STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525330	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on interview and record review, the facility did not ensure that each resident received, and the facility provided, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 7 of 27 residents (R58, R13, R66, R76, R79, R80 and R42 .) reviewed for change of condition. R58 and R13 are being cited at severity level 3 (actual harm). R66, R76, R79, R80 and R42 are being cited at severity level 2 (potential for more than minimal harm). R58 had an infection in his tooth (abscess) and the facility did not follow up with orders to obtain the antibiotic, did not initiate antibiotic therapy and did not monitor R58's mouth pain and oral condition. R58 was seen on 9/4/24 by a dentist and prescribed Amoxicillin for swelling in his gums this ordered was not followed by the facility and R58 did not receive the prescribed antibiotic. On 9/24/24 as part of a follow-up visit, an RDH (Registered Dental Hygienist) observed pus coming from the same area noted by the dentist on 9/4/24 and an antibiotic was re-prescribed 20 days later. The facility did not monitor or assess R58's oral status during this time (9/4 to 9/24). R13 had a blister develop on her right breast on 9/24/24, there was no initial measurement completed, staff did not complete treatments on 9/26/24 and 10/7/24. Staff document the blisters were no longer present on 9/30/24. On 10/3/24 the blisters are documented as open areas and have deteriorated necessitating a new order added for Santyl (used to remove damaged tissue) with a bordered foam dressing. No assessments/measurements of the wound were completed from 10/3 - 10/7/24. On 10/5/24 a new order was added for doxycycline (an antibiotic) for a wound infection. The facility failed to implement aggressive preventative measures to prevent R13's wound from deteriorating/worsening and to prevent additional wounds from developing. R66 presented to the facility at high risk for infection due to her immunocompromised status related to actively receiving chemotherapy and renal stent (a thin, flexible tube that's placed in the ureter to help urine pass from the kidney to the bladder.) At no point in this time period did R66 have a care plan related to her chemotherapy. A full set of vital signs, including temperature, were only taken in September on 9/10/24, 9/19/24, 9/20/24, and upon readmission to the facility on [DATE]. Facility staff did not complete a full nursing assessment to monitor any adverse effects that may occur as the result of R66's chemotherapy treatment and increased risk of infection. R76 did not have wound care documented that it was completed as ordered. R79 did not have wound care documented that it was completed as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R80 did not have an assessment documented prior to being sent to the ER (emergency room). The facility failed to assess and document R42's change in condition prior to sending R42 to the hospital. The facility failed to monitor and observe R42 for a minimum of 72 hours after R42's fall on 10/19/24. Example 1 According to the Cleveland Clinic, if left untreated, a tooth abscess (infection in the root of a tooth) can spread to your jawbone, the soft tissues of your face and neck, and beyond. In extremely rare cases, the infection can travel to your heart (endocarditis) and brain (bacterial meningitis). Abscesses are caused by broken, chipped or cracked teeth. Bacteria can then seep into any opening in a tooth and spread to the pulp. Signs of a tooth abscess include gum redness and swelling and open draining sore on the side of your gums. (https://my.clevelandclinic.org/health/diseases/10943-abscessed-tooth) According to the Mayo Clinic, leaving a tooth abscess untreated can lead to serious, even life-threatening, complications. Treatment of a tooth abscess include extraction, root canal, draining and antibiotics. R58 was admitted to the facility on [DATE] and has diagnoses that include Type 2 diabetes, atherosclerotic heart disease, respiratory failure, chronic pain syndrome and a history of MRSA (Methicillin-resistant Staphylococcus aureus). His most recent MDS (Minimum Data Set), dated 8/13/24, shows a BIMS score (Brief Interview for Mental Status) of 15, indicating R58 is cognitively intact. R58 is independent with oral cares. His care plan states, Focus: Resident has dental/oral problems .Goal: The resident will comply with mouth care .Interventions: Resident has no teeth/dentures. Of note, R58 does have a few remaining teeth. On 9/4/24, a DDS (Doctor of Dental Science) came to see R58 at the facility. DDS's post visit summary stated, Patient scheduled for initial exam by hygienist for draining broken tooth. Patient is edentulous upper arch with 4 lower teeth and root #27 present. Gingival swelling present, on facial of root #27. Patient reports no symptoms. Patient is very afraid of dentists and is unsure about oral surgery referral for extraction. Will advise staff on RX (prescription) Amoxicillin 500 mg x 30 tabs. Take 1-tab 3x/day until gone. Will follow-up at next visit for eval/consult. Patient understood and is satisfied. R58 was visited by RDH (Registered Dental Hygienst) on 9/24/24 as part of a regular cleaning and follow-up visit. RDH's post visit note states, Heavy plaque present, brushed patient's teeth first to remove prior to scaling moderate calculus (calcified dental plaque); scaled to patient's tolerance; toothette used to rinse and control bleeding; instructed patient to brush teeth/tongue; patient is still in a lot of pain and said that he has not received antibiotic yet-I did send a message to dentist to see if we still need this RX sent over. Patient is miserable; oral hygiene is not good at all, heavy bleeding, heavy plaque, moderate/heavy calculus, patient is not cooperative. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 9:56 AM, Surveyor interviewed RN Q (Registered Nurse) who stated that about a month or so ago R58 stated to her that his teeth hurt and she observed that R58 had a swollen area on his gums. RN Q stated that she then contacted the nurse practitioner. A nurse practitioner progress note on 9/24/24, with a noted time of service of 2:15 PM states, Patient complaining of increased pain to his right lower gum, noted small dental carry (cavity) on right gum with inflammation and redness, at this time we will treat for tooth abscess and recommending patient to follow-up with insurance coverage and to be seen by an oral surgeon. No reported chest pain, dyspnea, constipation, diarrhea, nausea, vomiting Chart reviewed. Care discussed with nursing staff offer no new concerns. Periapical abscess without sinus. Augmentin ordered for 7 days, follow up with oral surgeon It should be noted that R58's pain is evaluated each shift (3 times daily) at the facility and his self-described acceptable level of pain is 1 on a scale of 1 to 10. This evaluation does not indicate where his pain is, and there is no documentation showing the facility was specifically monitoring R58's oral pain or checking R58's oral status. Between 9/4/24 and 9/24/24, R58 rated his general pain at 5 or higher on 26 occasions. Additionally it should be noted that the facility weighed R58 only twice during the time period of 9/4/24 and 9/24/24. On 8/21/24, the facility logged R58's weight at 292.1 lbs. and on 9/9/24 registered him at 279.6 lbs. On 10/24/24 at 2:55 PM, Surveyor interviewed DON B (Director of Nursing), who provided Surveyor with an email that she received on 9/4/24 at 11:56 PM from the dental office with the attached after visit summary and order for Amoxicillin. DON B stated she just missed it. When asked what the process is for getting such orders from an outside provider such as the dentist, DON B stated that after-visit summaries are emailed within a few days of visits to her, the social services director and the assistant director of nursing. DON B stated that each person needs to open all emails and that she (DON B) looks at all emails and would be responsible for making sure orders are filled timely. Additionally, DON B stated that she was unaware that R58 did not get this antibiotic timely until it was brought to her attention by Surveyors. On 10/28/24 at 2:49 PM, Surveyor interviewed DDS O (Doctor of Dental Surgery) who stated that during his visit on 9/4/24, he could see swelling on the gums of R58, but he could not see any pus or drainage at that time and felt that an antibiotic was the best course of action as R58 did not want any surgical intervention and was afraid of dentists. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 11:56 AM, Surveyor interviewed RDH P (Registered Dental Hygienist) who stated that she was at the facility on 9/24/24 between 10:00 AM and 1:00 PM and she observed pus coming from R58's broken tooth and that R58 absolutely had a tooth abscess. RDH P described the gum area as red and swollen. RDH P stated that when she pushed on the inflamed gum tissue near the tooth, pus continued to ooze out. RDH P stated that R58 told her that he had not yet received the antibiotic prescribed by DDS O, so she contacted DDS O and confirmed that the order had been sent over to the facility. RDH P stated that she did not speak with a nurse at the facility. RDH P stated that when she sees an infection, she personally sends a message to her office to notify them. RDH P also stated that R58 told her that he couldn't eat, it was keeping him up at night, and that it was a throbbing pain that was making his face throb and making him miserable. RDH P stated what she observed was absolutely clear to me that it was infected. Additionally, RDH P stated that in her over [AGE] years as an RDH, she has seen abscesses spread to the neck of patients, which required emergency drainage. R58 was started on Amoxicillin on 9/25/24 with a first dose noted on his MAR (Medication Administration Record) at 9:00 PM. This course of antibiotics was concluded on 10/2/24. The facility was made aware by DDS O through his after-visit summary (emailed on 9/4/24) that R58 had a potential infection (abscess) on 9/4/24 with orders to treat with an antibiotic. The facility did not act on these orders and did not monitor/reassess R58 and on 9/24/24 RDH P observed the same area to be infected and emanating pus. 30992 Example 2 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility policy, Pressure Injury/Skin Integrity, reviewed 10/21/24, documents, in part, as follows: It is the policy of this facility to enable nursing staff to manage wounds and select appropriate interventions according to the National Pressure Ulcer Advisory Panel (NPUAP). Procedure Wound Care Team - Wound Care Team will include the participation of the Wound Care Nurse, Director of Nursing, Therapy Representative, Dietician, Director of Clinical Services, and the Medical Director as needed. The wound care team committee will meet at least monthly to review current wounds, change of conditions, and overall plan of care. The wound team will submit a report to be discussed at the quarterly QAPI (Quality Assurance and Performance Improvement) meeting. Wound rounds will be completed weekly by a licensed nurse and overseen by the Director of Nursing. Weekly documentation of wounds is completed by a licensed nurse. The goal for wound care is to prevent or manage the cause, provide a moist wound healing environment, avoid further trauma, protect surrounding skin, manage exudate, avoid infection, ensure adequate pain control. Interventions: Interventions will be implemented to mitigate the risk for skin breakdown, based on individual risk factors, and may include, but are not limited to: .devices to eliminate or reduce friction and shearing .Interventions should be documented in the residents' EMR (Electronic Medical Record), including the residents individualized resident-centered plan of care. Wound Identification: It is important that each pressure ulcer, or non-pressure wound be identified. Identification of factors that may have influenced development of the wound (root cause analysis), the potential for development of additional wounds, or for the deterioration of the pressure ulcer(s) should be recognized and may include Differentiate the type of wound (pressure-related versus non-pressure related); Describe and monitor the wound's characteristics. Monitor the progress toward healing and for potential complications. Determine if infection is present. Assess, treat, and monitor pain, if present, and Monitor dressings and treatments. Treatment/Management: Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services which may include Specific physician ordered medication/treatment, rehabilitation services, assessments/care to prevent infections. Interventions and treatments should be routinely evaluated for efficacy and modified/changed as needed. Documentation: Routine ongoing documentation should be conducted related to the resident's skin condition and the resident's response to the care and treatment of the skin. The frequency of documentation shall be determined based on the resident's individual needs in accordance with accepted standards of practice. Wound documentation is more detailed than routine skin documentation and shall include information related to the wound based on a clinical assessment. R13 was admitted to the facility on [DATE] with diagnoses including, but not limited to, displaced bimalleolar fracture, acute kidney failure stage 2 (mild), hepatitis C, cocaine and alcohol abuse, intervertebral disc degeneration, and osteoarthritis. Of note, R13 is not diabetic. R13's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R13 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 14. R13's MDS indicates she is at risk for skin impairment. R13 was admitted with no skin impairment. R13's Certified Nursing Assistant (CNA) Visual/Bedside Kardex, dated 10/23/24, documents the following: Skin: Apply barrier cream per orders as needed with episodes of incontinence. Encourage and assist with frequent repositioning while in bed an ensure to document refusals. Provide pericare after each incontinent episode. On 9/11/24, R13's Braden Score is 17, indicating she is at risk of skin breakdown. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/13/24, PTA/DOR D (Physical Therapy Assistant/Director of Rehab) documented the following note: . WC (wheelchair) switched out for one same size but easier to propel. Pt (patient) can propel x 66 ft (feet) and states she likes better. Note, PTA/DOR D is currently on leave and unavailable for interview. On 9/16/24, R13's Skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower Review: CNA & RN J (Registered Nurse) signed - No concerns documented. On 9/22/24, R13's Skin Check documents Redness under L (left) breast. On 9/23/24, R13's Skin Check documents Redness under L (left) breast. On 9/23/24, R13's Skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower Review: CNA & RN J (Registered Nurse) signed - No further skin issues. On 9/24/24 at 4:54 PM, RN I (Registered Nurse) documented the following progress note: *Skin Observation Note Text: Resident has NEW skin issue(s) observed. 1 Other (specify) - two big blisters to top of left [SIC] breast, states she has no idea where it came from, filled with fluid. Skin turgor with good elasticity. Skin color is normal for ethnic group. Skin temperature is warm (normal). Skin moisture is normal. Skin condition is normal. No other issues noted. Note, initially the facility has no documentation that the Physician/NP (Nurse Practitioner) was notified until Surveyor was investigating and asking questions related to Physician/NP notification. As a result, the following note (late entry) was entered by Physician E: On 9/24/24 at 5:15 PM, Physician E documented the following note (late entry): Chief Complaint: Skin blister Subjective: RN informed me of the patient's skin irritation underneath R (right) breast. Blister-like lesion as per report is not open, not weeping. Recommend applying skin prep on the affected area BID (two times daily) and reassess patient in 1 week or sooner. Consider wound RN consult. Physical Examination: N/A (Not Applicable) Assessment and Plan 1. Skin irritation/blister-apply skin prep BID. This note was electronically entered and signed by Physician E on 10/28/24 at 8:28 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/24/24, R13's TAR (Treatment Administration Record) documents the following treatment order: Wound care: R (Right) breast, skin prep BID (twice daily) to blister - two times a day for wound care. Order Date: 9/24/24; D/C (Discontinue Date): 10/2/24. The facility scheduled the treatments at 8:00 AM and 8:00 PM daily. On 9/26/24, the facility did not complete R13's 8:00 PM treatment per Physician orders. R13's TAR (Treatment Assessment Record) documents the facility continued the skin prep treatment from 9/24/24 - 10/2/24. On 9/30/24, RN J (Registered Nurse) documented the following: No new skin issues and blisters are no longer present to right breast. Note, on 10/10/24 NP F (Nurses Practitioner) documents R13's wound Developed from ruptured blister. On 10/28/24 at 9:05 AM, Surveyor spoke with RN J (Registered Nurse). Surveyor showed RN J her documentation from 9/30/24 and asked what she observed. RN J stated the blisters were flat with no fluid. RN J stated, They weren't popped, they were absorbed. On 10/1/24, there is no documented assessment or measurement of R13's blister. On 10/2/24, there is no documented assessment or measurement of R13's blister. On 10/3/24, Physician E ordered the following: Wound care R breast; cleanse area dry apply Santyl apply bordered foam dressing. To be done DAILY in the morning for wound care start on pm shift 10/3/24. Of note, there is no assessment/measurement of R13's wound. On 10/3/24, R13's TAR documents the following: Wound care: R (Right) breast: Cleanse area dry apply Santyl. Apply bordered foam dressing. To be done daily in the morning for wound care start on PM shift 10/3/24. On 10/3/24, handwritten Wound Rounds documents R13, refused stated she's using cocoa butter. Note, this was not provided to Surveyor until 10/28/24 after the facility was notified of serious concerns related to this wound. In addition, this information is not documented in R13's medical record. Also of note, R13 stated to Surveyor that she has not put cocoa butter or any lotion on the blisters when they were intact or open. On 10/5/24, NP F (Nurse Practitioner) documented the following order for R13: Doxycycline hyclate 100 mg tablet Route: by mouth two times a day for wound infection for 7 days. On 10/7/24, the facility did not complete R13's Santyl treatment and dressing change. On 10/4/24, 10/5/24, and 10/6/24, RN J completed R13's treatment to the right breast. There is no documented assessment, measurement, or description of the wound bed to R13's right breast. On 10/7/24, the facility did not complete R13's treatment per Physician orders. On 10/7/24 at 2:35 PM, RN J (Registered Nurse) documented the following progress note: Resident has no new skin issues observed. It is important to note, because R13's treatment was not completed staff did not visualize R13's wound on this date. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/8/24, the facility documented the following assessment and measurement of R13's right breast: 4.71 x 1.87 - 70% slough, 30% epithelial. No evidence of infection. Santyl, silicone dressing. Blister that opened. In house acquired. On 10/8/24, MDS RN G (Minimum Data Set Registered Nurse) updated R13's comprehensive care plan documents the following: The resident has actual skin impairment to R (right) breast. (Date Initiated: 10/8/24) Goal: Resident skin impairment will improve by review date. (Date Initiated: 10/8/24) (Target Date: 11/17/24) Interventions: Evaluate and treat per physicians orders. (Date Initiated: 10/8/24) On 10/10/24, R13's Skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower Review: CNA and RN J - Shower given, hair washed, sheets changed, wound cleaned and dressing changed; circled 9. Blisters. RN J documented Wound care in place. On 10/10/24, NP F (Nurse Practitioner) documented the following: Chief Complaint: Initial evaluation of breast Initial evaluation ruptured blister R (right) breast wound necrotic tissue, slough to majority of wound bed, no warmth or purulent drainage. Subjective: Patient seen today for initial evaluation of ruptured blister to right breast. Wound examined and noted to have necrotic tissue, slough to majority of wound bed. Patient reports tenderness to right breast. No warmth or purulent drainage. No current S/SX (signs/symptoms) of infection. Full assessment and plan as below. Diagnosis that could affect wound healing: CKD (Chronic Kidney Disease), hep C (hepatitis), obesity, tobacco use. Interventions in place: Continue nutritional support, continue hygiene care, continue weekly wound assessment with treatment plan as directed. Plan: Cleanse wound apply Santyl over areas of slough followed by bordered foam to be changed daily. Orders given for lidocaine 5% ointment for potential debridement next week. Assessment: Unspecified open wound of right breast, initial encounter. Developed from ruptured blister now with necrotic tissue covering majority of wound bed. No erythema or warmth to periwound. There is some tenderness to right breast. It does not appear to have active infection to wound. Full assessment and plan as above. On 10/14/24, R13's Skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower Review: CNA and RN J (Registered Nurse) signed (Circled both breasts.) On 10/15/24, NP F (Nurse Practitioner) documented the following assessment: 4.71 x 1.87 80% epithelial. 20% granulation. Santyl, silicone. Blister opened. On 10/21/24 at approximately 11:15 AM, Surveyor spoke with R13. Surveyor asked R13 if she has any open areas on her skin. R13 stated yes and pointed to the side of her right breast. R13 asked Surveyor if she would like to see a photo of her open area. R13 showed Surveyor a photo of the open area on her right breast. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/21/24 at approximately 11:30 AM, Surveyor asked DON B (Director of Nursing) what caused the wound to R13's right breast. DON B stated she will check and find out. On 10/21/24 at 12:05 PM, DON B stated R13's wound to her right breast was caused by, Ruptured blisters from new wheelchair so she can propel. On 10/21/24, R13's Skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower Review: CNA & RN J (Registered Nurse) Right breast circled, wound care in place, bandage. On 10/22/24, NP F (Nurse Practitioner) documented the following assessment: 1.22 x 1.01 Santyl, silicone. Ruptured blister in house acquired. On 10/22/24, MDS RN G (Minimum Data Set Registered Nurse) updated R13's comprehensive care plan with the following intervention: Resident encouraged to choose clothing that avoids skin on skin friction and encouraged to store personal belongings in bag rather than undergarments. (10/22/24) It is important to note, this intervention related to friction was not added to the care plan until survey was in process and Surveyor was asking questions regarding the root cause of R13's wound to her right breast. On 10/23/24 at 3:04 PM, Surveyor spoke with OT/Acting DOR U (Occupational Therapist/Acting Director of Rehab). OT/Acting DOR U stated, R13 is currently receiving PT (Physical Therapy) and works with PTA/DOR D (Physical Therapy Assistant/Director of Rehab) and PT H (Physical Therapist). Surveyor asked OT/Acting DOR U what R13 was receiving PT for. OT/Acting DOR U stated, R13 was originally seen for a fracture of her leg and has been long term care since that point. OT/Acting DOR U stated, R13 would like to transition to a lower level of care however, right now she is still a Hoyer (total body lift for transfers). Her insurance has only approved so many days or only approved for OT (Occupational Therapy), so we have been seeing her on and off. OT/Acting DOR U stated, R13 is working with PT for strengthening and eventually for her to stand. Surveyor asked OT/Acting DOR U, is therapy working with R13 on her positioning. OT/Acting DOR U stated, we might have switched out her wheelchair as she had trouble propelling her wheelchair a few months ago. OT/Acting DOR U added, R13 had trouble pushing the wheelchair with her arm. Surveyor reviewed therapy documentation with OT/Acting DOR U. OT/Acting DOR U stated, she thinks R13 has always had a good size (correct fit) for her width. Surveyor asked OT/Acting DOR U, since R13 got her new wheelchair have you seen her since. OT/Acting DOR U stated, no, most of our work with R13 has been on strengthening. OT/Acting DOR U added, R13 also worked on wheelchair propulsion. After reviewing R13's therapy notes, OT/Acting DOR U stated, No, there's nothing related to positioning. OT/Acting DOR U stated, on 9/13/24 PTA/DOR D (Physical Therapy Assistant/Director of Rehab) documented the following note: .WC (wheelchair) switched out for one same size but easier to propel. Pt (patient) can propel x 66 ft (feet) and states she likes better. Note, PTA/DOR D is currently on leave and unavailable for interview. OT/Acting DOR U stated, R13 is not currently receiving OT but is receiving PT. OT/Acting DOR U stated, PT H (Physical Therapist) just saw R13 today. Surveyor asked OT/Acting DOR U, has the facility made therapy staff aware of a wound to R13's breast. OT/Acting DOR U stated no. Surveyor asked OT/Acting DOR U, has the facility made therapy aware that R13 puts items in her bra, tops or under her arm. OT/Acting DOR U stated, I am not. Surveyor asked OT/Acting DOR U, could friction from items in her bra, top, or under her arm cause an open area to the side of her right breast. OT/Acting DOR U stated, Potentially. OT/Acting DOR U stated, If something large was there it could, I guess it would depend on the amount of pressure or time it's placed there. (continued on next page)

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Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 3:48 PM, Surveyor spoke with MDS RN G (Minimum Data Set Registered Nurse). Surveyor asked MDS RN G about the following care plan intervention: Resident encouraged to choose clothing that avoids skin on skin friction and encouraged to store personal belongings in bag rather that undergarments, dated 10/22/24. MDS RN G stated, over the summer when R13 was outside in the smoking area R13's phone fell on to the ground. MDS RN G stated, she was wrongly under the impression it fell off R13's lap until R13 stated it fell out of her shirt. MDS RN G stated, R13 got a wheelchair upgrade so she can propel more. MDS RN G stated, sometimes there was rubbing as she was self-propelling more. MDS RN G stated R13 would often keep her cell phone and other things in her bra. MDS RN G stated, now R13 has a purple backpack on the back of her wheelchair to carry belongings (added 10/22/24). MDS RN G stated, she got the backpack, she was proud and showing off where she puts her phone. Surveyor asked MDS RN G, did you have conversations with R13 regarding not storing her phone in her bra, top, under her arm. MDS RN G stated, yes, she had ongoing conversations with R13 especially during the summer. MDS RN G stated, I have a feeling she didn't change her behavior for me. MDS RN G stated when R13 is outside smoking, she has a pack of cigarettes in her bra or under her arm. MDS RN G stated she has not seen R13 put anything else besides her phone or cigarettes in her bra, top, or under her arm. Surveyor asked MDS RN G, did you document, or care plan this concern. MDS RN G stated No. MDS RN G stated now that it's cooler, R13 wears a hoodie with pockets and stores her phone there. MDS RN G stated she just heard R13 has an open area. MDS RN G stated, this past summer was the last time MDS RN G could tell R13 had something in her bra or inside her top because it fell out. MDS RN G stated she was worried about R13's hygiene and moisture trapped in there. MDS RN G stated, I didn't think about the fact it could cause issues. MDS RN G stated R13 is sweaty, and moisture accumulates in folds. MDS RN G stated it is her expectation that R13 not put stuff in her bra, top, and under her arm. Surveyor asked MDS RN G, when was this care plan intervention added to R13's care plan. MDS RN G stated, we talked about it the evening of 10/21/24 and she added it to R13's care plan on 10/22/24. (Note, this intervention was added after survey was in process and Surveyor was asking questions related to R13's wound.) On 10/23/24 at 4:08 PM, Surveyor spoke with PT H (Physical Therapist). PT H stated PTA/DOR D (Physical Therapy Assistant/Director of Rehab) has been working with R13 and he is currently on leave. PT H stated she has worked with R13 the last few weeks on lower extremity strength, ankle weights, and stand lift. PT H stated PTA/DOR D has been working with R13 doing a lot of standing exercises. PT H stated she saw R13 today and together they made a plan to work on standing exercises on 11/1/24. PT H reviewed R13's therapy documentation indicating PTA/DOR D switched R13's wheelchair on 9/13/24. Surveyor asked PT H, has the facility made you aware of a wound on R13's right breast due to propelling in her wheelchair. PT H stated, I was not aware of that, no. PT H stated she worked with R13 today and neither staff nor R13 mentioned anything to her regarding a wound. It is important to note, the facility did not talk with therapy regarding other possible options related to positioning or padding the armrest that may prevent the wound from worsening and prevent further skin breakdown and wounds. PT H added, as it gets cold R13 is wearing more layers, maybe it could be with the layers. PT H stated nursing address the treatments, but therapy may be able to assist with positioning. On 10/24/24 at 8:50 AM, Surveyor contacted RN I (Registered Nurse), the staff member that R13 reported the open area to. Surveyor did not receive a return phone call. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/24/24 at 9:08 AM and 10/28/24 at 11:53 AM, Surveyor spoke with NP F (Nurse Practitioner). Surveyor asked NP F, would you have expected an initial measurement of R13's wound to her right breast. NP F stated usually she measures the wounds, the facility brings them to her attention. NP F stated it would need to be an RN (Registered Nurse) who measures typically when a resident has an open wound. NP F stated she would not expect the facility to measure intact blisters. NP F stated she expects the facility to notify her. NP F stated she doesn't ask the facility what the measurement is, she just goes and does her own assessment. Surveyor asked NP F, on 9/30/24 when R13's blisters were noted to be no longer present would you expect staff to continue to assess the area. NP F stated, not if it was resolved, they would then just proceed with their normal skin checks. Surveyor shared documentation with NP F from 9/24/24 that reads as follows: On 9/24, staff noted two big blisters to top of left breast, states she has no idea where it came from, filled with fluid. Surveyor asked NP F, when did the facility notify you regarding the blisters. NP F stated, I can just go off when I saw them, they notified me at some point because I started seeing her on 10/10/24. NP F stated sometime the week prior to 10/10/24 she was notified and her initial assessment of R13's wound was on 10/10/24. NP F stated maybe the other provider for Internal Medicine was notified before. NP F stated the clinic has a record of when the facility notified them. Surveyor asked NP F, how often should staff assess and measure the wound. NP F stated, At least weekly and I'll do the measurements weekly with LPN C (Licensed Practical Nurse). Surveyor asked NP F, would you expect staff to describe the wound bed during the assessments. NP F stated, that's what I do and then they have a report too. NP F stated LPN C writes it down and puts it in their system (electronic medical record). Surveyor asked NP F, do you know what caused R13's open area to her right breast. NP F stated, Honestly I don't. NP F added, R13 has no history of blisters, I don't know if it [TRUNCATED]

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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** 38882 Based on interview and record review, the facility did not ensure each resident receives care, consistent with professional standards of practice (SOP), to prevent pressure injuries (PI) and each resident with PIs receives necessary treatment and services, consistent with professional SOP, to promote healing, prevent infection, and prevent new injuries from developing in 1 of 2 sampled residents (R41). R41 developed an in house acquired, stage 3 pressure injury on her coccyx. Surveyor observed R41 to be lying directly on her wound and to have her heels directly on the mattress/not floating several times during survey. The facility delayed changing out R41's bed to a mattress designed to treat pressure injuries stage 3 or higher. The facility did not perform wound care per physician orders. Evidenced by: Facility policy, titled Pressure Injury/Skin Integrity, review date 10/21/24, includes: It is the policy of the facility to enable nursing staff to manage wounds and select appropriate interventions according to the National Pressure Ulcer Advisory Panel . The facility will ensure a resident receives care, consistent with professional standards of practice, to prevent pressure injuries and does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing . Interventions will be used to mitigate the risk for skin breakdown, based on individual risk factors, and may include, but are not limited to: the use of pressure redistribution devices such as mattresses or cushions; devices to eliminate or reduce friction and shearing; or the implementation of individualized turning and repositioning schedules. Interventions should be documented in the electronic medical record, including the residents individualized resident-centered plan of care . It is important that each pressure ulcer or non-pressure ulcer wound be identified. Identification of factors that may have influenced development of the wound/root cause analysis, the potential for development of additional wounds, or for the deterioration of the pressure ulcers should be recognized and may include: the type of wound: pressure versus non pressure related . the wound stage . describe and monitor the wounds characteristics . monitor the progress toward healing and for potential complications . determine if infection is present . assess, treat, and monitor pain . mind your dressings and treatments . wound documentation is more detailed than routine skin documentation and shall include information related to the wound based on a clinical assessment . wound documentation guidelines: document size: length times width times depth . document any undermining tunneling sinus tract . describe any exudate: type, amount, and/or odor . describe the various types/characteristics of tissue in wound bed . describe wound edges . describe surrounding tissue . R41 admitted to the facility on [DATE] with the following diagnoses: morbid obesity, muscle weakness, asthma, metabolic encephalopathy, heart disease, and age-related osteoporosis. Her most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 8/21/24 indicates R41's cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R41's Comprehensive Care Plan, initiated 12/22/18, includes: The resident has potential for skin impairment related to incontinence, limited mobility . Goal: 12/22/18 The resident will remain free of new skin impairment through the review date. Interventions: 12/22/18 Apply barrier cream per facility protocol to help protect skin from excess moisture. 1/3/19 ensure heels are elevated while resident is lying in bed. 12/22/18 change bedding/clothing if moist. Determine cause of moisture and eliminate if possible. 12/22/18 Monitor skin when providing cares, notify nurse of any changes in skin appearance. 4/23/23 Apply barrier cream per orders as needed with episodes of incontinence. R41's TAR (Treatment Administration Record) for September 2024, includes Order: Barrier cream to buttocks/coccyx every shift and as needed. Start date: 12/27/18: This is signed out as completed on all three shifts 9/1/24-9/30/24, except for on the following dates where each date on one of the shifts is left blank or not signed off as completed: 9/3 PM shift not completed, 9/6 PM shift not completed, 9/7 NOC shift not completed, 9/10 PM shift not completed, 9/15 AM shift not completed, 9/27 AM shift not completed. Order: Start date: 1/14/20 Resident may wear double briefs every shift for FYI (For Your Information) this is signed out as completed on 85 of 90 shifts. Order: Float heels using pillows while in bed every shift. Start date: 12/27/18. This is signed out as completed all but 3 shifts. (It is important to note double briefing is not a current SOP, double briefing adds another layer between R41 and her pressure reducing mattress and it can significantly increase the risk of developing pressure injuries due to excessive moisture trapped against the skin, creating a hot and humid environment that can break down skin integrity.) R41's Braden Scale for Predicting Pressure Sore Risk, dated 9/4/24, indicates R41 is at risk for pressure injury development with a score of 15. R41's Comprehensive Care Plan entry, added on 9/12/24, includes the following: 9/12/24 The resident has an actual skin impairment to sacrum. Goal: 9/12/24 Resident's skin impairment will improve by review date. Intervention: 9/12/24 evaluate and treat per physician orders. (It is important to note R41's Medical Record does not contain any measurements or character description of this skin impairment. There is no evidence that the facility contacted R41's MD regarding this skin impairment.) R41's Nurse Note, dated 9/18/24, includes Enabler bar/assist bar: Resident has been assessed for risk of entrapment . Observed that there is proper fit to the bed frame. Bed dimensions are appropriate for the resident's size and weight . Resident is able to safely utilize grab bar . R41's Skin Observation Tool, dated 9/23/24, indicates R41 has redness under her breasts, but no other skin concerns. (It is important to note there is no mention of R41's skin impairment that is mentioned on R41's comprehensive care plan.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R41's Nurse Notes, dated 9/29/24, include CNA (Certified Nursing Assistant) informed this writer that resident had small amount of blood and was not sure where it was from when doing cares. This writer observed small amount of vaginal bleeding when wiping. Also, a small skin impairment noted to coccyx. Area cleaned and Mepilex applied. PCP (Primary Care Physician) notified via fax due to not using facility provider. (It is important to note there is no description of this skin impairment in R41's medical record. There is no evidence the wound is stable, if it is worsening, or if it is improving. It is also important to note R41's care plan was not updated with this new skin impairment.) An email correspondence with R41's physician group, dated 10/2/24, includes, in part: . I will be sure to add (R41's name) to NP F's (Nurse Practitioner) wound schedule for tomorrow. R41's Skin Observation Tool, dated 10/3/24, includes: No new skin issues observed. (It is important to note R41's Skin Observation Tool does not reflect her skin impairment while her medical record indicates in two separate documents she has a skin impairment, on 9/12/24 in her care plan and on 9/29/24 in her nurses notes. There are no measurements, no description of characteristics, no monitoring of the impairment to compare if the impairment is stable, worsening, or improving. It is important to note there is no root cause analysis completed in R41's medical record to indicate what could have been the cause of this skin impairment.) R41's TAR, October 2024, includes Order: Sacrum: Apply bordered foam dressing to prevent further skin breakdown in the morning for wound care Start date: 10/2/24. End date: 10/10/24 . This treatment is signed as completed on all days, except for on 10/3/24 and 10/9/24. These boxes are blank. Order: Sacrum: Apply Medi honey followed by bordered foam. To be done daily in the morning for wound care. Start date 10/10/24. End date 10/17/24 . This treatment is signed out as completed all days except for 10/12/24. This box is blank. Order: Sacrum: Cleanse with normal saline. Fit collagen to wound bed followed by duoderm. To be done Monday, Wednesday, and Friday for wound care. Start date: 10/17/24. These treatments were signed out as completed on all days. Order: Float heels using pillows while in bed every shift. Start date: 12/27/18. This is signed out as completed all but 3 shifts. Order: Air mattress for wound care. Check function every shift for wound healing. Start date: 10/16/14. These are all signed as completed. Order: May wear double briefs every shift for FYI. Order date: 1/14/20. These are signed off as completed all but 3 shifts. (It is important to note R41's medical record had no evidence in it of R41's treatment being completed or R41 refusing wound care on 10/9 or 10/12.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R41's Nurse Practitioner Note, dated 10/10/24, includes: Patient seen today for initial evaluation of coccyx wound. Wound has been open for greater than 2 weeks however she declined assessment last week. She is lying in bed, no acute distress. She denies any pain, fever, or chills. Wound examined with full assessment and plan . Stage 3 pressure injury to coccyx, measuring 1.0cm x 0.6cm x unable to determine . 100% slough with scant serous drainage . Plan: cleanse wound, apply Medi honey to wound bed followed by bordered foam to be changed daily . Continue offloading measures per facility protocol, continue nutritional support, continue medical management of multiple comorbidities, continue wound assessment weekly with treatment plan as directed . R41's Nurse Practitioner Note, dated 10/17/24, includes: Patient seen today for follow up of coccyx wound. Wound appears improved with decrease in slough. No current signs and symptoms of infection. Patient reports pain with any palpation to area is 7 out of 10. She is now on offloading mattress . Stage 3 pressure injury to coccyx, measuring 1.2cm x 0.6cm x 0.2cm, 10% slough, 90% granulation tissue with scant serous drainage . Plan: Continue offloading measures per facility protocol, continue nutritional support, continue medical management of multiple comorbidities, continue wound assessment weekly with treatment plan as directed . Cleanse wound, apply collagen followed by duoderm to be changed 3 times a week and as needed . R41's Skin Observation Tool, dated 10/17/24 includes: No new skin issues observed. (It is important to note R41 has a stage 3 pressure injury that is not captured on her skin observation tool.) R41's Nurse Practitioner Note, dated 10/24/24, includes chief complaint - evaluation to coccyx . Patient seen today for reevaluation of coccyx wound. She is lying in bed. No acute distress. Denies pain at rest. She has mild pain with any pressure to coccyx. Wound without signs and symptoms of infection . Stage 3 pressure injury to coccyx, measuring 0.6cm x 0.5cm x 0.1cm, 100% smooth red with scant serous drainage . Plan: Continue offloading measures per facility protocol, continue nutritional support, continue medical management of multiple comorbidities, continue wound assessment weekly with treatment plan as directed . Cleanse wound, apply collagen followed by duoderm to be changed 3 times a week and as needed . On 10/23/24 at 9:44 AM, Surveyor observed R41 to be lying on her back, directly on her pressure injury with her heels in direct contact with her mattress. R41 indicated staff did not offer to put pillows or other offloading device under her feet but that she should have them up on pillows. R41 indicated she had a concern that the facility did not give her an air mattress until a few days ago. (It is important to note on or before 10/10/24, R41 developed a stage 3 pressure ulcer, and an air mattress was not placed until 10/16/24.) On 10/23/24 at 2:39 PM, Surveyor observed R41 to be lying on her back, directly on her pressure injury with her heels in direct contact with her mattress. R41 stated, They do sometimes put my feet up on pillows, but they didn't today. On 10/23/24 at 2:40 PM, CNA KK stated, R41's heels should be floated with pillows. I don't know why the first shift did not float them. Surveyor asked if R41 should be lying directly on her wound. CNA KK indicated she should not be. CNA KK indicated R41 was on a regular foam, bariatric mattress before she received this air mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 AT 9:46 AM, DON B (Director of Nursing) indicated R41 was on a bariatric foam mattress until 10/16/24. Then R41 was given a bariatric air mattress. On 10/23/24, NHA A (Nursing Home Administrator) indicated R41 was on a Medline bariatric foam mattress until 10/16/24 when she was given a Proactive Protekt Aire, air mattress. Medline Bariatric Foam Mattress manufacturer recommendations for use, Medline.com, includes, in part: Three-layer foam mattresses helps prevent formation of pressure injuries . pressure injury risk level: high risk stage 1 and 2 . Proactive Protekt Aire Mattress 8000BA42 manufacturer's recommendations for use, undated, includes: 10x20 cells . prevention and treatment for pressure ulcers stage 1 to stage 4 On 10/23/24 at 4:34 PM, ADON X (Assistant Director of Nursing) indicated R41's heels should be floated. ADON X indicated R41's skin was fragile looking but there was no open area on 9/29/24. ADON X indicated she should have described the skin impairment in R41's medical record. ADON X indicated it was not open until the facility had her added to NP F's list to be seen. (It is important to note the facility sent an email on 10/2/24 asking that R41 be added to the list for NP F's wound rounds.) On 10/24/24 at 7:44 AM, CNA CC indicated she never saw the wound uncovered after initially finding it on 9/29/24. At the time she found it, it was not opened but was reddened and fragile looking. On 10/24/24 at 9:02 AM, NP F (Nurse Practitioner) indicated she has only seen R41's wound three times. NP F indicated the wound had 100% slough over the wound bed the first time she saw it and it was a stage 3 caused by pressure. NP F stated, It had been present for greater than a week when I first saw it. She refused to let me see it the week before. NP F indicated she expects the facility to follow SOP(Standard of Practice) for wound care including description and measurements to be completed weekly. NP F stated, I would expect them to be monitoring it. I don't know exactly what day it opened. They should have notified me when it opened or changed. I expect the facility to follow physician orders for wound care and heels floated. It was open for a week when I saw it, because the first time we went in on October 3rd, she refused to allow me to see it. She (R41) kicked us out of her room. (Of note, a wound with 100% slough should be classified as unstageable.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/24/24 at 9:48 AM, Surveyor observed R41 to be lying directly on her wound with her heels in direct contact with her mattress. Surveyor observed R41's wound to be bright red without slough present. Facility staff had already completed wound care and did not inform Surveyor to be able to observe the wound care. During an interview, LPN C (Licensed Practical Nurse) indicated she and NP F did wound rounds together this morning. LPN C indicated NP F debrided the wound during wound rounds. LPN C described the debridement to Surveyor, stating, She took a q tip and roughed it up a little to remove the biofilm and to increase blood flow. LPN C indicated on 10/3/24, she was on vacation when NP F came to do wound rounds and R41 refused to allow NP F to assess the wound. LPN C stated, We don't usually reapproach for wound assessment. If NP F doesn't get it done or if R41 doesn't let NP F complete wound care, we wait until the next week. Surveyor asked how often wounds should be assessed. LPN C indicated she was not sure. LPN C indicated she added the air mattress on 10/16/24, stating, I asked (R41) if she wanted an air mattress and she did so I got her one on the 16th. After wound observation, Surveyor observed LPN C assist R41 back to lying directly on her wound and with her feet in contact with her mattress. LPN C exited the room. Surveyor asked LPN C if R41 should be lying directly on her wound and if her heels should be in direct contact with R41's mattress. LPN C began to walk down the hallway, Surveyor asked if LPN C was able to assist R41 with positioning off her wound and getting her heels floated. LPN C indicated she was, and she went back into R41's room and assisted R41 off her wound and positioned her heels to be floating. On 10/24/24 at 4:05 PM during an interview, DON B (Director of Nursing) and NHA A (Nursing Home Administrator) indicated R41 should not be positioned directly on her wound and her heels should be floated, not in direct contact with her mattress. DON B indicated R41's mattress should have been changed when her wound was staged at a stage 3 pressure injury, on 10/10/24. DON B and NHA A indicated when R41 refuses to be assessed by NP F another staff should attempt to complete the wound assessment, because the standard of practice and facility policy is to assess wounds weekly. DON B indicated a description should have been recorded in R41's medical record of R41's skin impairment when it was noted on 9/12/24 and on 9/29/24. DON B indicated she is unsure how the staff are monitoring the skin impairment without measurements or a description. NHA A and DON B indicated wound care should be completed as ordered and refusals should be charted in resident's medical record. DON B indicated a blank box on the TAR indicates the wound care was not completed.

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	525330	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0688 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on interview and record review, the facility did not ensure that a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for 1 of 1 resident's reviewed for mobility (R58). The facility was not walking R58 in accordance with his plan of care. Findings include. R58 was admitted to the facility on [DATE] and has diagnoses that include Type 2 diabetes, atherosclerotic heart disease, respiratory failure, chronic pain syndrome and morbid obesity. His most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 15, indicating R58 is cognitively intact. His care plan states, Focus: Resident requires restorative nursing. Resident has a behavior of refusing to participate in walking program .Goal: Ambulation - resident will maintain current functionality (Target Date: 10/30/2024) .Interventions: CNAs (Certified Nursing Assistant) to assist resident to ambulate once during each AM and PM shift daily using 2 wheeled walker, gait belt and wheelchair to follow (1 assist). Distance as tolerated. Please see therapy staff with any questions (Date Initiated: 12/19/2022). Notify nurse if resident refuses restorative program. Additionally, his CNA Kardex states, CNAs to assist resident to ambulate once during each AM and PM shift daily using 2 wheeled walker, gait belt and wheelchair to follow (1 assist). Distance as tolerated. A physical therapy discharge note, dated 8/31/24 states, .encouraged patient to ambulate with CNAs and perform bilateral lower extremity exercise throughout the day. On 10/23/24 at 2:28 PM, Surveyor interviewed R58 who stated that the facility does not walk him much. He stated that he has to ask them frequently but doesn't know if it is his responsibility to ask them or if they should be prompting him. According to facility documentation, R58 was not walked on 9/25, 9/29 - 10/1, 10/6 - 10/9, 10/12, 10/14, 10/15, and 10/20, 10/22, and 10/24 (12 days) and no refusals were documented. On 10/24/24 at 3:26 PM, Surveyor interviewed CNA BB who stated that it had been a couple weeks since she had seen R58 walk and that he refuses frequently. On 10/24/24 at 3:26 PM, Surveyor interviewed MT K (Medication Technician) who stated that she doesn't always ask R58 to walk but he does refuse a lot and that he can tell us if he wants to walk. On 10/24/24 at 3:31 PM, Surveyor interviewed LPN N (Licensed Practical Nurse) who stated that nobody has told her about anyone refusing restorative, but if they did, she would try to intervene to encourage the resident to take part in the restorative or walking program. On 10/24/24 at 10:04 AM, Surveyor interviewed DON B (Director of Nursing) who stated that R58 refuses to walk a lot of the time but that refusals should be reported and documented to nurse. DON B stated that it is hard to say if the walking or restorative plan is happening.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interviews, and record review, facility staff did not ensure that each resident who required pain management received such services according to the comprehensive person-centered care plan and the resident's goals and preferences for 1 of 2 residents (R26) reviewed for pain management resulting in R26 experiencing uncontrolled pain. R26 was experiencing breakthrough pain at 9 out of 10 severity and the facility staff did not provide her with pain medication over a period of 5 hours on 10/22/24. The facility had R26's as needed pain medication in contingency stock, however R26 was told the facility was out of her medication. R26's comprehensive care plan does not include individualized non-pharmacological interventions, and the medical record does not indicate any of these interventions being performed. This is evidenced by: The facility policy titled, Pain Management, dated 11/28/17, states in part: Purpose . Residents are observed for pain regularly during daily care and interactions. The facility clinicians use standardized pain scales when caring for residents that are able to assist in determining the severity of pain and effectiveness of interventions . The Interdisciplinary team (IDT), together with the resident and/or resident representative develop a Care Plan that will address the individual goals of comfort and individualized interventions to [NAME] those goals . General Guidelines . The resident experience of pain is highly individual and subjective. Pain is what the resident says it is . Be familiar with the physiological and behavioral signs of pain . Acute pain should be assessed every 30-60 minutes after the onset and reassessed as indicated after analgesic relief is obtained. Pain observation consists of gathering both subjective and objective data . Observation . Pain in our residents will be evaluated and/or observed as needed and: . before and after PRN analgesics . Suggestive Signs and Symptoms of Pain: . sighs, groans, crying, labored breathing .facial grimacing . Documentation: The resident's clinical record will include documentation on pain, pain medications and their effects. Specific areas include: -Each pain observation -Pharmacological and non-pharmacological interventions and their effects. Documentation should be recorded on the pain monitoring tool provided each residents individual Medication Administration Record (MAR) and should including the following, with regard to observation, evaluation and/or report of pain: Date, Time, Pain Rating, Pain Location, Pain Quality, Pain Duration, Non-Pharmacological Interventions, PRN Analgesics if provided and initial, Follow up Pain Rating, Time and Initial . Follow Up: Pain will be assessed regularly, Follow Up: . The resident's response to interventions and comfort level will be monitored. Side effects of pain medications will be monitored . If an acceptable comfort range is not met the interdisciplinary team, along with the physician shall reconsider approaches and make adjustments as indicated. R26 was admitted to the facility on [DATE] with diagnoses that include in part: Acute on Chronic Diastolic (Congestive) Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Infection, and Inflammatory Reaction due to Internal Right Hip Prosthesis, and Presence of Right Artificial Hip Joint. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R26's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/24/24 indicates R26 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates R26 is cognitively intact. Section J indicates R26 is on a scheduled pain regimen, is receiving PRN (As Needed) pain medication, and receives non-medication pain intervention. Section J also indicates R26 occasionally has pain and that her pain occasionally affects sleep, therapy activities, and day-to-day activities. R26's Comprehensive Care Plan states, in part: Residents Acceptable Level of Pain is 1 on a 0-10 scale. Focus: The resident is on pain medication therapy per orders. Date Initiated: 9/27/24. Goal: The resident will be free of any discomfort or adverse side effects from pain medication through the review date. Date Initiated: 9/27/24. Target Date: 12/19/24. Interventions: Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT (every shift). Date Initiated: 9/27/24. Focus: The resident has the potential for pain. Date Initiated: 9/19/24. Goal: The resident will not have an interruption in normal activities due to pain through the review date. Date Initiated: 9/19/24. Target date: 12/19/24. The resident will not have discomfort related to side effects of analgesia through the review date. Date Initiated: 9/19/24. Target Date: 12/19/24. Interventions: Provide the following non-pharmacological pain interventions: (specify: Heat/Ice as ordered/tolerated, Distraction/Quiet Room, Repositioning). Date Initiated: 9/19/24. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Date Initiated: 9/19/24. R26's Physician Orders state in part: Acetaminophen Capsule 500 MG (Milligrams) Give 2 capsule by mouth three times a day for pain Not to exceed 4000 MG APAP (Acetaminophen)/24 Hours. Start date: 9/25/24. Tramadol HCL Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for moderate and severe pain. Start date: 9/25/24. Tylenol Extra Strength Oral Tablet 500MG (Acetaminophen) Give 2 tablet by mouth at bedtime for pain Not to exceed 4000MG APAP/24 hours. Start date: 9/25/24. R26's Medication Administration Record (MAR), from October 2024, indicates, in part: 10/21/24: 12:03 AM- Tramadol 500MG x1 tablet administered for pain . Pain rating: 4 out of 10. Medication indicated to be effective. 8:00 PM- Acetaminophen 500MG x2 capsules administered as scheduled for pain . Pain rating: 0 out of 10. 8:00 PM- Tylenol Extra Strength 500MG x2 tablet administered as scheduled for pain . Pain rating 0 out of 10. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	10/22/24: 8:00 AM- Acetaminophen 500MG x2 capsules administered as scheduled for pain . Pain rating: 4 out of 10. 1:00 PM- Acetaminophen 500MG x2 capsules administered as scheduled for pain . Pain rating: 4 out of 10. 1:55 PM- Tramadol 500MG x1 tablet administered for pain . Pain rating: 4 out of 10. No indication provided at time document was printed on 10/22/24 at 17:59:33 (5:59 PM) On 10/22/24 at 8:55 AM, Surveyor observed R26 tell a facility CNA (Certified Nursing Assistant) that she wanted her pain medication. CNA acknowledged R26 then went directly to speak to LPN HH (Licensed Practical Nurse). On 10/22/24 at 8:56 AM, Surveyor interviewed R26. R26 was seated in a wheelchair during the interview. Surveyor observed R26 to be tremorous and visibly winced whenever she moved. R26 stated that she noticed her pain start to become worse when they started to reduce her prednisone (steroid). R26 confirmed that she had just requested her pain medication from the CNA. On 10/22/24 at 11:44 AM, Surveyor was in the process of interviewing LPN HH, when Surveyor and LPN HH were approached by RN LL (Registered Nurse). RN LL is employed by an outside agency. RN LL advised LPN HH that R26 was in severe pain and was requesting pain medication. LPN HH stated that R26 had already received her scheduled pain medication. RN LL asked LPN HH if R26 had any PRN (as needed) pain medications available. LPN HH stated the resident is out of her PRN pain medication. RN LL asked if maybe a provider should be called then so that R26's pain can be treated. LPN HH stated, I was just getting to that. RN LL provided LPN HH her business card and requested a phone call once R26's pain medication was provided. LPN HH indicated she would call RN LL. On 10/22/24 at 11:55 AM, Surveyor interviewed R26. R26 appeared visibly upset. Surveyor observed R26 to be teary-eyed and wincing with movement. Surveyor asked R26 if she had received her pain medication as she requested. R26 stated she had not. R26 also stated that she can't bend down due to the pain and was crying before her (Agency Nurse's Name) arrival because she was in so much pain. R26 stated, I've just been sitting here suffering. On 10/22/24 at 3:19 PM, Surveyor interviewed R26. R26 confirmed that facility staff did come in and administer her pain medication. Surveyor advised R26 that the MAR (Medication Administration Report) indicates she reported a pain level of 4 out of 10 today to facility staff, Surveyor asked R26 if this is correct. R26 appeared visibly angry and stated If I'm crying you know I'm in pain. I don't cry over a 4. R26's Medication Administration Record (MAR), from October 2024, indicates, in part: 10/22/24: 1:55 PM- Tramadol 500MG x1 tablet administered for pain . Pain rating: 4 out of 10. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	(Of note, R26 waited 5 hours for pain medication for breakthrough pain. It should be noted the pain medication was available in the facility contingency.) On 10/22/24 at 4:34 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B to show Surveyor how the contingency stock worked. DON B led Surveyor to the medication room and to a machine containing a variety of medications. While DON B was accessing R26's contingency stock, Surveyor asked DON B what she what the expectation is for staff prior to administering pain medication. DON B states, she would expect a resident assessment and based off assessment findings, appropriate interventions would be decided, either non-pharmacological or pharmacological interventions. Surveyor asked DON B how soon an assessment or treatment should be provided to the resident following a complaint of pain. DON B states as soon as possible. DON B demonstrated that the facility has a machine that is stocked with R26's PRN pain medication. Surveyor asked DON B which staff members in the facility have a code for the contingency stock. DON B stated all licensed nurses who are directly employed by the facility staff along with some agency nurses. DON B also states that per diem nurses who are not regularly on the schedule do not have a contingency code and should seek assistance from facility nurses. Surveyor asked DON B what the process is for pulling medication from the contingency stock. DON B states, nurses are expected to call the pharmacy for a contingency code, and once they have the code the medication should be pulled from the machine and administered to the resident. Surveyor asked DON B if the medication is available in contingency stock, would she expect it to be administered to the resident if no stock is available in the medication cart. DON B states, yes. Surveyor asked DON B if she would expect agency staff without contingency codes to seek assistance from other staff members to obtain contingency stock medication. DON B states, yes. On 10/23/24 at 11:35 AM, Surveyor interviewed RN LL. RN LL is employed by an outside agency. Surveyor asked RN LL if R26 told her she was in pain during her visit on 10/22/24. RN LL stated that she was told the resident asked for her pain medication, but that facility staff told her they had nothing to give R26. RN LL also stated that R26 told her that her pain was at 9 out of 10 severity. Surveyor asked RN LL if she made any visible observations of the resident's status. RN LL stated that she could visibly see that the resident was in pain. Surveyor asked if the facility ever returned the call that RN LL had requested. RN LL stated they did not, so she called R26 directly to check on her. R26 was admitted with diagnosis including Acute on Chronic Diastolic (Congestive) Heart Failure and Infection and Inflammatory Reaction due to Internal Right Hip Prosthesis. R26 was in severe, breakthrough pain and the facility did not provide R26 with her prescribed PRN pain medication or document non-pharmacological pain management causing the resident to experience severe pain for 5 hours.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 36253 Based on observation and interview, the facility did not ensure that garbage and refuse was disposed of properly. This has the potential to affect all 75 residents. On 10/21/24 at 10:10 AM, surveyors observed the facility's main dumpster (located outside) lid open and the following on the ground near the dumpster: *Surgical Masks *8 sealed condiment packets *2 pre-made condiment containers with lids *Numerous used disposable gloves *Plastic straws and plasticware *Paper towels *Various pieces of scattered cardboard On 10/21/24 at 10:11 AM, DM Y (Dietary Manager) stated that facility tries to keep the area clean whenever garbage is brought out and stated it should be cleaned up and it would get done immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38882 Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, affecting 1 of 21 sampled residents (R41). Surveyor observed CNA KK (Certified Nursing Assistant) don gloves (put on), assist R41, and then exit R41's room. CNA KK went into the clean linen storage, gathered an armful of bedding, and enter another resident's room wearing the same pair of gloves. Surveyor observed dirty linens to be stored in R41's room on the floor. R41 voiced concerns regarding the cleanliness of her room. Evidenced by: Facility policy, titled Handwashing/Hand Hygiene, dated 8/2014, includes: all personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol or soap and water for the following situations: before and after direct contact with residents . after contact with the residents intact skin . the use of gloves does not replace hand hygiene . Example 1 On 10/24/24 at 9:48 AM, R41 indicated she had a concern with the cleanliness of her room. Surveyor and LPN C (Licensed Practical Nurse) observed R41's room to have a strong odor of urine. LPN C and Surveyor observed a pile of soiled linens on the floor, including a flat sheet, a fitted sheet, a comforter, pillowcases, and soiled undergarments. LPN C indicated the dirty linens should not be stored on R41's floor. LPN C indicated she did not place them there and that staff who assisted R41 with her morning cares left the linen on the floor. Example 2 On 10/23/24 at 2:40 PM, Surveyor observed CNA KK (Certified Nursing Assistant) don a pair of gloves and assist R41 by placing a pillow at the foot of her bed and lifting her feet up on the pillow. Surveyor then observed CNA KK exit R41's room, go to the clean linen closet, gather clean bed linens, and walk into another resident's room. Surveyor followed CNA KK and conducted an interview. CNA KK indicated she did not remove her gloves after assisting R41 and before touching clean linens and before entering another resident's room. CNA KK indicated she should have removed her gloves and washed her hands after assisting R41 and before exiting R41's room. On 10/23/24 at 4:34 PM, ADON X (Assistant Director of Nursing) indicated soiled/dirty linens should not be stored on the floor in R41's room. ADON X indicated CNA KK should doff her gloves (take off) and wash her hands after assisting a resident and before handling clean linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 4:05 PM, DON B (Director of Nursing) and NHA A (Nursing Home Administrator) indicated staff are to remove gloves and wash hands after assisting a resident and before handling clean linens. DON B indicated staff are not to store dirty/soiled linens on the floor.