STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525290	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Manor	8800 Hwy 61 Lancaster, WI 53813

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39849 Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. the facility failed to ensure that all alleged abuse violations are reported to the administrator and other officials in accordance with State law through established procedures for 1 of 2 sampled residents (R13) and 1 of 1 (R34) supplemental residents reviewed for abuse. On 5/5/24, the facility became aware of an alleged violation of abuse between R13 and R34. This allegation of abuse was not reported to the administrator or state agency. Evidenced by: The facility policy, Reporting Abuse to the Facility Management, with a revision date of 4/20/23, indicates, in part: Policy Statement: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, volunteers, etc., to immediately report any incident or suspected incident of . resident abuse .to the administrator . Policy Interpretation and Implementation: .3. Employees, facility consultants, volunteers and/or attending physicians must report any suspected abuse or incidents of abuse or alleged abuse to the Administrator or their immediate supervisor, who will in turn report to the Administrator, promptly. If such incidents occur or are discovered after normal business office hours, the Administrator must be called and informed of such incidents, as soon as possible .4. When an alleged or suspected case of .abuse is reported, the facility Administrator or his/her designee will promptly notify the following persons or agencies of such incident (as appropriate): .c. The DQA (Division of Quality Assurance) through the online Misconduct Incident Reporting (MIR) system .7. To assist one in recognizing incidents of abuse, the following definitions of abuse are provided: .b. Verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability . R13's 5/5/24 Certified Nursing Assistant (CNA) Behavior/Cognitive .Summary note, authored by CNA H, includes, in part: 5/5/24 - Day - Verbally Abusive (Yes), Verbally Abusive Comment: telling her roommate [sic] her boyfriend doesn't love her and is with another woman and making resident cry. told [sic] her romate [sic] to shut up and stop crying. being [sic] rude and cussing at staff for trying to help her and the other resident . (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: R13's roommate is R34. On 8/14/24 at 11:35 AM, Surveyor interviewed CNA H, reviewed the behavior note she wrote on 5/5/24 regarding R13 and R34, and asked what she recalled of the incident. CNA H indicated that the call light had gone off and it was R34 and she was upset and mad that R13 was in the bathroom too long and she was crying and I tried to calm her down. R13 told R34 to stop crying and she was calling her names. CNA H indicated R13 was using a loud voice, not yelling, but raising her voice and that R13 was being very rude and demeaning to R34. CNA H indicated that on this same day, R34 was worked up because her boyfriend couldn't come. R34 was crying and CNA H indicated she had gone in her room because you could hear her crying from the top of the hall by the nurse's station. CNA H indicated when she went in the room R34 told her she was sad her boyfriend couldn't come. CNA H indicated she was trying to console her and was trying to distract her and was trying to find her something to watch on TV. CNA H indicated after she tried calming R34 down, R13 told R34 that she (CNA H) was lying to her and that the real reason her boyfriend wasn't coming was because he doesn't love her and was cheating on her. CNA H indicated this got R34 all sorts of worked up and she started crying more. CNA H indicated she heard R13 tell R34 to shut up and quit crying. Surveyor asked CNA H if she felt this should have been reported as a potential abuse. CNA H indicated, yes, it was not OK, I witnessed something that I thought should be reported for potential abuse. CNA H indicated she reported this to the nurse but could not recall the nurse's name. CNA H indicated she is to report abuse to the nurse and if they don't say they are going to inform SSM I (Social Services Manager), then we tell her. CNA H indicated she sent SSM I an e-assignment (internal electronic messaging) and pulled this up in the computer to show surveyor. CNA H indicated she sent a summed up version of the incident and that usually SSM I comes to talk to them after but she could not recall if she did or not for this incident. On 8/14/24 at 1:14 PM, Surveyor interviewed SSM I. During the interview SSM I indicated staff should report abuse to herself as the grievance officer, the charge nurse, DON (Director of Nursing) or the NHA (Nursing Home Administrator). SSM I indicated she did not recall an incident between R13 and R34 from 5/5/24. Surveyor asked SSM I if she recalled receiving an e-assignment regarding an incident on 5/5/24 from CNA H. SSM I reviewed the e-assignments with surveyor present and surveyor asked if she recalled what she did with the information. SSM I indicated she was trying to remember if she even saw it and that she did not recall getting a phone call about it or if the CNA H even told her nurse. Surveyor asked SSM I how often she is supposed to check her e-assignments. SSM I indicated she would have to ask what the expectation is and that it would depend on if she was in the office. SSM I indicated she tries to check it daily depending on what other things are happening. SSM I indicated that she does not believe she followed up on the e-assignment on 5/5/24 from CNA H regarding the incident with R13 and R34. SSM I indicated if CNA H reported this to her nurse then the DON or NHA should have been called as it was a Sunday and she was not in the office. SSM I indicated that if a resident told another resident to shut up and quit crying it should be reported as a potential allegation of abuse. Surveyor asked SSM I if she is involved in the abuse training and if so who are staff trained to report abuse to. SSM I indicated she is and staff should report immediately to their immediate supervisor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1:52 PM, Surveyor interviewed NHA A regarding reporting of abuse and the incident from 5/5/24 between R13 and R34. During the interview NHA A indicated staff should first stop the abuse, ensure safety, and then report suspected or allegations of abuse immediately to the charge nurse who should then reference the policy and contact the administrator. NHA A indicated they can then work together on figuring out what needs to happen. NHA A indicated that the incident should have been reported to her, there was a break down in reporting, an e-assignment message would not be considered immediate, and that she would report this to the state agency as an allegation of verbal abuse. This incident was not reported to the NHA or to the state agency within the required timeframes.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 39849 Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, all alleged violations were thoroughly investigated for 1 of 2 sampled residents (R13) and 1 of 1 (R34) supplemental residents reviewed for abuse. On 5/5/24, the facility became aware of an alleged violation of abuse between R13 and R34 and did not conduct an investigation. Evidenced by: The facility policy, Abuse Investigation Protocol, with a reviewed date of 3/20/24, indicates, in part: Policy Statement: All reports of alleged resident abuse in any form .resident-to-resident abuse .are promptly and thoroughly investigated by facility management .Policy Interpretation and Implementation: 1. Should an incident or suspected incident of resident abuse .be reported, the administrator, or her designee, will appoint an individual to investigate the incident .11. The administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency . R13's 5/5/24 Certified Nursing Assistant (CNA) Behavior/Cognitive .Summary note, authored by CNA H, includes, in part: 5/5/24 - Day - Verbally Abusive (Yes), Verbally Abusive Comment: telling her roommate [sic] her boyfriend doesn't love her and is with another woman and making resident cry. told [sic] her romate [sic] to shut up and stop crying. being [sic] rude and cussing at staff for trying to help her and the other resident . On 8/14/24 at 11:35 AM, Surveyor interviewed CNA H, reviewed the behavior note she wrote on 5/5/24 regarding R13 and R34, and asked what she recalled of the incident. CNA H indicated that the call light had gone off and it was R34 and she was upset and mad that R13 was in the bathroom too long and she was crying and I tried to calm her down. R13 told R34 to stop crying and she was calling her names. CNA H indicated R13 was using a loud voice, not yelling, but raising her voice and that R13 was being very rude and demeaning to R34. CNA H indicated that on this same day, R34 was worked up because her boyfriend couldn't come. R34 was crying and CNA H indicated she had gone in her room because you could hear her crying from the top of the hall by the nurse's station. CNA H indicated when she went in the room R34 told her she was sad her boyfriend couldn't come. CNA H indicated she was trying to console her and was trying to distract her. CNA H indicated after she tried calming R34 down, R13 told R34 that she (CNA H) was lying to her and that the real reason her boyfriend wasn't coming was because he doesn't love her and was cheating on her. CNA H indicated this got R34 all sorts of worked up and she started crying more. CNA H indicated she heard R13 tell R34 to shut up and quit crying. On 8/14/24 at 1:52 PM, Surveyor interviewed NHA A regarding the incident from 5/5/24 between R13 and R34. During the interview NHA A indicated the incident should have been investigated through their abuse process. The incident between R13 and R34 was not investigated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on observation, interview, and record review, the facility did not ensure residents received care consistent with professional standards of practice to prevent or heal pressure injuries (PI) for 2 of 2 sampled residents (R9 & R3) reviewed for pressure injuries out of a total sample of 12. R9 was admitted with bilateral heel pressure injuries. The facility did not implement immediate offloading of the bilateral heels and the heels deteriorated. R9's wounds were not measured weekly, and her physician was not updated timely on changes to her wounds. R9 was observed not having her heels offloaded while seated in her recliner. R3 developed a facility acquired PI. The facility failed to measure and assess the PI weekly. R3's PI became infected multiple times requiring antibiotics. The facility states R3 has a Stage 3 PI - R3's medical record indicates PI, abscess, and diabetic wound. Evidenced by: Facility policy entitled Pressure Injury (ulcer) Treatment, revision date of 5/9/24, states in part: Purpose: The purpose of this procedure is to provide guidelines for the care of new and/or existing pressure injuries.2. When eschar is present, a pressure injury cannot be accurately staged until the eschar is removed .4. At the time a pressure injury is noted: assess the wound; Notify the physician for treatment orders; notify responsible party/family; initiate a wound/other treatment progress report 4; update care plan; update wound board & wound nurse. Definitions and Descriptions: Suspected deep tissue injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.the wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. Stage I pressure injury: Intact skin with non-blancheable redness of a localized area usually over a bony prominence . Stage II pressure injury: Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: presents as a shiny or dry shallow ulcer without slough or bruising .bruising indicates suspected deep tissue injury. Stage III Pressure Injury: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss . Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefor stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility policy entitled Pressure Injury (ulcer) Prevention, revision date of 5/9/24, states in part: Purpose: The purpose of this procedure is to provide information regarding pressure injury (formerly pressure ulcer) prevention. General Guidelines. 1. Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. 2. The most common site of a pressure injury is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes.4. Pressure injuries are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e., perspiration, feces, urine, wound, discharge, soap residue, etc.,) decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition.Interventions and preventive measures: General .3. For a person in a w/c, geri chair, etc.: a. change position at least every hour; b. use foam, gel or air cushion as indicated to relieve pressure, unless the resident specifies otherwise. 4. When repositioning, reduce friction and shear by lifting (using appropriate lifting technique and equipment) rather than dragging. 5. Do not position directly on bony prominences . 2. Risk Factor - Friction and Shear.i. shoes need to be monitored for proper fit to avoid development of blisters, corns, and calloused areas . m. protect bony prominences as needed.5 .b. use pillows or wedges to keep bony prominences such as knees or ankles from touching each other. Do not massage bony prominences. C. when in bed, every attempt should be made to float heels (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician . Facility policy entitled Pressure Injury (ulcer) Risk Assessment, revision date of 5/9/24, states in part: Purpose. The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure injuries. General guidelines. 1. Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues.4. Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin .5. Once a pressure injury develops, it can be extremely difficult to heal.9. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury to the supervisor. Assessment .3. Because a resident at risk can develop a pressure injury within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure injuries. The admission evaluation and Braden scale helps define those initial care approaches. 4. In addition, the admission evaluation may identify pre-existing signs (such as a purple or very dark area that is surrounded by profound redness, edema, or induration) suggesting that deep tissue damage has already occurred, and additional deep tissue loss may occur. This deep tissue damage could lead to the appearance of an unavoidable stage III or IV pressure injury or progression of a stage I pressure injury to an injury with eschar or exudate within days after admission . Example 1: R9 was admitted on [DATE] with diagnoses to include Diabetes mellitus type 2, pressure ulcer of unspecified heel stage 1, and mild cognitive impairment of uncertain or unknown etiology. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Baseline care plan dated 10/23/23 states in part: problems/strengths: Baseline care plan for new admission related to diagnoses: Type 2 diabetes mellitus with diabetic chronic kidney disease, major depressive disorder, non-pressure chronic ulcer of back limited to breakdown of skin, stage 1 pressure ulcer of heel . Goals: Nursing: skin goal - skin will regain integrity. Interventions: Nursing: Assess skin and treat/report for follow up as needed. Provide precautions for preventions of skin impairment. Has the following skin condition: chronic ulcer of back and a stage 1 pressure ulcer of heel. At risk for skin issues secondary to congestive heart failure . R9's admission assessment dated [DATE] indicates: Skin condition: body is marked with left heel and right heel both indicating 2x2 (2 centimeters by 2 centimeters). General skin condition intact, dry, cool, pink, pale and warm. Comments: scattered bruising, PI to bilateral heels, and PI to coccyx - WN (wound nurse) needs to verify staging of all PI. (Of note: No description of the wound is documented; it is not clear the stage of R9's PI upon admission.) R9's Care Plan dated 11/7/23 states in part: .potential for altered skin integrity related to decreased mobility/hx (history) of pressure injury.will regain skin integrity & remaining intact skin will continue to be free from skin impairments (skin tears, pressure injury, abrasions) . interventions: (12/07/23) Remind resident to lock both brakes on w/c (wheelchair) prior to transfer to prevent chair from moving and hitting resident. (11/7/23) inspect skin daily with cares for unusual findings, report concerns as indicated. (11/7/23) assess unusual findings, consult with MD/wound nurse for tx. (treatment) orders. (11/7/23) whirlpool bath or shower 2 days/wk. (per week) . (11/07/23) toilet on regular basis, incontinent products to wick away moisture from skin, prompt perineal cleansing after episodes of incontinence. (11/07/23) pressure redistribution mattress on bed and cushion in w/c and/or recliner. (11/7/23) encourage fluids at & b/t (between) meals to promote hydration. (11/7/23) lotion skin after bath or shower .& with cares daily to help keep skin moisturized per resident preference. (11/07/23) update MD on recommendations for findings/consult with wound care nurse PRN (as needed) for wound tx. (11/07/23) perform prescribed treatment regimen for deep tissue injury to bilateral heels, monitor response. R9's Minimum Data Set (MDS) dated [DATE] indicates R9 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R9 is cognitively intact. R9 is indicated as needing partial/moderate assist with toileting hygiene and upper/lower body dressing. R9 is indicated as needing supervision with sit to stand, sit to lying, and chair/bed transfers and transferring to the bathroom. Section M indicates that R9 is at risk for pressure injuries and has unhealed pressure injuries that were present on admission. R9 is marked as having 2 (two) deep tissue injuries. R9's MDS date 8/2/24, indicates R9 is independent with transfers and toileting. Section M indicates R9 has two stage 2 pressure injuries present that were present on admit. R9's October 2023 Treatment Administration Record (TAR) has no pressure injury treatments indicated. R9's November 2023 TAR indicates the following: 11/2/23 Skin - prep wipes pad (barrier skin protectant) to bilateral heels topical two times daily for wound. (Stop date: 11/17/23.) 11/2/23 offloading boots to bilateral heels when in bed topical every shift for wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/17/23 Skin - prep wipes pad (barrier skin protectant) to bilateral heels topical two times daily for wound. (Stop date 12/13/23) On 11/1/23, R9's PI documentation indicates: Right heel measures 2.5cm (centimeters) x 3.7cm x 0cm. (length x width x depth) stage is marked as a deep tissue injury. Wound bed is indicated as 100% dark purple. Left heel measures 2.5 cm x 2.4 cm x 0 cm, with deep tissue injury (DTI) marked. Wound bed is indicated as 100% dark purple. Physician updated. Notes: offloading boots and pt (patient) education provided. Of note: R9's PI went from a stage 1 upon admit to a DTI within 7 days of admission. R9 did not have PI interventions in place until 11/2/23 after R9's PI had deteriorated to a DTI. On 11/8/23, R9's Admission History & Physical Physician visit note, states in part: .physical exam: .skin: . comments: She has some shallow desquamation of the bilateral heels.Assessment and plan: .skin: Pressure sores ankles - daily prep and offloading boots . On 11/9/23, R9's PI documentation indicates: Right heel measures 3 cm x 3.3 cm x 0 cm. Wound bed is indicated as 100% black. R9 is marked as having pain. Left heel measures 2 cm x 2.4 cm x 0 cm, wound bed indicated as 100% black. R9 is marked as having increased pain. Physician updated for possible scheduled Tylenol. On 11/16/23, R9's PI documentation indicates: Right heel measures 2.6 cm x 3.6 cm x 0 cm. Deep tissue injury is marked as the stage. Wound bed is indicated as 100% black. Physician updated indicates on going. Left heel measures 2 cm x 2.4 cm x 0 cm. Wound bed is indicated as 100% black. Of note, both wounds are marked as a DTI and Physician update indicates ongoing, but does not indicate if the Physician/provider was updated on this date. On 11/23/23, R9's PI documentation indicates: Right heel measures 2.5 cm x 3 cm x 0 cm and wound bed is 100% black. Left heel measures 2.4 cm x 2.5 cm x 0 cm with a wound bed that is 100% black. On 11/30/23, R9's PI documentation indicates: Right heel measures 2.5 cm x 2.9 cm x 0 cm. Stage is marked deep tissue injury. Wound bed is marked close/resurfaced and indicated as 100% black. Left heel measures 2 cm x 2.2 cm x 0 cm. Stage is marked as a deep tissue injury. Wound bed is indicated as being 100% black. R9's December 2023 TAR indicates the following: 12/13/23 Betadine to bilateral heels 1 application topical one time daily for heel wounds (Stop date: 12/27/23) Betadine to bilateral heels 1 application topical on day shift for heel wounds. (Start date 12/27/23. Stop date 1/22/24) R9 should have a measurement on or around 12/7/23. There is no documentation of a wound assessment around this time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/13/23, R9's Physician visit note, states in part: .we examined the heel wounds. A black scab is present overlying area. She has ankle pillows and does well in wearing them and offloading the heels. On 12/15/23, R9's PI documentation indicates left heel - wound bed is necrotic tissue. Percentage of tissue type: 100% dry black eschar and measures 2.5 cm x 2.5 cm x 0 cm. The wound is indicated to be a non-stageable. Update section indicates physician updated - name of doctor updated, and date notified: ongoing. Right heel wound is non-stageable and is 100% dry black eschar measuring 2.5 cm x 2.9 cm x 0 cm. On 12/29/23, R9's PI documentation indicates right heel measures 2.7 cm x 2.8 cm x 0 cm, wound bed is 100% dry black eschar. Left heel measures 2 cm x 2 cm x 0 cm, wound bed is 100% black eschar. R9's January 2024 TAR indicates the following: 1/22/24 betadine to right heel BID (Twice a day) 1 application topical two times daily for heel wounds. 1/22/24 tx (treatment) to left heel: cleanse with normal saline (NS), pat dry and cover with Opti foam every 3 days and as needed (PRN) if soiled or falling off on day shift for skin irritation. (Stop date: 3/7/24) 1/22/24 monitor left heel dressing daily, replace Opti foam if not intact on day shift. On 1/5/24, R9's PI documentation indicates left heel measures 2 cm x 1.9 cm x 0 cm with 100% eschar. Right heel measures 2.4 cm x 2.8 cm x 0 cm and 100% eschar. On 1/11/24, R9's Physician visit note states in part: .Being treated for pressure sores on posterior of her ankles. Daily wound care. She does not like the offloading boots. She prefers the bolster pillows so nursing wondering if order can be changed to that .Assessment/plan: .bolster pillow for ankle wounds. Continue betadine daily . R9's January 2024 TAR indicates the following: 1/11/24 Bolster pillow under legs when in bed to elevate bilateral heels every shift. (Stop date 2/4/24) On 1/12/24, R9's PI documentation indicates right heel is 100% light brown scab measuring 2.3 cm x 2.4 cm x 0 cm indicated as closed/resurfaced. Left heel 100% eschar measuring 2 cm x 1.9 cm x 0 cm. R9's January 2024 TAR indicates: Betadine to bilateral heels 1 application topical on day shift for heel wounds. (Stop date 1/22/24) this treatment is indicated as missed (M) on 1/14/24. R9's January 2024 TAR indicates the following: 1/11/24 Bolster pillow under legs when in bed to elevate bilateral heels every shift. Indicated as being missed on 1/13 on night shift and 1/14 on PM shift. On 1/19/24, R9's PI documentation indicates right heel is 100% black measuring 2 cm x 2 cm. Left heel indicated as 100% yellow slough measuring 1.5 cm x 2.2 cm x <0.1 cm with serosanguineous drainage and 2+ pitting edema. MD (medical doctor/physician) updated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R9's January 2024 TAR indicates the following: 1/22/24 betadine to right heel BID (Twice a day) 1 application topical two times daily for heel wounds. 1/22/24 tx (treatment) to left heel: cleanse with normal saline (NS), pat dry and cover with Opti foam every 3 days and as needed (PRN) if soiled or falling off on day shift for skin irritation. (Stop date: 3/7/24.) 1/22/24 monitor left heel dressing daily, replace Opti foam if not intact on day shift. Betadine to bilateral heels 1 application topical on day shift for heel wounds. (Stop date 1/22/24.) On 1/26/24, right heel measures 1.5 cm x 2.0 cm x <0.1 cm with light serous drainage, wound bed indicated as 100% epithelial. Left heel measures 1.5 cm x 2.0 cm x none indicated as 100% necrotic. On 1/31/24, R9's PI documentation indicates: right heel measures 2 cm x 2 cm x undetermined. Wound bed is indicated as 100% (dried) necrotic. Notes: needs encouragement to participate in whirlpool baths. (R9's right heel was 100% epithelial tissue on 1/26.) Left heel measures 1.5 cm x 2.0 cm x <0.3 cm with 100% slough, MD update as indicated. (Of note, the wound bed depth would be obscured by the slough, and would not be able to be determined) R9's February 2024 TAR indicates the following: 2/4/24 right heel cleanse right heel with NS, pat dry and cover with Opti foam. Check daily and change every 3 days as directed every AM for pressure ulcer of unspecified heel, stage 1. (Stop date 3/7/24) On 2/2/24 at 9:06 PM, Message to R9's Physician indicates (R9's) right heel is no longer dry, stable eschar, has opened with small amount of bleeding. Can we d/c (discontinue) iodine and start cleanse with NS, pat dry and cover with Opti foam Q (every) 3 days and PRN if soiled? Physician response on 2/4/24 at 1:10 PM indicates, agree with nursing wound care recommendations. On 2/6/24, R9's PI documentation indicates right heel measurement of 2.0 cm x 2.2 cm x scabbed over, unable to determine 100% necrotic - encourage to elevate heels and take w/p (whirlpool) baths resident is scheduled to take a w/p bath this PM and is in agreeance. New dressing applied. Left heel - measurement 1. 7 cm x 1.2 cm x <0.1 cm and 100% slough. Notes: encourage to elevate heels and take w/p bath. Resident had a w/p bath last night (2/6) new dressing applied to heel. On 2/14/24, R9's PI documentation indicates left heel measures 1.5 cm x 1.1 cm x 0.1 cm. Stage is marked as stage III, with serosanguineous drainage, wound bed is 100% epithelial tissue. Signs and symptoms of infection edema. Surrounding tissue warm, pink, dry, intact, edematous. Pain is marked yes, intermittent, PRN (As Needed) Tylenol. Update: Physician ongoing. Right heel measures 2 cm x 2 cm x 0.1 cm, marked as a non-stageable (unstageable.) Wound bed is 60% black and 40% pink with light serosanguineous drainage. On 2/21/24, R9's PI documentation indicates: Left heel measurement is 1.5 cm x 1.1 cm x<0.1 cm with light serous drainage and wound bed is 100% granulation tissue. Right heel measurement is 2 cm x 2 cm x <0.1 cm with light serous drainage. Wound bed is 25% slough and 75% granulation tissue. Physician update: N/A R9 should have a measurement on or around 2/28/24. There is no documentation of a wound assessment around this time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R9's March 2024 TAR indicates the following: 3/7/24 Bilateral heel tx: check daily take whirlpool bath, pat area dry and apply piece of Aquacel AG to wound bed and cover with padded Tegaderm (or comparable dressing) two times a week and prn every am for wound. (Stop date 4/3/24) On 3/6/24, R9's PI documentation indicates: Right & Left heel wounds indicated both as having early granulation tissue present to both wound beds. Both wounds indicated as measuring 2 cm x 2 cm x 0.1 cm. Wounds are staged as a stage II. Physician updated: would recommend changing treatment to twice weekly/PRN with bath: remove dressing, take w/p. Pat areas on heels dry and apply piece of Aquacel AG to wound bed and cover with a Suresite + pad or comparable dressing. (Of note: R9's wounds have been downstaged at this time from an unstageable to a stage II pressure injury which does not follow the standard of practice for PIs. Wounds are not downstaged. There is no indication of what percentage of the wound bed is granulation tissue.) R9 should have a measurement on or around 3/13/24. There is no documentation of a wound assessment around this time. On 3/13/24, R9's Physician Visit note, states in part: .a shallow ulcer is present on bilateral heels. Skin surrounding ulcer is blancheable. She has her ankle over plenty of pillows and with legs elevated.Skin: pressure sores ankles. Daily prep and offloading boots . (R9's offloading boots were changed to a bolster pillow during the last MD visit) On 3/19/24, R9's PI documentation indicates: Right & Left heel (both are in the same wound review) documentation indicates the Right measures 1.5 cm x 1.9 cm x 0.1 cm and the left measures 0.5 cm x 1 cm x 0.1 cm. Stage is marked as stage II. The wound bed has slough and granulation tissue marked. Mixture of both 75% granular 25% yellow slough in RT (right). (There is no indication of what the Left heel wound bed percentage is.) Physician update: No changes. Notes: Both wounds are measuring smaller. Treatment remains appropriate. Will hold off on w/p this week until Friday since dressing just changed today. Recommend continuing current treatment. Offload heels as much as possible. Of note: Facility indicates Stage 2; wound should not be backstaged, and a Stage 2 wound would not present with slough. On 3/27/24, R9's PI documentation indicates: Left heel measures 0.8 cm x 0.5 cm x <0.1 cm, wound bed is 100% granulation tissue. Right heel measures 1.4 cm x 1 cm x <0.1 cm, wound bed is 100% granulation tissue. R9's April 2024 TAR indicates the following: 4/3/24 Aquacel AG to wound beds bilateral heels. Skin prep peri wound, cover with a composite dressing. Change 3 times a week and as needed for stage II pressure ulcer. (Stop date 5/2/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/3/24, R9's PI documentation indicates: Right measures 1.5 cm x 1.4 cm x 0.1 cm left measures 0.5 cm x 1.8 cm x 0.1 cm, stage II is marked. Wound bed Right is 75% granulation tissue 25% yellow slough. Left granulation tissue 100%. (R9's right heel went from 100% granulation to having 25% slough present.) Signs/symptoms of infection, edema is marked. Surrounding tissue: wound edges with maceration, skin prep applied. Aquacel AG to wound beds, covered with composite dressing. Update: Physician: current treatment remains appropriate, would recommend increasing dressing changes to 3 times a week, healing stalled out likely due to weeping edema/increase in edema. Notes: Bolster pillow remains in room under legs to float heels in bed. No active weeping noted from wound beds .Will continue with Aquacel AG to help with drainage control. Increase dressing changes to 3 times a week. On 4/10/24, R9's PI documentation indicates left heel measures 1.5 cm x 2 cm x 0.1 cm light serous drainage, no odor. Wound bed is 100% slough. Right heel measures 1.5cm x 2cm x 0.1 cm with light serous drainage. No odor. Wound bed is 100% slough. Update Physician is blank. Notes: continue plan of care. (Of note: R9's wounds worsened from 25% slough to 100% slough and no Physician notification was provided. R9's wounds would be unstageable.) On 4/17/24, R9's PI documentation indicates: Right heel measures 1.5 cm x 1.4 cm x 0.1 cm and the left measures 0.3 cm x 0.6 cm x 0.1 cm. Marked as stage II. Light serosanguineous drainage. Wound bed is marked slough and granulation tissue. Right heel is 90% granulation tissue, 10% yellow slough. Was able to mechanically debride some off of wound bed. Left is 100% early granulation tissue. Left heel wound with purple discoloration above and below wound bed. (R9) does not remember bumping or causing injury to area. Suspect DTI hopefully will resolve with applying skin prep peri wound as previously ordered. (There is no measurement of the area that is being indicated as a suspected DTI.) Surrounding tissue: slightly macerated dressing wet when removed. Enc (Encourage) staff to take dressing off, give W/P and have nurse reapply dressing. Skin prep peri wound and apply Aquacel AG to wound bed. Follow with a composite dressing. Change three times a week. Edema has improved to BLE (Bilateral Lower Extremities), helping the amount of moisture in wound beds. MD updated regarding left wound with purple tissue above and below wound. R9 should have a measurement on or around 4/24/24. There is no documentation of a wound assessment around this time. R9's May 2024 TAR indicates the following: 5/2/24 Aquacel AG to wound beds bilateral heels. Skin prep peri wound, cover with a composite dressing on day shift for stage II pressure ulcer. (Stopped on 7/3/24 then restarted on 7/3/24 then stopped on 7/31/24.) On 5/2/24, R9's PI documentation indicates: Wound document does not indicate which heel the documentation is on. Unable to say which is the left or which is the right heel. One heel measures 1.5 cm x 2 cm x 0.2 cm with foul odor, moderate amount of serosanguineous drainage and a wound bed with 10% slough and granulation tissue. Signs/symptoms of infection has redness and increased exudate marked. Physician update has N/A (Not Applicable) documented. Notes: dressing changes Aquacel AG applied followed by bourdered [sic] gauze. The other heel measures 1 cm x 1.5 cm x 0.5 cm with moderate amount of serosanguineous drainage. No odor. Wound bed is marked slough and granulation tissue with 10% slough. Signs/symptoms of infection has redness and increased exudate marked. Surrounding tissue is macerated. Physician updated N/A. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/2/24 at 10:37 AM, message sent to R9's Physician indicates: FYI resident heel dressings have increased serosanguineous drainage and area around wounds is macerated. No signs of infection will continue 3x week dressing change with Aquacel AG and bordered gauze. Physician response on 5/3/24 at 10:12 AM, agree with increase dressing changes. (Of note: R9's wound evaluation indicates redness and increased exudate (drainage) and a foul odor for one of the heels. The message to the MD says no signs/symptoms of infection.) On 5/8/24, R9's PI documentation indicates: Right heel measures 1.8 cm x 1.5 cm x 0.1 cm left heel measures 1.5 cm x 1.5 cm x 0.1 cm. Stage is marked as a stage II. Both are marked as 100% granulation tissue. Surrounding tissue macerated. Recommend changing to daily dressing change. Currently is experiencing weeping edema 2+ pitting edema BLE (bilateral lower extremities). Physician update: updated and new orders noted. Will change dressings daily d/t (due to) maceration concerns. On 5/8/24, R9's Physician Visit note states in part: .patient seen in her room .appears she has been struggling with increased leg swelling which have now caused some wounds in her heels. We examined heel wounds. A shallow ulcer is present on bilateral heels. Skin surrounding ulcer is blancheable. She has ankle over plenty of pillows and with legs elevated. Leg swelling 3+ with weeping noted . On 5/22/24, R9's PI documentation indicates: Right heel measures 1.3 cm x 1.1 cm x 0.1 cm and left heel measures 1.4 cm x 1 cm x 0.1 cm. Stage marked is stage II. Moderate serous drainage. Wound bed indicates 50%/50% slough/granulation tissue. (Both wounds are on the same document.) Surrounding tissue: maceration present d/t weeping edema present. Will recommend to staff to use more Aquacel AG over top wound [sic] to help pull fluid away from peri wound. Is already on a daily dressing change. 2-3+ pitting edema present BLE. Update: Physician updated: N/A (Not Applicable). (R9's wounds changed from 100% granulation to 50% slough and there is no indication the MD was updated. R9's heels would be unstageable at this time.) R9 should have a measurement on or around 5/29/24. There is no documentation of a wound assessment around this time. On 5/31/2024, R9's bed was removed from her room as she prefers to use her own recliner to sleep in. R9's June 2024 TAR indicates the following: Bolster pillow under legs when in bed to elevate bilateral heels every shift for wound remains on R9's TAR, when R9 no longer has a bed in her room as of 5/31/24 and sleeps in her recliner. On 6/5/24, R9's PI documentation indicates: Right heel measures 1 cm x 1 cm x 0.1 cm and left measures 1 cm x 1 cm x 0.1 cm. Stage is marked as stage II. Light serosanguineous drainage. Wound bed is 100% pale pink. Notes: wounds show improvement. Measure smaller. No active weeping edema noted. Peri wound with no maceration. Checked 2 ruptured blister areas on RLE (Right Lower Extremity.) Remains clean, no s/sx infection. Covered with a composite dressing. Treatments remain appropriate. Continues with 2+ pitting edema. Enc. to elevate legs. Tubigrips on. Instructed staff to monitor for rolling down. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/12/24, R9's PI documentation indicates: Left measures 1.5 cm x 1.5 cm x <0.1 cm and the Right measures 2 cm x 1.5 cm x <0.1 cm, light serous drainage, wound bed granulation tissue, 100% pale pink. Update: not initial assessment, PCP (primary care provider) has been updated previously. Notes: Continue current plan of care. On 6/13/24, R9's Provider visit note, states in part: .follow-up on her leg swelling and skin lesions. She has been experiencing significant swelling in her legs, which has been persistent and has not shown improvement. She has been diligent about keeping her legs elevated when resting. She uses Tubigrips but they are not on yet today .the bandages on her heel sores and shin sores were changed yesterday and are intact . R9 should have a measurement on or around 6/19/24 and 6/26/24. There is no documentation of a wound assessment around either time. R9's July 2024 TAR indicates the following: Apply Medihoney to bilateral wound beds covered by a composite dressing. Change dressing with bath days (Tues. and Fri.) or twice weekly and prn. For stage II pressure ulcer. (Start 7/31/24.) On 7/3/24, R9's PI documentation indicates: Right heel measures 1 cm x 0.7 cm x 0.2 cm and Left measures 0.5 cm x 0.6 cm x 0.1 cm, stage marked is stage II. Wound bed indicates right with 10% slough 90% granulation. (Of note the left wound bed percentage of tissue type is not documented.) Pain, yes episodic with cleansing. Physician update: N/A. On 7/10/24, R9's PI documentation indicates: Right and left heel measures 1 cm x 1 cm drainage is marked as light and purulent, no odor. Wound bed is marked as granulation tissue. Percentage 100% pale pink. Physician update: No, not initial assessment, PCP (Primary Care Provider) has been updated previously. On 7/16/24, R9's PI documentation indicates right heel measures 0.6 cm x 0.5 cm x 0.1 cm and left measures 1 cm x 1 cm x 0.1 cm. Stage is marked as stage II. Wound bed is marked slough and granulation tissue. Percentage 50% slough 50% granulation. (Of note, this does not differentiate if the left or the right percentage is different, the wounds would be unstageable due to 50% slough being present.) Surrounding tissue peri wound maceration, skin prep applied. Physician update: N/A. Notes: (right) ulcer is measuring smaller. (left) larger. (left) ulcer was drier when checked. Wounds cleansed with normal saline. Reapplied Aquacel AG to wound beds. No weeping edema noted from wounds like in the past. Does present with a 3+ pitting edema BLE . educated (R9) to continue to float heels. Did have them lying on bolster pillow. Current tx. remains appropriate at this time. On 7/24/24, R9's PI documentation indicates left measures 1 cm x 1 cm x 0.1 cm, wound bed marked as 100% granulation tissue. Notes: continue treatment Aquacel AG to wound beds. Skin prep peri wound, cover with a composite dressing. Right measures 1 cm x 1 [TRUNCATED]

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure that residents that are diabetic received routine diabetic foot checks in accordance with professional standards of practice for 2 of 2 sampled residents (R3, R9), and 2 of 2 supplemental residents (R11, R27) reviewed for diabetic foot checks. R11 has no documentation of diabetic foot checks. R27 has documentation of once per month diabetic foot checks. R3's diabetic foot checks are not done daily. R9's diabetic foot checks are not done daily. This is evidenced by: The facility's Policy and Procedure entitled Foot Care Guideline dated 7/15/21 with last revision date of 5/9/24 states in part: .The nursing staff will provide residents' foot care with licensed nurses performing nail care for the diabetic individual .Objectives: To prevent infection of the feet .To assess skin integrity . Of note: The facility policy did not address the issue of diabetic foot checks or ongoing monitoring. Per American Diabetes Association (ADA), dated 2017, foot checks/screens should be conducted daily with a comprehensive exam conducted annually. Per American Medical Director Association (AMDA), dated 12/9/14, these foot checks/screens are vitally important for treatment of foot problems in patients with diabetes. Common foot problems in diabetic patients are broken down into three categories: at risk foot, current mild foot/ankle or heel infection or ulcer, and limb-threatening foot/ankle/heel ulcer. Example 1 R11 was admitted on [DATE]. R11 has a diagnosis of type 2 diabetes mellitus. R11's medical record was reviewed for documentation of diabetic foot checks for June, July and August 2024. R11's medical record does not include any documentation of the facility completing diabetic foot checks. Example 2 (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R27 was admitted on [DATE]. R27 has a diagnosis of type 2 diabetes mellitus. R27's medical record was reviewed for documentation of diabetic foot checks for June, July and August 2024. R27's medical record only includes documentation of diabetic foot checks on 6/24/24 and 7/24/24. 36192 Example 3: R3 was admitted on [DATE] with a diagnosis of diabetes mellitus type 2. R3's Treatment Administration Record (TAR) for March through August 2024 indicate: (R3) is diabetic check feet monthly for skin impairments. one time daily, start date 3/6/24. This order is signed out once a month. Example 4: R9 was admitted on [DATE] with a diagnosis of Diabetes mellitus type 2. R9's Treatment Administration Record (TAR) for October 2023 through December 2023, and January 2024 through August 2024, indicate: 10/24/23 Diabetic foot check; this order is signed out once a month. On 8/14/24 at 3:24 PM, Surveyor interviewed DON B (Director of Nursing) regarding diabetic foot checks. Surveyor asked how often diabetic foot checks are done, DON B indicated foot checks should be done monthly. Surveyor asked what standard of practice the facility follows, DON B indicated she needed to check. No further diabetic foot check information was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on observation, interview, and record review, the facility did not ensure provision of an environment free from accidents and hazards for 1 of 1 sampled residents (R3) with a power wheelchair out of a total sampled of 12 residents. R3s electric wheelchair was being charged in R3's room. This is evidenced by: Facility policy entitled Motorized scooter/wheelchair, revision date 5/9/24, does not address where electric chairs are to be charged. R3 was admitted on [DATE]. R3's Minimum Data Set (MDS) dated [DATE], indicates R3 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, which indicates R3 is cognitively intact. On 8/13/24 at 9:45 AM, Surveyor observed R3 to be in her recliner sleeping and the electric wheelchair appeared to be plugged in to a cord behind the nightstand. On 8/13/24 at 10:01 AM, Surveyor observed R3 to have an electric wheelchair in her room. The chair was not plugged at this time but R3 had the charger in her room on the floor behind her nightstand near the window. Surveyor asked R3 where her wheelchair gets charged, R3 and her husband replied, In here, while pointing towards the cord. On 8/15/24 at 8:24 AM, Surveyor and CNA D (Certified Nursing Assistant) went into R3's room. Surveyor asked CNA D to look at R3's cord in her room. CNA D looked at the cord plugged into the outlet, and CNA D indicated, This is the wheelchair cord. CNA D indicated we did charge it in the lounge, they may have moved it since I was off the last 2 weeks. On 8/15/24 at 10:11 AM, CNA D indicated she moved the cord where it's supposed to be, in the day room. On 8/15/24 at 10:06 AM, Surveyor interviewed LPN G (Licensed Practical Nurse) regarding electric wheelchairs. Surveyor asked where electric wheelchairs get charged? LPN G indicated in the middle day rooms. LPN G indicated the wheelchair is not to be charged in R3's room. On 8/15/24 at 1:30 PM, Surveyor spoke with NHA A (Nursing Home Administrator), NHA A asked if Surveyor asked R3's husband if he moved the cord. Surveyor had not asked R3's husband if he moved the charging cord into their room. NHA A indicated the chair should not be charged in R3's room.