 through 11/16/22 indicated, Spondylosis without myelopathy or radiculopathy, cervical - pain controlled.<br><br>A nurse practitioner noted dated 12/06/22 read, Patient is stable in no acute distress. Assessment/Plan: 8. Spastic quadriplegia stable on muscle relaxers (Tizanidine HCL).<br><br>Review of the November 2022 MAR indicated R22 received:<br><br>~PRN acetaminophen once on 11/01/22, 11/02/22, 11/05/22, 11/06/22, 11/08/22, 11/09/22, 11/10/22, 11/11/22, 11/14/22, 11/15/22, 11/16/22, 11/17/22, 11/19/22, 11/20/22, 11/21/22, 11/22/22, 11/24/22, 11/25/22, 11/26/22, 11/28/22, 11/29/22, and 11/30/22, (a total of 22 times) and twice on 11/03/22<br><br>PRN oxycodone HCL once on 11/02/22, 11/03/22, 11/0522, 11/06/22, 11/09/22, 11/10/22, 11/11/22, 11/12/22, 11/14/22, 11/15/22, 11/16/22, 11/17/22, 11/18/22, 11/19/22, 11/25/22, 11/26/22, 11/27/22, and 11/29/22, (a total of 18 times) and twice on 11/08/22, 11/13/22, 11/19/22, 11/20/22, 11/21/22, and 11/30/22 (a total of 6 times); and<br><br>PRN tizanidine HCL once on 11/01/22, 11/02/22, 11/05/22, 11/14/22, 11/15/22, 11/19/22, 11/22/22, 11/23/22, 11/25/22, 11/27/22 and 11/30/22 (a total of 11 times) and twice on 11/08/22, and 11/13/22.<br><br>Review of the December 2022 MAR from 12/01/22 through 12/13/22 indicated R22 received:<br><br>PRN acetaminophen on 12/01/22 at 8:59 p.m. for a pain level of 5, 12/04/22 at 11:04 a.m. for a pain level of 5, 12/05/22 at 9:57 p.m. for a pain level of 4, and on 12/06/22 at 9:53 a.m. for a pain level of 5 and at 9:44 p. m. for a pain level of 4.<br><br>PRN oxycodone HCL on 12/02/22 at 9:48 a.m. for a pain level of 3, 12/04/22 at 11:07 a.m. for a pain level of 5, and 12/05/22 at 9:57 p.m. for a pain level of 5. The medication was administered twice on: 12/01/22 at 9:09 a.m. for a pain level of 7 and at 9:00 pm for a pain level of 5 and on 12/06/22 at 9:53 a.m. for a pain level of 5 and at 9:44 p.m. for a pain level of 4.<br><br>PRN tizanidine HCL on 12/02/22 at 9:08 a.m., 12/04/22 at 11:04 a.m., 12/05/22 at 9:58 p.m., and 12/06/22 at 9:54 a.m.<br><br>Icy Hot Patch on 12/01/22 at 9:00 p.m., 12/05/22 at 9:57 p.m. and 12/06/22 at 9:43 p.m.<br><br>(continued on next page) |

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|---|---|---|---|
| | 525730 | A. Building<br>B. Wing | 12/14/2022 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/06/22 at 11:00 a.m., R22 was interviewed and indicated he was currently having pain that he rated 9 out of 10. R22 said, Sometimes the nurses ask me about my pain but a lot of the time they don't. I have to ask when I want something for pain. The pain medication helps but when it wears off the pain comes back. I have never had a pain consult that I know of. Don't remember ever being asked if I wanted one. I started using a patch (Icy Hot patch) for my shoulders about a month ago. It helps but I have to ask for it. I don't think I am on any scheduled pain medications. When I was standing with the sit-to-stand lift to get into my chair I had to hold onto the bars and sometimes it really hurt (the resident's shoulders). I don't get up anymore so I don't know if it would still hurt. I don't know why they ordered a pain consult (on 12/06/22) - never asked me about it. I think it is a good idea.<br><br>On 12/06/22 at 1:49 p.m., LPN-M (Licensed Practical Nurse) was interviewed about R22's pain. LPN-M indicated that R22 frequently asks for his PRN medications for pain and spasms. LPN-M said that when she goes into his room, R22 will tell her if he needs pain medication and stated, Often the pain is in his shoulders. He is supposed to be repositioned with pillows every 2 hours. He stays in bed and doesn't get up. LPN-M indicated that she did not know why R22 did not receive scheduled pain medication rather than PRN. LPN-M confirmed that R2 was not on any scheduled pain medication.<br><br>On 12/06/22 at 2:50 p.m., CNA-J (Certified Nursing Assistant) was interviewed. CNA-J said that R22 complains of pain with repositioning at times and when he complains of pain she informs the nurse.<br><br>On 12/07/22 at 11:46 a.m., R22 was interviewed and indicated he woke up during the night with a lot of pain in his shoulders. R22 said, I was stiff. I usually have pain in my shoulders. I have spasms that I receive medication for. I ask for that medication when I need it. The resident did not specify the pain medication he was referring to.<br><br>On 12/13/22 at 10:00 a.m., RN-L (Registered Nurse) was interviewed about R22's pain management. RN-L did not know why a referral was made to pain management or why R22 did not receive scheduled pain medication rather than PRN. RN-L said, He is alert and oriented times 4, is reliable in what he tells you and can definitely let us know when he is having pain and rate it. He also has spasms that he has medication for when he needs it. The nursing staff work 12 hour shifts so we monitor his pain every shift.<br><br>On 12/13/22 at approximately 1:00 p.m., NHA-A (Nursing Home Administrator) and DON-B (Director of Nursing) were interviewed regarding R22's pain management. DON-B stated she did not know the referral was made to pain management on 12/06/22. DON-B said, When staff move his legs he complains of pain. He is pretty vocal and lets the nurses know if he is having pain. He is able to ask for pain medication when he needs something. I don't know why he is not on scheduled pain medication. He receives as needed gels and patches for pain which he uses quite frequently. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation and record review, the facility did not ensure that 2 of 2 residents (R17 and R18) reviewed for behavioral health.<br><br>R17 demonstrated a series of behaviors that appeared to be triggered by R18 and/or their actions. The facility did not document R17's behaviors and did not identify the pattern of R17's behaviors.<br><br>R18 had care plan in place related to behaviors. Staff were not provided with direction on how to approach R18 when behaviors were observed. In addition, staff did not decrease stimulation when the behaviors were noted.<br><br>Findings include:<br><br>Example 1:<br><br>R17 was admitted on [DATE] with multiple medical conditions including Bipolar 1 and Schizophrenia, Parkinson's Disease, encephalopathy, tremors, diabetes, and failure to thrive.<br><br>R17's admission MDS completed on 10/24/22 indicated the resident scored 9 on the BIMS suggesting the resident had moderately impaired cognition, risk for depression, had clear speech and was usually understood by others. R17 was dependent on staff for all activities of daily living.<br><br>R17's care plan initiated 10/18/22 indicated the resident had behavioral symptoms related to dementia, bipolar 1 disorder, and schizophrenia. Interventions included in part, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 10/18/2022<br><br>R17's care plan also indicated the resident had a psychosocial wellbeing problem (potential) r/t (related to) recent hospitalization . Date Initiated: 10/18/2022. Interventions included in part:<br><br>Encourage participation from resident who depends on others to make own decisions. Date Initiated: 10/18/2022<br><br>Increase communication between resident/family/caregivers about care and living environment: Explain all procedures and Treatments, Medications, Results of labs/tests , Condition , All changes, Rules, Options. Date Initiated: 10/18/2022<br><br>Provide opportunities for the resident and family to participate in care. Date Initiated: 10/18/2022<br><br>When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. Date Initiated: 10/18/2022<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A third focus area in R17's care plan addressed depression and stated, Resident/guest has depressive symptoms as evidenced by PHQ-9 interview. Date Initiated: 10/19/2022. Interventions included, Encourage resident/guest to express feelings. Date Initiated: 10/19/2022<br><br>R17 had the following provider orders:<br><br>~10/18/22: Hydroxyzine HCL 25 mg one two times a day for anxiety.<br><br>~10/18/22: psychologist or psychiatrist consult as needed<br><br>~10/19/22: staff to monitor the resident for targeted behaviors that included pacing, irritability, and sadness. Interventions to be documented included: 1=Redirect, 2=Remove from Environment, 3=See Notes, 4=PRN [as needed medication] Given. Staff were to document the effectiveness of interventions as follows: Outcome: 1=Effective, 2=Not Effective Monitor resident for s/s [signs or symptoms] of medication side effects and notify physician if noted. Every shift for Anxiety, Depression. Document corresponding numbers for #episode, Interventions, and Outcome .<br><br>~11/22/22: QUETIAPINE Fumarate [an antipsychotic medication] one tablet (25 mg) by mouth at bedtime.<br><br>According to the resident's treatment record and progress notes, the resident had no documented behavioral symptoms in December 2022.<br><br>On 12/05/22 at 9:37 a.m., R17 was observed sitting in the common area where the TV was located with an overbed table in front of her. The resident had a throw blanket around her shoulders and the resident was quiet. R17 had a water bottle sitting in front of her and within reach.<br><br>On 12/06/22 at 8:52 a.m. R17 was observed sitting in front of a large TV with an overbed table in front of her. Breakfast was being served and the resident was asking staff to provide her with more water. The resident appeared agitated with increased movements and verbalization until staff responded at 9:30 a.m. and provided the resident with a beverage. These behavioral symptoms were not documented.<br><br>On 12/06/22 during the noon meal at 12:20 p.m., R17 was in the dining hall. During this time R18 was playing a radio with country music at a loud volume. Staff walked by and told R18 to turn the radio down on several occasions because they could not hear if call lights were on or if residents were calling for help. R18 turned the volume down until the staff member left the area and then turned it back up. When the volume was turned up R17 would cry out and moan and yelled, He's a pain in the [expletive]. These behavioral symptoms were not documented and no approaches were implemented to address R17's behavioral symptoms that were triggered by interactions with R18.<br><br>On 12/07/22 at 10:36 a.m., R17 was sitting in her wheelchair in the common area where the TV was located with an overbed table in front of her. R17 was crying out and yelling and there was an increase in arm movements and legs. R17 was sitting in front of the TV and R18 was self-propelling his wheelchair towards R17. R17 yelled at R18 to Get out. Then said, I'm afraid he's going to hurt me. He's crazy. These behavioral symptoms were not documented, and no approaches were implemented to address R17's behavioral symptoms that were triggered by interactions with R18.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/08/22 at 12:56 p.m., R17 was in the TV area eating. R18 was pushed by a staff member past R17 and R17 yelled out, No, no you can't do that. Staff did not respond. These behavioral symptoms were not documented, and no approaches were implemented to address R17's behavioral symptoms that were triggered by interactions with R18.<br><br>A Psychiatric Assessment was documented on 12/08/22 that stated, R17 noted to be distressed. Writer approached and attempted to redirect however, unable to and staff came to assist. Appetite is noted to be good per patient with current weight 132 pounds which is a 16 pound weight loss since 10/12/22. Sleep pattern stable per Resident per documentation. Discussed with staff at behavioral meeting. Resident recently moved to the unit. They report that she was doing well on previous unit with no behaviors or mood concerns. Staff are hoping that behaviors and mood will improve as Resident adjusts to the new unit. Would not recommend any medication changes at this time. Will plan to follow up in one month to reassess. Staff encouraged to monitor mood and behaviors and notify .with any concerns. Recommendations: No medication changes at this time. Maintain individualized plan of care, encourage activities of interest and social interactions. Please contact me with psychosis, mood or behavioral concerns. Plan of care discussed with staff.<br><br>On 12/09/22 at 8:33 a.m. was taken to her room by staff and returned to the TV area. R18 was in the hall near his room across from the TV area. R17 said, I don't like him. I want another wing someplace - I need a doctor. These behavioral symptoms were not documented and no approaches were implemented to address R17's behavioral symptoms that were triggered by interactions with R18.<br><br>Example 2:<br><br>R18 was admitted to the facility on [DATE] with diagnoses which included mental health disorder.<br><br>The most recent completed Minimum Data Set (MDS) dated [DATE] included a BIMS of 11 indicating moderate cognitive impairment. The MDS indicated R18 exhibited verbal behaviors toward others four of six days in a seven-day period. The resident was assessed to be non-ambulatory and used a wheelchair for mobility. R18 was dependent on staff for extensive to total assistance with all activities of daily living except for eating.<br><br>R18's care plan did not address him playing his music in the dining hall at a loud volume with approaches or interventions to ensure other residents were not disturbed. The care plan addressed other behaviors: sexually inappropriate and yelling out at times. Date Initiated: 08/11/2022. Interventions included:<br><br>Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 08/11/2022<br><br>Anticipate and meet the resident's needs. Date Initiated: 08/11/2022<br><br>Assist the resident to develop more appropriate methods of coping and interacting listening to music. Encourage the resident to express feelings appropriately. Date Initiated: 08/11/2022<br><br>If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Date Initiated: 08/11/2022<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide a calm and safe environment to allow resident to express feelings as needed Date Initiated: 08/11/2022<br><br>Provide resident with area for decreased stimulation as needed for negative behaviors. Date Initiated: 08/11/2022<br><br>Psychiatric/Psychogeriatric consult as indicated. Date Initiated: 08/11/2022<br><br>The resident Kardex included a direction to staff to report any changes in mental status caused by situational stressor. Notify the MD if and changes in mood, behavior and/or psychosocial status is observed. It also included direction related to Mood and Behavior which directed staff to Observe and report any changes in mental status caused by situational stressor. Notify the MD if and changes in mood, behavior and or psychosocial status is observed.<br><br>Neither the care plan nor Kardex included directions to staff on how to approach R18 when he was playing loud music in the dining hall that disturbed other residents.<br><br>R18 had psychotropic medication order that included:<br><br>~Divalproex Sodium Tablet Delayed Release 500mg Give 2 tablets by mouth two times a day for schizophrenia 12/12/2022<br><br>~Fluphenazine HCL Tablet 10 mg Give 1 tablet by mouth two times a day for schizophrenia 10/28/2022<br><br>~Abilify Tablet 20 mg Give 1 tablet by mouth one time a day for schizophrenia 10/29/2022<br><br>~Benztropine Mesylate Tablet 0.5 mg Give 1 tablet by mouth two times a day for AIMS (movement disorder).<br><br>On 12/06/22 R18 was observed in the dining hall playing a radio with country music at a loud volume. Staff walked by and told R18 to turn the radio down on several occasions because they could not hear if call lights were on or if residents were calling for help. R18 turned the volume down until the staff member left the area and then turned it back up. When the volume was turned up R17 would cry out and moan and yelled, He's a pain in the [expletive].<br><br>Although one of the interventions was to provide the resident with an area to decrease stimulation as needed for negative behaviors, the facility did not identify playing music at elevated volumes as a problem area and did not use this intervention for playing music at elevated volumes. There were no directions to staff on how to approach R18 when he was playing loud music in the dining hall that disturbed other residents. |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>03397<br><br>Based on interview and record review, the facility did not obtain ordered lab services for 1 of 46 sampled residents (R15)<br><br>R15 was to have labs drawn every Thursday. There is no evidence that the ordered labs were drawn 7 out of 10 weeks since 10/1/22.<br><br>Findings include:<br><br>R15 was admitted to the facility from an acute care hospital on 06/09/22 with diagnoses including orthostatic hypotension, failure to thrive, dehydration, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and protein calorie malnutrition.<br><br>R15's provider orders included an order for lab work dated 06/09/22: CBC (complete blood count), BMP (basic metabolic panel) .Phos [sic] order one time a day every Thu (Thursday) for labs<br><br>Review of Medication Administration Records (MARs) from 10/01/22 through 12/09/22 showed the labs were not obtained on 10/06/22, 10/13/22, 10/20/22, 10/27/22, 11/17/22, 11/24/22, and 12/08/22 as ordered.<br><br>On 12/09/22 at 9:56 a.m., AC-AA (Assistant Chief) stated, If resident is on the PAN (post-acute network) program; labs are usually ordered per provider request. Their standing order is weekly. AC-AA confirmed that the labs were not obtained as ordered and staff did not contact the provider for further clarification regarding the frequency the lab tests should be obtained. |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>03397<br><br>Based on observations, interviews, and record reviews, the facility was not administered in a manner that allowed all residents to reach their highest level of well-being.<br><br>The administration inaction led to the issuance of 14 other deficiencies of which facility management should have been aware. Review of facility history for the past year indicates of the 14 deficiencies issued 9 citations have previously been cited for regulatory noncompliance.<br><br>This deficient practice has the potential to affect all 105 residents in the facility at the time of the survey.<br><br>Findings include:<br><br>During this past year, the facility has had 7 different surveys; 6 surveys were related to complaints with one including a focused infection control survey. The facility also had a recertification survey that included complaint investigations. The facility received multiple citations on each survey. During this most recent survey on 12/5/22-12/14/22 the facility has been issued a total of 15 deficiencies (which includes F835) with 9 citations previously cited during this past year. The current 14 deficiencies include:<br><br>F565 - Resident/Family Groups and Response<br><br>The resident group reported concerns during Resident Council Meetings. A facility staff member is present at the meetings and was at the meetings that the concerns were voiced. Although they opted not to file a formal grievance, the facility was responsible to respond to the Resident Council concerns. There was no evidence the facility took any action on these concerns and did not report back to the Resident Council on actions taken.<br><br>F610 - Investigate/Prevent/Correct Alleged Violations<br><br>Family complained about a staff member refusing to assist a resident to the bathroom. The facility was made aware of the allegation and did an investigation; however, the facility did not thoroughly investigate to determine if other residents were affected.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F610 at a scope and severity (S/S) of a D (potential for harm/isolated) on 1/27/22, 8/15/22 and 9/21/22 in addition to this most recent survey.<br><br>F677 - Activities of Daily Living for Dependent Residents<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 6 residents were not provided with showers for extended periods of time. On 12/14/22 at 2:15 p.m. DON-B stated that if a resident is diagnosed with COVID-19, those residents do not receive a bath or shower for 14 days. Instead, the staff should wash the resident up at bedside and record that a bed bath was provided. Upon review of Tasks section of the documentation and nurses' notes, bed baths were not addressed as being given in the place of a shower or full bath. DON-B confirmed that the dates for when baths/showers were provided to residents was inclusive; no other dates were located in the residents' records.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F677 on 1/27/22 - S/S - D (potential for harm/isolated), 2/16/22 -S/S - E (potential for harm/pattern), 3/30/22 - S/S-E, and 8/15/22 - S/S - E in addition to this most recent survey.<br><br>F679 - Activities Meet Interest/Needs of Each Resident<br><br>4 residents voiced concern that there was very little to do. Activity calendar includes approximately 1 group activity a week. The facility has been without activities staff since November. On 12/13/22, DH-U (Director of Hospitality) she oversees the activity department but has been filling in for the activities staff providing 1:1 and group activities for residents and scheduling/organizing of activities since the beginning of November. DH-U explained that she develops the activity calendar, including four activities a week and she also provides 10-15 activity packet to each unit; activity packets include items such as sudoku, crossword puzzles and coloring. Surveyors did not observe any packets in resident rooms during survey. When interviewed on 12/14/22 at 11:00 a.m. DH-U confirmed that she was currently the only staff member in both the hospitality department and activity department for 105 residents at the facility; her goal was to hire someone to work Sundays through Thursdays and DH-U would cover Fridays and Saturdays.<br><br>F686 - Treatment/Services to Prevent/Heal Pressure Ulcers<br><br>3 residents had facility acquired pressure injuries. Ordered treatments/interventions were not followed though on and not placed on the residents' care plans. DON-B indicated the residents refused interventions such as pressure relief boots even though there was no evidence that they had been offered or trialed by the resident. The facility relied on the residents to tell the staff what care they needed and when they needed it and did not have a proactive plan in place. As a result, residents were noted to go extended periods of time without assistance with repositioning.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F686 on 12/15/21 at a scope and severity (S/S) of a J (immediate jeopardy/isolated), on 2/16/22 - S/S - G (actual harm/isolated), on 3/30/22 - S/S - G, and 9/21/22 - S/S - G in addition to this most recent survey.<br><br>F688 - Increase/Prevent Decrease in ROM (Range of Motion)/Mobility<br><br>(continued on next page) |

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|---|---|---|---|
| | 525730 | A. Building<br>B. Wing | 12/14/2022 |

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

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A resident had a significant decline in transfer and ambulation abilities after being discharged from therapy services. The facility does not have a restorative program or plan to assist residents in maintaining their abilities. On 12/13/22 at 4:00 p.m., Surveyor spoke with DON-B and NHA-A. NHA-A confirmed that the facility does not have a restorative program. DON-B indicated restorative care was incorporated into the direct care provided by CNAs for activities of daily living, stating, It's just the movement with dressing. We do not have anyone in charge of a restorative program.<br><br>F689 - Free of Accident Hazards/Supervision/Devices<br><br>According to review of facility fall documentation completed by Surveyor the facility had a total of 351 falls since 04/01/22. NHA-A and DON-B shared that a new process for managing falls was implemented approximately three months prior to the survey. Surveyor reviewed the fall information and found the facility had 179 falls in 5.5 months (4/1/22-9/14/22) and 172 falls in less than 3 months (9/15/22-12/05/22) after implementing a new fall management program. These numbers demonstrate an increase in the number of falls. Surveyors identified that care planned approaches were not implemented, such as anti-roll back breaks, and that the facility did not complete a thorough review of the falls to identify a root cause of the fall and to implement appropriate interventions.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F689 at a scope and severity (S/S) of a D (potential for harm/isolated) on 12/15/21, on 8/15/22 at a S/S - G (actual harm/isolated) in addition to this most recent survey.<br><br>On 12/13/22 at 1:00 p.m., the Surveyor met with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. DON-B stated 2-hour checks is the facility policy for all residents. Surveyor noted this policy is universally applied and does not take into consideration individual residents' assessments or individualized needs to prevent falls and ensure supervision.<br><br>Surveyor reviewed the facility's fall documentation and noted there had been 351 falls at the facility since 04/01/22. NHA-A (Nursing Home Administrator) and DON-B (Director of Nursing) shared that a new process for managing falls was implemented approximately three months prior to the survey. Falls for the past 3.5 months (09/15/22-12/05/22) were reviewed and 172 falls were documented.<br><br>F690 - Bowel/Bladder Incontinence<br><br>1 resident experienced decline in their bowel and bladder continence since admission to the facility. Resident interviews found staff were not responding to their requests to use the bathroom, and not placing a urinal within the resident's reach. On 12/13/22 at 4:00 p.m. DON-B stated she did not have a list of residents on a bowel and bladder program, and no one was responsible for a bowel and bladder program. Surveyor requested a copy of the bowel and bladder training program; the program was not provided to the Surveyor. No list of residents who were on a bowel and bladder program was provided. Of all the record reviews completed there were no resident MDS's that identified the resident was on a program, and no reviewed care plans identified a bowel and bladder program.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F690 at a scope and severity (S/S) of a D (potential for harm/isolated) on 12/15/21 and 2/16/22 in addition to this most recent survey.<br><br>F692 - Nutrition/Hydration Status Maintenance<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | R17 was not weighed at appropriate intervals. When she was weighed at the request of the surveyor, it was found she had an over 15-pound weight loss. Observations found resident was not consistently receiving an ordered supplement or snack. Staff were not recording the intakes of the supplement or snack. R10 had an over 100-pound weight gain in 3 days. There was no evidence the weight was reviewed or that a reweight was obtained to determine if this was accurate. The facility's policy and procedure for managing weights that was last revised November 2018 that stated, All residents will be weighed on admission, readmission, weekly for the first 4 weeks and then at least monthly All weights, upon completion, will be given to the DON or designee to determine a list of reweighs. Once the reweighs have occurred any resident with an unexplained significant to insidious weight loss will have a weight loss investigation completed . Dietary recommendations will be forwarded to the physician or NP by the DON or designee. There was no evidence that the weights were reported to the DON.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F692 at a scope and severity (S/S) of a D (potential for harm/isolated) on 8/15/22 at a S/S - D (potential for harm/isolated) in addition to this most recent survey.<br><br>F695 - Respiratory/Tracheostomy Care and Suctioning<br><br>R15's care plan includes an intervention for sustained deep breaths and order from Respiratory Therapy to do deep breathing exercises, 10 repetitions 4 times a day. There is no evidence R15 completed the exercises and no evidence that staff were instructing or monitoring R15 for completion. During the exit conference on 12/14/22 at 4:00 pm., DON-B indicated that R15 performed breathing exercises independently. DON-B was informed that R15 was not aware of what the breathing exercises were. Surveyor asked how staff were monitoring and ensuring R15 was completing the breathing exercises correctly, with the correct number of repetitions, 4 times a day. DON-B indicated the breathing exercises will be added to the medication administration record. NHA-A (Nursing Home Administrator) indicated the breathing exercises would be placed on the treatment administration record.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F695 at a scope and severity (S/S) of a D (potential for harm/isolated) on 3/30/22 in addition to this most recent survey.<br><br>F697 - Pain Management<br><br>Resident received almost daily PRN pain medications. There was no assessment of the regimen to determine the effectiveness. Staff interviews all indicated that they relied on the resident to tell them he wanted pain medication and did not proactively address the pain needs. On 12/13/22 at approximately 1:00 p. m., NHA-A and DON-B were interviewed regarding R22's pain management. DON-B stated she did not know the referral was made to pain management on 12/06/22. DON-B said, When staff move his legs he complains of pain. He is pretty vocal and lets the nurses know if he is having pain. He is able to ask for pain medication when he needs something. I don't know why he is not on scheduled pain medication. He receives as needed gels and patches for pain which he uses quite frequently.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F697 at a scope and severity (S/S) of a D (potential for harm/isolated) on 3/30/22 in addition to this most recent survey.<br><br>F740 - Behavioral Health Services<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Facility staff did not monitor for and document resident behaviors and did not assess behavioral symptoms to determine if there is a pattern that could be addressed. The interventions for these behaviors did not give staff clear direction on how to approach the residents to address the behaviors. Staff did not consistently implement care planned interventions to address behaviors.<br><br>F773 - Lab Services Physician Order/Notify of Results<br><br>Staff did not recognize that a resident's labs were drawn as ordered by the physician. On 12/09/22 at 9:56 a.m., AC-AA (Assistant Chief) stated, If resident is on the PAN (post-acute network) program; labs are usually ordered per provider request. Their standing order is weekly. AC-AA confirmed that the labs were not obtained as ordered and staff did not contact the provider for further clarification regarding the frequency the lab tests should be obtained.<br><br>F880 - Infection Prevention and Control<br><br>Staff were observed to not wear the appropriate or clean PPE when assisting residents who were on contact and/or droplet precautions. Although staff and visitors were instructed to sanitize their hands and don PPE before entering the affected units, there was no hand sanitizer provided.<br><br>Review of the facility's survey history for the past year indicates the facility has been cited for noncompliance at F880 at a scope and severity (S/S) of an E (potential for harm/pattern) on 3/30/22 and at a S/S of L (immediate jeopardy/widespread) in addition to this most recent survey. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03397<br><br>Based on observation and interviews, the facility has not ensure staff used appropriate Personal Protective Equipment (PPE) when entering rooms of resident who are on transmission based precautions. This has the potential to affect all residents.<br><br>Dietary staff were observed not implementing appropriate precautions when distributing meal trays to residents on transmission based precautions.<br><br>Nursing staff were observed assisting a resident who was positive for COVID-19 with a meal. The roommate asked for assistance. The nursing staff did not doff the contaminated PPE or perform hand hygiene before assisting the roommate with their meal.<br><br>Findings include:<br><br>Contact Precautions Signs provided the following instructions: Perform hand hygiene before entering and before leaving room. Wear gloves when entering room or cubicle and when touching patient's intact skin, surfaces, or articles in close proximity. Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces.<br><br>Contact and Droplet Precautions Signs provided the following instructions: Clean hands with soap and water when entering and leaving room. Gown and glove before entering room. Masks and face shields were to be worn when there was a potential for splashes of blood or body fluid. The facility required all staff were required to wear masks and eye protection at all time.<br><br>On 12/05/22 during the initial tour at approximately 9:40 a.m., Surveyor 03397 observed the doors to [NAME] were closed. A sign on the door indicated that staff and visitors were required to wear a gown, gloves, face mask and eye protection when entering the neighborhood/unit. A Personal Protective Equipment (PPE) cart was outside the closed doors with the required PPE. No hand sanitizer was located in the PPE cart or on the wall in the hallway; there was no hand sanitizer dispenser leading to the closed doors.<br><br>On 12/05/22 during the initial tour at approximately 10:15 a.m., the doors to Kindle were closed. A sign on the door indicated staff and visitors were required to wear a face mask and eye protection. A PPE cart was outside the closed doors with the required PPE and gloves and gowns. No hand sanitizer was located in the PPE cart or on the wall in the hallway leading to the closed doors.<br><br>Staff and visitors were observed entering and exiting Kindle on 12/05/22, 12/06/22, and 12/07/22 without performing hand hygiene. The first hand sanitizer dispenser was located outside of room [ROOM NUMBER] after entering Kindle, approximately twenty feet from the entrance. Staff and visitors who entered and exited the unit were not observed using the dispenser.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On the Kindle Unit, 7 residents were on contact/droplet precautions (requiring gown and gloves in addition to the masks and eye protection) while 1 resident was on contact precautions (requiring gloves when entering the room and the use of a gown if the staff/visitor have any chance of coming in contact with surfaces in the room, in addition to masks and eye protection). Signs were posted outside of each door for residents who were on precautions.<br><br>On 12/05/22 at 12:33 p.m., Surveyor observed Dietary Server (DS-T) delivering meal trays on the Kindle Unit. DS-T was observed to enter 6 resident rooms to deliver meal trays. Each time coming into contact with a potentially contaminated surface in the room. After exiting each room, DS-T did not performed hand hygiene before picking up the next resident meal tray.<br><br>DS-T exited the Kindle unit with the food cart without performing hand hygiene and proceeded down the hallway. DS-T indicated she was only serving on Kindle for that meal.<br><br>On 12/05/22 at 1:29 p.m., Dietary Server (DS-S) was observed, pushing a food cart and pulling a wheeled garbage can down the hallway on the Kindle. DS-S was observed to enter 2 rooms touching potentially contaminated surfaces. When exiting rooms, DS-S carried used foam containers and placed them in the garbage. DS-S did not perform hand hygiene after exiting the rooms with garbage.<br><br>DS-S then approached a room with a Contact/Droplet Precaution sign on the door. Without performing hand hygiene or donning a gown and gloves, DS-S entered the room, picked up the resident's used foam containers, placed them in the garbage can and transported the food cart and garbage can to the doorway to another room.<br><br>Without performing hand hygiene DS-S continued to transport the food cart and garbage can from room to room without conducting hand hygiene or donning gloves. 3 of these rooms had resident who were on contact/droplet precautions and would require the donning of gloves and a gown. DS-S did not don the appropriate PPE before entering the rooms and did not perform hand hygiene after exiting. Before exiting the unit, DS-S was observed to push the foam containers down into the garbage can without wearing gloves. DS-S exited the Kindle Unit transporting the food cart and garbage can without performing hand hygiene.<br><br>Both staff continued to work in the dietary department for the remainder of their shift.<br><br>On 12/12/22 at 9:00 a.m. Surveyor was notified by RN-GG (Registered Nurse) that one resident in room [ROOM NUMBER]A tested positive for COVID-19 that morning. RN-GG who was caring for the resident stated, The resident felt hot to the touch this morning so I took her temperature and tested her for COVID-19. The resident's COVID-19 result was positive.<br><br>On 12/12/22 at 12:33 p.m., a nursing staff member was observed in room [ROOM NUMBER]A. There were signs posted on the room door directed staff to gown, gloves, wear a face mask and goggles or a face shield. The nursing staff member performed hand hygiene, donned a gown, gloves, and eye protection prior to entering the room. The nursing staff member provided meal assistance for the resident who was positive for COVID-19. The other resident (who was negative for COVID-19) asked for assistance. The nursing staff member went to the roommate who was located on the other side of the room and provided assistance without first changing out the gown, gloves and performing hand hygiene. |