STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525386	A. Building B. Wing	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Health Services	1319 Beaser Ave Ashland, WI 54806

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 17661 Based on interviews and record reviews, the facility did not complete and submit a Significant Change in Status (SCS) Minimum Data Set Assessment (MDSA) within 14 days after determining a SCS has occurred for 1 of 12 residents (R25) reviewed for assessments. This is evidenced by: The facility completed a SCS MDS with an Assessment Reference Date (ARD) of 3/11/23 for R25. The next assessment was due 6/11/23. However, R25 experienced a fall and sustained a fracture of the right hip on 5/21/23, significantly altering the plan of care. R25 returned to the facility from the hospital on 5/24/23. The facility completed a SCS MDSA with an ARD of 6/11/23. However, this assessment was not yet submitted as of 6/27/23. On 6/27/23 at 5:07 PM, Surveyor interviewed Staff K via telephone. Staff K is the Corporate Director of Clinical Reimbursement. Staff K stated that she oversees the MDS schedules and has direct discussions with the facilities regarding changes in residents that would constitute a significant change assessment. Staff K stated that she is the main contact for the MDSA's. Staff K stated that when the assessments are completed, she goes over them to ensure accuracy and then she will submit them. Staff K and Surveyor discussed R25 and the fall with hip fracture. Staff K stated that the team did discuss R25 and determined that R25 is a true significant change and the MDSA should have already been submitted. She will review the MDS to ensure it is completed and will submit later that evening. Surveyor explained the regulation is 14 days after the determination that a significant change occurred. Staff K stated, Yeah, I know that, but it's just easier to wait a bit instead of doing a significant change rather than to have to go back and do another one in another two weeks if they improve. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff K stated that she received an E-Mail from DON B (Director of Nursing) that a SCS MDSA should be completed and that she would provide Surveyor with this E-Mail. On 6/29/23, Surveyor received a copy of this E-Mail. It was submitted to Staff K by DON B on 5/30/23 and indicated that a SCS MDSA should be completed for R25. However, as of the discussion between Surveyor and Staff K on 6/27/23, the SCS MDSA had not yet been submitted.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on record review, the facility did not ensure accuracy of Minimum Data Set Assessments (MDSA) for 2 of 12 residents (R16 and R25) reviewed. - Resident #16 was admitted [DATE]. An admission MDSA was completed with an Assessment Reference Date (ARD) of 1/6/23 in which several critical areas were left blank and not assessed, including that of Cognitive Status, Mood and Pain. - R25 did not have a Significant Change in Status (SCS) MDSA completed timely. When it was completed, the assessment did not include the development of a Stage II Pressure Injury to the Coccyx or the development of an Unstageable Deep Tissue Injury (DTI) to the heel. This is evidenced by: Example 1 R16 was admitted [DATE] with diagnoses that include but are not limited to Hemiplegia and Hemiparesis following Cerebrovascular Infarction affecting right dominant side, Abnormalities of Gait and Mobility, Difficulty walking, Dysarthria following Cerebrovascular Accident (CVA), Aphasia following CVA, Muscle Weakness, Hypertensive Heart Disease with heart Failure, Acute on Chronic Diastolic (Congestive) Heart Failure and Unilateral Primary Osteoarthritis Left knee. In reviewing R16's medical record, Surveyor noted the Admission MDSA was incomplete. The following areas were left unassessed and blank: 1. Cognitive status- Section C0100 asks the evaluator, Should Brief Interview for Mental Status be conducted? The response was coded as yes However, the following sections in Section C were left blank or incomplete: - Section C0200 Repetition of Three Words - Section C0300 Temporal Orientation - Section C0400 Recall - Section C0500 Brief Interview of Mental Status Score - Section C0600 Should the staff assessment for Mental Status be conducted? - Section C0700 Short-Term Memory - Section C0800 Long-Term memory - Section C0900 Memory/Recall Ability (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Section C1000 Cognitive Skills for Daily Decision-Making 2. Mood- Section D0100 asks the evaluator, Should Resident Mood Interview be conducted? The response was coded as Yes however the following sections were not evaluated or completed and left blank: - Section D0200 Resident Mood Interview with D0300 Total Severity Score OR - Section D0500 Staff assessment of mood for non-interviewable resident with D0600 Total Severity Score 3. Section J Health Conditions Section J0100 indicates that resident has been on a scheduled pain medication regimen; Section J0200 asks the evaluator if a pain assessment interview should be conducted. The response was Yes However, the following sections were not evaluated or completed and left blank: - Section J0300 Pain Presence - Section J0400 Pain Frequency - Section J0500 Pain effects on function (difficulty sleeping or limiting day to day activities as a result of pain) - Section J0600 Pain Intensity As of 6/28/23 2:18 PM, Surveyor noted the assessment was not yet modified to reflect R16's true status. Example 2 R25 was admitted [DATE]. Medical Diagnoses for R25 include but are not limited to Diabetes Mellitus Type 2, Cognitive Communication Deficit, Disorder of Bone Density and Structure, Dementia, Polyosteoarthritis, Chronic Kidney Disease- Stage 3, Atherosclerotic Heart Disease and Major Depressive Disorder. On 5/21/23, R25 had a fall and was transferred to the hospital where she was diagnosed with a right hip fracture. R25 returned to the facility on [DATE]. In reviewing the MDSAs completed for R25, Surveyor noted the most recent assessment had an ARD of 3/11/23, which was a SCS assessment. According to the Resident Assessment Instrument, the next assessment was due 6/11/23. This assessment was not yet completed at the time of Survey (6/26/23). On 6/27/23 at 5:07 PM, Surveyor interviewed Staff K via telephone. Staff K is the Corporate Director of Clinical Reimbursement. Staff K stated that she oversees the MDS schedules and has direct discussions with the facilities regarding changes in residents that would constitute a significant change assessment. Staff K stated that she is the main contact for the MDSA's. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated that when the assessments are completed, she goes over them to ensure accuracy and then she will submit them. Staff K and Surveyor discussed R25 and the fall with hip fracture. Staff K stated that the Team did discuss R25 and determined that R25 is a true significant change and the MDSA should have already been submitted. She will review the MDS to ensure it is completed and will submit later that evening. Surveyor reviewed the SCS MDS on 6/28/23 at 2:32 PM and noted two key areas that were inaccurate. They were: 1. The Stage II Pressure Injury on R25's Coccyx (onset date 6/26/23) was not indicated on this assessment. 2. The Unstageable Deep Tissue Injury (DTI) on R25's heel (onset date of 6/26/23) was not indicated on this assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47284 Based on observations, interviews and record review, the facility did not ensure a comprehensive care plan for pain management was achieved for 1 of 12 residents (R) reviewed for care plans (R10). R10 had pain in the perineal area related to vulvar (the outer surface area of female genitals) cancer with radiation burn to the area. The perineal area is the layer of skin between the genitals (vaginal opening) and the anus/sacral area. There was no care plan to direct staff on managing R10's pain. This is evidenced by: Review of the facility policy, entitled Pain Management, dated 8/09/22, states: .The facility .Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences .Based on the evaluation, the facility ., will develop, implement, monitor, and revise as necessary the interventions to prevent or manage each individual resident's pain beginning at admission. The interventions for pain management will be incorporated into the components of the comprehensive care plan, Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences and revise the plan of care as needed . On 6/27/23, Surveyor reviewed R10's medical record to find the following: On 2/03/23, R10 was admitted to the facility with medical diagnoses that include but not limited to, malignant neoplasm of the vulva with radiation burn to the vulva area. R10's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 10. BIMS score ranges from 00-15. 13-15: cognitively intact. 08-12: moderately impaired. 00-07: severe impairment. Surveyor reviewed R10's current pain regimen. According to the physician's orders, R10 had the following orders related to pain control: *Observation: Pain - Observe every shift. If pain is present, complete the pain flow sheet and treat it by trying non-pharmacologic interventions prior to medicating if appropriate. Document in the progress notes. Start date 2/03/23. *Apply a frozen perineal pad to the perineal area for discomfort as needed (PRN) every 3 hours. Start date 3/16/23. *Saline gauze to the perineal area for comfort PRN 3 times daily. Start date 3/16/23. *Gently wash the vulvar and sacral area daily with soap and water, rinse, and pat dry. Apply the Silvadene cream to the vulva one time a day related to burn of unspecified body region, unspecified degree. Start date 3/27/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Prophylactic wound care to sacrum - Keep the sacral area covered with sterile bordered gauze wound dressing with an adhesive border 4 x 4 every 3 days and PRN. Apply a thin layer of Vaseline or Aquaphor to the vulvar/vaginal area to protect the skin from urine. Change undergarments frequently throughout the day. Start date 6/26/23. *Monitor areas of impaired skin integrity (perineal area and left lower extremity) - Monitor areas for redness and report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Start date 6/26/23. *Medicated Pads External Pad (Witch Hazel (Hamamelis Virginiana)) Apply to vaginal area topically PRN for burns related to burn of unspecified body region, unspecified degree. Start date 4/13/23. *Silvadene External Cream 1 % (Silver Sulfadiazine) Apply to the vulva topically everyday shift related to malignant neoplasm of overlapping sites of the vulva. Apply a very thin layer to the vulva daily. Start date 3/16/23. *Tylenol 1000mg every 12 hours PRN for pain. Start date 4/28/23. *Tylenol 500mg two times a day for pain. Start date 2/03/23. *Tramadol 12.5mg every 4 hours PRN for pain related to malignant neoplasm of the vulva. Start date 6/27/23. A review of R10's care plan revealed no comprehensive care plan developed to direct staff in R10's care and needs concerning pain control. A review of R10's Certified Nursing Assistant (CNA) Kardex (care plan) also revealed no information on how to specifically care for R10 during perineal cleaning or information about R10's pain control. On 06/26/23 at 2:59 PM, R10 told this Surveyor that she had pain in the private area. R10 said it hurts her at times while sitting and is worse with having to be cleaned up. R10 said she had pain at this time while sitting up in her wheelchair. R10 had a grimacing facial expression during this time. On 06/27/23 at 11:10 AM, R10 was in the physical therapy room working with physical therapy assistant (PT) I. Surveyor asked R10 if she had any pain in the private area at this time. R10 stated she had some pain in the area now. Surveyor asked PT I if R10 had pain often in that area. PT I said yes, that is where her cancer is located. On 06/27/23 at 12:25 PM, Surveyor interviewed Certified Nursing Assistant (CNA) D concerning R10's pain in the private (perineal) area. CNA D stated R10 had told her it was painful in the area. CNA D stated R10 appeared to be in pain when cleaning the perineal area. Surveyor asked what did CNA D do if R10 was in pain. CNA D said she would tell the nurse that R10 was in pain to see if there was anything the resident could get for the pain. On 06/27/23 at 12:30 PM, Surveyor spoke with Registered Nurse (RN) H concerning R10 being in pain. RN H stated she received in report that R10 had a painful perineal area due to cancer. R10 was getting Silvadene treatment for the area of the pain. RN H said she was unaware of anything else specifically used for R10's perineal pain. RN H said R10 does get scheduled Tylenol for pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/23 at 12:35 PM, Surveyor spoke with the Director of Nursing (DON) B concerning R10's pain in the perineal area. DON B said the pain for R10 was not constant. It was worse when sitting for a long time or during cares. Silvadene was applied as scheduled and medicated pads have been ordered for the pain if needed. DON B stated the area had improved. On 06/28/23 at 7:53 AM, Surveyor spoke with CNA C about how perineal care went for R10 regarding pain. CNA C stated R10 did not have much pain during perineal care, but more so when R10 was sitting. CNA C stated she was extra gentle when doing perineal care to R10 due to vulvar cancer with radiation burn. Surveyor asked how a new CNA would know how to care for R10's perineal area. CNA C stated she would tell the new staff about how to properly care for R10's perineal area and there should be information on the Kardex about this. On 06/28/23 at 8:04 AM, Surveyor spoke with the Nursing Home Administrator (NHA) A to obtain the reviewed documentation for R10. Surveyor asked for R10's care plan concerning pain, CNA Kardex, facility policy on pain management, physician orders, administration records, and pain assessments. On 06/28/23 at 11:22 AM, NHA A provided the requested documentation for R10 to this Surveyor. NHA A stated they just noticed there was no care plan for R10 concerning pain, so they developed one today.

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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** 44863 Based on interview, observation and record review, the facility did not ensure all residents received treatment and care in accordance with professional standards of practice for 1 of 1 residents (R9) sampled for skin integrity out of a total sample of 12. R9 developed Moisture Associated Skin Damage (MASD) while residing in the facility. R9's schedule for offloading the area was not followed. R9 was having loose bowel movements that irritate and excoriate the skin; there was no follow up with the provider to reduce the laxatives to promote healing of the MASD. R9's MASD worsened, becoming larger in size and a new area of MASD developed. Findings include: The facility policy titled Pressure and Non-pressure Injuries, dated 8/2/21, states: .For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. R9 was admitted to the facility on [DATE]. Diagnoses include dementia, seizures, stroke affecting left side, depression, and anxiety. R9 has an activated Power of Attorney (POA) to assist in making healthcare decisions. A Minimum Data Set (MDS), dated [DATE], confirmed R9 is understood and understands others. R9 scored an 8/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R9's care plan includes the following: 1. Activities of Daily Living (ADLs), interventions include: -12/10/20, I am typically incontinent of bladder, but usually continent of bowel. -1/20/23, Bariatric mattress and bilateral assist bars on bed for positioning and mobility. -1/21/23, Toilet use: . He is to be helped to the TOILET in the shower room per his request, with routine cares, during rounds and as needed. OK for check and change while in bed if he desires. -6/9/23, upright and out of bed for all meals, as patient tolerates. 2. Resident has actual skin integrity break - MASD to coccyx and open area to left buttocks secondary to incontinence-associated dermatitis, interventions include: -2/2/23, Turn and reposition to limit as much time as possible off coccyx. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	3. Potential for Constipation related to medications, interventions include: -9/3/20, Monitor for frequency of bowel movements and administer softeners and laxatives as needed per MD orders. 4. Urinary Incontinence, interventions include: -1/21/23, During daytime hours: Provide incontinence and peri care upon waking, 30-60 minutes after all meals, at bedtime. During night hours: must be changed with each round (approximately every 2 hours). On 12/7/22, nursing documented that R9 was .Presenting with bilateral upper and lower extremity weakness, a decline in transfers status and a decline in self-care management skills . R9 was referred for physical and occupational therapies. Surveyor reviewed the Braden Scale for Predicting Pressure Ulcer Risk completed for R9 and noted the following: - 11/13/22 scored R9 as a moderate risk for the development of Pressure Injuries (PI.) - 12/13/22 scored R9 a moderate risk, as above. SKIN INTEGRITY: On 12/18/22, nursing documented .noted redden area on the sacral area with small amount of bleeding . Nurse reported using Mepilex during last dressing change. No dressing intact. This nurse cleaned the area with wound cleanser and dried and applied Mepilex dressing to the sacral area . Note: Surveyor was unable to locate this treatment order in record. On 12/20/22, documentation was noted that R9 had a dark reddish rash with superficial top layer of skin excoriated to gluteal cleft extending 10-12 cm (centimeters) long (L) by 4.5-5 cm wide (W) on both buttocks. On 12/28/22, R9 developed a facility-acquired breakdown to the coccyx. A treatment was ordered by the physician on 12/29/22, but there was no assessment of the area located. There is no documentation describing if this is a pressure injury or MASD. The first measurements of this area after 12/20/22, were dated 2/1/23 in which documentation indicated the area was 9.0 cm L x 15 cm W x 0.1 cm deep. This is 35 days after the area was first noted, with increase in width and depth. On 2/14/23, R9 was seen at the wound clinic in which they ordered R9 to be up in wheelchair for 1 hour at each meal and otherwise in bed to offload coccyx. R9 had no further appointments at the wound clinic. Surveyor then reviewed most recent documentation of the skin breakdown. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- 6/9/23 Left buttock 3.5 x 1 cm x 0.1 Note: This area is actually the right buttock, making this entry inaccurate. There is no mention here of the MASD to the coccyx. - 6/12/23: continues with MASD to coccyx. Facility identified a new area to the left buttock, which again, is actually the right buttock. - 6/13/23: treatment order for left buttock (note that actual area is right buttock.) Inaccurate documentation of the location of the MASD continues. - 6/13/23 new treatment orders were received: - COCCYX: cleanse, apply calazime and cover with bordered sacral foam 7.2 x 7.2 dressing every 3 days and as needed for prophylaxis - LEFT BUTTOCKS: cleanse, apply calazime and cover with bordered foam 4 x 4 dressing every 3 days and as needed for prophylaxis (note that actual area is right buttocks.) - 6/19/23, Left buttock MASD angry red, 3.5 cm x 4 cm x 0.1 cm (note that actual area is right buttocks.) Note: This is an increase in size from 6/9/23 - 6/23/23, Left buttock MASD angry red, 3.5 cm x 4 cm x 0.1 cm (note that actual area is right buttock). The angry red description indicates increased inflammation of the skin. Surveyor observed R9 throughout the survey and noted the following: On 6/26/23 at 10:30 AM during the screening process of the survey, R9 was not in his room. Surveyor noted that R9 had a regular mattress on his bed. Surveyor located R9 attending an activity. He was sitting in his wheelchair. At 1:37 p.m., Surveyor observed staff transfer R9 into bed with mechanical lift. Note: According to Wound Clinic orders stated above, R9 is to be up for 1 hour at each meal, then placed into bed in order to offload the pressure sustained to the coccyx. R9 had been observed by Surveyor up in his wheelchair for over three hours. On 6/27/23 at 7:45 AM, R9 was up in his wheelchair in his room. He was assisted to the dining room at 7:48 AM. At 9:18 AM, Surveyor noted R9 was still up in the wheelchair. Surveyor interviewed CNA E (Certified Nursing Assistant) regarding R9's skin condition and care needs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	CNA E stated that R9's .butt is horrible, it has been a problem . CNA E continued to state that staff are changing and repositioning him every hour. He is to be up for all meals. CNA E continued to state that R9 has a cushion in the wheelchair and in bed, uses bilateral grab bars for repositioning side to side. She stated that R9 will grab the bars but still needs help by staff. At 11:15 AM, Surveyor observed staff use a mechanical lift to transfer R9 into bed. Surveyor observed incontinence care provided. R9 was observed by Surveyor to be up in wheelchair approximately 3.5 hours. At 2:56 PM, Surveyor interviewed Director of Nursing (DON) B regarding R9's skin. DON B stated that R9's coccyx wound changes, it will improve then worsen. DON B stated that she believes R9 is having increased incontinence, and this is causing his MASD. She confirmed that R9 does not have an air mattress on his bed as he chose to have repositioning bars. According to facility policy, DON B stated that a resident cannot have both an air mattress and repositioning bars. On 6/28/23 at 11:26 AM, Surveyor observed staff providing perineal cleansing on R9, as well as the treatment to the buttocks by DON B. There was a dressing that was intact in which DON B removed. Surveyor observed a large, reddened area, with damage to the top layer of skin across gluteal cleft and extending down and across both buttocks. There was also a small red open area in the fold of the right buttock and right thigh, in which there was no dressing in place. DON B measured the area to be: - Coccyx 12 cm length x 14 cm width. The coccyx last measurement on 2/1/23, was 9 cm long x 15 cm width x 0.1 cm depth. This areas has increased length and width noted on Surveyor observation. - Right Buttock 4 cm length x 3 cm. width. Note: The prior measurement of the right buttock on 6/23/23 was 3. 5 cm x 4 cm x 0.1 cm. This indicates worsening of the MASD. BOWELS: R9 was receiving the following medications to prevent constipation: - Miralax 17 grams twice daily for constipation - Milk of Magnesia 30 ml once daily - Docusate sodium 100 mg give two tablets at bedtime - Senna Plus 8.6-50 mg twice daily On 5/7/23, nursing documented that a request was made to the Physician to decrease Miralax (laxative) to once daily related to explosive bowel movements in the evening. The Physician responded to the facility request via facsimile that R9's bowel routine would be addressed on rounds with a visit planned for either 5/10 or 5/17. Facility monitored R9's bowels and Surveyor noted the following: (continued on next page)

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	525386	A. Building B. Wing	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Health Services	1319 Beaser Ave Ashland, WI 54806

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- From 5/1/23-5/31/23, 26 of 29 bowel movements were documented as being watery/diarrhea. - From 6/1/23-6/28/23, 11 of 24 bowel movements coded as watery/diarrhea. The watery diarrhea on a frequent basis would excoritate R9's skin, increasing skin breakdown. As of 6/27/23, Surveyor was unable to locate that R9's bowel routine was addressed. On 6/27/23 at 2:51 PM, Surveyor interviewed DON B regarding request to provider to decrease Miralax to once daily. DON B stated that she did not think provider had completed rounds. DON B requested provider documentation of most recent nursing home rounds. Documentation supports provider completed rounds on 5/18/23 and 6/16/23, with no new orders for laxative medication. On 6/28/23 at 8:57 AM, interview with CNA F, who stated that he works with R9, and he is aware that R9 is on several medications for bowel regulation. CNA F reported that R9 has a bowel movement every few days, maybe every other day, and bowel movements are watery, like diarrhea, and explosive. On 7/6/23 at 2:00 PM, Surveyor interviewed MD N (Medical Doctor for R9). MD N stated that he had several conversations over the past few months regarding the skin damage. He stated that he received a fax from the facility regarding the loose stools and facility wanting to decrease the bowel meds. R9 has long-standing constipation and any changes to the bowel medication routine will cause a potential issue. MD N stated that he dislikes fax messages as they do not allow discussion, so he telephoned the facility and spoke with the nurse on duty at the time. He stated they discussed R9's history of constipation and his normal pattern. MD N stated that R9's normal pattern is that his bowels are loose for 6-7 days then he goes 2-3 days without any bowel movements. He then indicated that he thought the loop was closed on the matter, but it appeared to go sideways and he learned that the loop really wasn't closed after the State Surveyors were in the building. On 6/29/23, he telephoned DON B and discussed R9's bowel program further, after surveyors left the building. MD N stated that he made a small change in R9's bowel program and doesn't want to do any dramatic changes. There is no evidence that follow-up with R9's physician was completed regarding the laxatives R9 is currently receiving, and the ongoing diarrhea and loose stools, which are contributing factors for R9's skin breakdown.

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F 0686 Level of Harm - Minimal harm or potential for 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** 17661 Based on observations, interviews and record reviews, the facility did not ensure 2 of 4 residents (R25 and R27) reviewed for high risk of Pressure Injury development received the necessary treatment and services to promote healing of existing skin impairments or prevent new pressure injuries from developing. - R25 has an existing PI to her coccyx and a Deep Tissue Injury (DTI) to her right heel. An observation was made of 3 hours 49 minutes in which staff did not offer or attempt repositioning or toileting. - R27 is high risk for the development of PIs. R27 was observed for 4 hours 29 minutes in which she was sitting in a Broda chair without staff offering or attempting to reposition or toilet. This is evidenced by: According to the NPIAP (National Pressure Injury Advisory Panel) 2019, page 115, . Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. The underlying cause and formation of pressure injuries is multifaceted; however, by definition, pressure injuries cannot form without loading, or pressure, on tissue. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues and, ultimately, in tissue damage . According to Wound Care Education Institute (2018), for immobile or bed bound individuals, a full change in position should be conducted a minimum of every two hours. Some individuals require more frequent repositioning due to their high risk status. The facility Policy and Procedure titled Pressure Injuries and Non-Pressure Injuries, dated 8/2/21 and last reviewed/revised 7/20/22 states in part, The center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents . Under the section of Care Planning, the policy states under Activity, . If a resident is chair bound or bed bound, provide good positioning, good support surface and scheduled repositioning in the plan . Example 1 R25 has Medical Diagnoses that include but are not limited to Fracture of the Right Femur, Cognitive Communication Deficit, Diabetes Mellitus Type 2, Muscle Weakness, Lack of Coordination, Disorders of Bone Density and Structure, Alzheimer's Disease, Dementia, Chronic Kidney Disease (CKD) Stage 3 and Mild Major Depressive Disorder. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Minimum Data Set Assessment (MDSA) was a Significant Change in Status (SCS) assessment dated [DATE] (Assessment Reference Date). According to this assessment, R25 requires extensive assistance of staff to meet her most basic needs of bed mobility, personal hygiene, toileting, bathing and dressing. R25 is non-ambulatory related to the recently acquired right hip fracture. R25 is also incontinent of bowel and bladder status. Observations were made throughout the survey (6/26/23 - 6/28/23) in which R25 remained on bedrest. Surveyor reviewed the Braden Scale For Predicting Pressure Sore Risk Assessments completed for R25 and noted the most recent was dated 6/26/2023, which scored R25 a number of 13. According to this assessment scores between 13-14 indicate a moderate risk for the development of a PI. Surveyor reviewed the Care Plan (CP) developed for R25 and noted the following plans: 1. Resident is at risk for skin integrity condition, or pressure sores r/t: Impaired mobility, Thin/Fragile skin (Initiated 5/11/21). The goal of this plan was The Resident will not develop pressure related tissue injury through next care plan review date. Interventions included in this plan were: - Apply alternating pressure air mattress to bed if indicated. Assure proper inflation - check frequently. - Apply pressure reduction chair cushion on wheelchair and pressure reduction mattress on the bed. Ensure cushion is properly placed, clean and dry - Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately - Avoid friction/shearing while repositioning: if Resident is unable to assist, use at least two staff members, use lift sheet, bed should be as flat as possible with lifting. - Frequent repositioning in bed and chair. 2. I have a physical functioning deficit related to: Self care impairment (Initiated 5/12/21 last revised 6/20/23). Interventions for this plan included: - BED MOBILITY: assist x1. Provide reminders/cueing to turn and reposition with routine cares, during rounds, as needed and per request. (Initiated 5/12/21 and last revised 5/ 25/23) - BLADDER: . is incontinent of bladder. - BOWEL: [R25] is sometimes incontinent of bowel - TOILETING: Max assist x 2. She isn't always able to make toileting needs known and frequently declines help to use bathroom Offer toileting assistance with routine cares, during rounds, as needed and per request. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Actual impaired skin integrity surgical incision to right hip and open area (Moisture Associated Skin Damage) to right buttocks, pressure injury to right heel. Note: On 6/1/23, this plan was revised to reflect surgical incision to right hip and open area (MASD) to right buttocks. This was again revised on 6/26/23 to reflect the pressure injury to the right heel, but not yet revised to reflect the Stage II PI to the coccyx. Interventions for this plan included: - Dressings in place to buttocks and right heel. If dressing is not in place, or needs to be replaced, notify nurse immediately. - Encourage and assist as needed to turn and reposition; use assistive devices as needed - Float heels as able - Special mattress/cushion on bed/wheelchair (AIR MATTRESS) - Use pillows and/or positioning devices as needed Further review of R25's Medical Record revealed the development of Moisture Associated Skin Damage to the Right Buttock on 6/1/23 and the development of an initial Stage II blister to the right heel on 6/26/23. On 6/27/23, Surveyor observed R25 from 6:40 AM - 10:29 AM in which no offers or attempts were made to reposition resident (3 hours 49 minutes). The observation was as follows: - At 6:40 AM, R25 was noted to be lying in bed on her back with the upper part of her body, waist to neck, leaning to her left side. She was sitting up at a 90 degree angle. She was asleep and remained in this position until 7:48 AM, when DON B (Director of Nursing) entered the room with R25's meal tray. There was no offloading or toileting completed at that time. Surveyor noted R25 to still be at 90 degrees with the meal tray positioned over the bed and in front of the resident. She had a waffle with syrup, scrambled eggs, a bowl of oatmeal, 4 ounces of orange juice, 8 ounces of milk and coffee on the tray in front of her. - At 8:12 AM, R25 was nearly finished with her meal. - At 9:26 AM Speech Therapy and Occupational Therapy entered the room to work with R25. They were both in the room together and left at 9:36 AM. There was no repositioning of R25 at that time and she was again noted by Surveyor to still be in the 90 degree position in bed. - No additional staff entered the room after the two therapy staff left the room. At 10:00 AM, Surveyor approached CNA D (Certified Nursing Assistant) and asked what R25's care needs were. CNA D stated that R25 is able to perform some of her cares but relies on staff assistance for toilet changes and repositioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked if she assisted R25 yet on this date, CNA stated that she did not. She reported to duty at 9:00 AM and was not sure yet, what tasks needed yet to be completed on the unit. At 10:10 AM, Surveyor approached CNA C and asked her what R25's care needs were. CNA C also stated that R25 requires assistance of staff to toilet her, often refuses and is currently being transferred with a mechanical lift related to the recent hip fracture. CNA C stated R25 is incontinent of bowel and bladder and does not inform staff of the need to be changed. CNA C stated R25 was to be repositioned every two hours. Surveyor then asked CNA C why R25 was not yet repositioned for the morning. CNA C stated that when she first came on duty at 6:00 AM, she was told there were staff on the unit doing cares. She learned at 6:20 AM that no staff was actually on the unit so she came down to the unit to work. She indicated she was behind schedule as a result. She had not yet been able to assist R25. After learning that R25 had not yet received toileting or repositioning for this morning, CNA C stated she would take care of R25 now. She entered R25's room at 10:15 AM along with CNA D. Surveyor observed the bathing activity. Upon rolling R25 onto her left side at 10:29 AM, Surveyor noted the incontinent brief was wet with urine and there was a soiled dressing on R25's coccyx. CNA C removed the dressing and revealed a Stage II PI over the coccyx bone, surrounded by macerated skin damage extending approximately 2 centimeters (CM) outward. She had an approximately 5 inch surgical wound over her right hip and a Deep Tissue Injury to her right heel that did not contain a dressing. CNA C left the room to report to RN H (Registered Nurse) that a new dressing needed to be applied to R25's coccyx. At 10:31 AM, RN H entered the room to apply Mepilex to the open area. The open area measured approximately 0.5 CM in diameter. RN H also examined the DTI to the right heel. It was flush with the skin and there was no fluid contained to the area. It measured approximately 3.5 cm x 2.0 cm and appeared as a purple bruise. Both CNA D and CNA C were unaware of the DTI or the coccyx wound. Also, RN H stated this was the first she had knowledge of either wounds, even though a dressing was in place on the coccyx. At 10:43 AM, DON B (Director of Nursing) entered the room and stated a dressing of a bordered foam was supposed to be in place and both DON B and RN H searched for the missing dressing in R25's bed and in the heel boots that were sitting on R25's wheelchair. They also searched the garbage can and were unable to locate the old dressing. DON B stated that she removed the boots when she set R25 up for the morning meal. R25 did not want them on through the meal. Surveyor asked DON B what the expectation for dressings to wounds and repositioning R25 was. DON B was reluctant to give Surveyor a time schedule but upon further questioning, stated R25 should be repositioned at least every two hours and whenever a dressing comes off, CNA staff were to notify the nurse to have it replaced. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note: A period of 3 hours and 49 minutes was noted in which R25 was not offered or encouraged to be repositioned. Further review of the Interdisciplinary Progress Notes indicated no entries in which R25 refused repositioning or toileting. Example 2 R27 was admitted on [DATE]. Medical Diagnoses for R27 include, but are not limited to Dementia, Major Depressive Disorder, Obstructive and Reflux Uropathy, Polyosteoarthritis, Generalized Anxiety Disorder and Radiculopathy of the Lumbar Region. On 11/19/22, R27 was admitted to the hospital following a fall in which she sustained a left hip and left elbow fracture. She returned to the facility 11/21/22, and enrolled in Hospice Services on 11/22/22. According to the most recent Minimum Data Set Assessment (MDSA), which was a Quarterly assessment with an Assessment Reference Date of 6/3/23, R27 requires extensive assistance of staff to meet her most basic tasks of bed mobility, toileting, personal hygiene and dressing. She is dependent on staff for bathing and transfers, is non-ambulatory and is incontinent of bowel and bladder function. R27 also has impaired short and long term memory and severely impaired daily decision-making abilities. R27 is 63 inches tall and last recorded weight was on 6/24/2023, in which R27 was 80.2 pounds. Surveyor then reviewed R27's Care Plan and noted the following included concerns: 1. I have a physical functioning deficit related to: Mobility impairment, Self care impairment (Initiated 9/2/22 and last revised 1/5/23) Interventions included: - assist of one for bathing - staff assist for bed mobility. Staff to turn and reposition during routine cares, with rounds, as needed and per request - Incontinent of bowel and bladder - Enrolled in hospice. Work with nursing, IDT and hospice team and family as resident declines to determine level of assist needed to ensure needs are met, with dignity, without having to express them while maintaining comfort. Provide staff assist accordingly - May be up in Broda chair if she chooses. Therapy recommending supervision while in Broda chair. - Total dependence for personal hygiene - Total dependence for toileting; check and change. Assist with routine cares, during rounds, as needed and per her request. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Transfers: may pivot transfer on Right Lower Extremity to chair if she can tolerate movement. Non-weight bearing left upper Extremity. May use Hoyer lift if transfers aren't tolerated. Full body sling size small. 2. Resident is at risk for skin integrity condition, or pressure sores r/t: Impaired mobility, Recent illness/surgery, Thin/Fragile skin (Initiated 9/2/21) Interventions for this plan included: - Frequent repositioning in bed and chair. The most recent Braden Scale For Predicting Pressure Sore Risk was completed for R27 on 12/14/22 and scored R27 a 12, indicating High Risk (High Risk is for scores of 10-12). There were no additional assessments completed after this. On 6/27/23, Surveyor made the following observation: - At 6:40 AM, R27 was sitting up in a Broda chair in the Unit 3 dining room. R27's legs were slightly extended and she was fiddling with the lap blanket over her legs and the straps to the mechanical lift sling, which were under her legs. She remained this way until her meal was served. - At 7:35 AM, R27 was served her meal of a waffle and scrambled eggs with a bowl of cream of wheat, 4 ounce orange juice, 4 ounce health shake and an 8 ounce milk and coffee. Surveyor monitored R27 while she was eating. - At 8:10 AM, R27 had eaten all of the waffle and eggs and one-half of the cream of wheat, She had take approximately 1 ounce of the shake but no other liquids. The meal tray was removed from in front of her. - At 9:01 AM, R27 was still up in the Broda chair at the table in the Unit 3 dining room. No staff had yet approached to offer or encourage toileting or repositioning. - At 9:10 AM, AA M (Activity Aide) began to set the room up for an activity and placed R27 and two other residents into a partial circle. She then left the room to retrieve additional residents. - At 9:30 AM, the activity began, it was Daily Chronicles followed by Exercise. R27 listened intently but did not participate in either program. - At 10:30 AM, the two programs had ended and R27 remained in the room. - At 11: 02 AM, CNA D and CNA C (Certified Nursing Assistants) removed R27 from the dining room and took her to her room to perform cares. Surveyor followed. - R27 was assisted onto the bed via a mechanical lift at 11:09 AM and rolled onto her side at that time to remove her pants and the heavily urine saturated incontinent brief. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's buttocks was dark red but no open areas were noted. Surveyor continued to observe while CNA C cleansed R27 and placed a clean incontinent brief on her. Surveyor then asked both CNAs what time R27 was assisted to the Broda chair. Neither staff knew the time but stated that R27 was assisted by the night shift staff, which would have been before the day shift started at 6:00 AM. Surveyor then explained that R27 was being observed since 6:40 AM and there were no offers or attempts made to reposition and asked why the cares were not performed for this length of time. CNA C stated that she arrived to work at 6:00 AM and was told there was staff down on the unit doing cares. She learned at 6:20 AM that there was no staff on the unit so she came down. As a result, she was already 20 minutes behind in her tasks. CNA C stated R27 should have been repositioned every two hours but, . I guess we were just busy today. It got really busy. Note: This was a 4 hour 29 minute period of time in which R27 was not offered or attempted toileting or repositioning.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews and record reviews, the facility did not ensure 1 of 3 residents (R25) reviewed for Urinary Tract Infections (UTIs) received the necessary treatment and services to prevent infections and to restore continence to the extent possible. R25 is currently being treated for an active UTI with antibiotic therapy. An extended observation was made of 3 hours 49 minutes in which toileting or incontinence care was not provided for R25 to keep R25 clean and prevent infection. This is evidenced by: The Long-Term Care Nursing Desk Reference. HCPro, Inc. Chapter 13, pages ,d+[DATE] offers the following discussion on urinary incontinence in Long Term Care: . Incontinence is a medical problem that is, in many instances, beyond the resident's control. Incontinence is not a normal consequence of aging and can frequently be cured or improved . Most believe that toileting residents every two hours is the best means of keeping them dry, when in fact this is a dated and ineffective method. Effective urinary management is assessment-based and individualized to the resident. Incontinence management is a 'catch' program that keeps residents dry . R25 has Medical Diagnoses that include but are not limited to Fracture of the Right Femur, Cognitive Communication Deficit, Diabetes Mellitus Type 2, Muscle Weakness, Lack of Coordination, Disorders of Bone Density and Structure, Alzheimer's Disease, Dementia, Chronic Kidney Disease (CKD) Stage 3 and Mild Major Depressive Disorder. On [DATE], R25 was diagnosed with a UTI for which antibiotic therapy was prescribed. The most recent Minimum Data Set Assessment (MDSA) was a Significant Change in Status assessment dated [DATE] (Assessment Reference Date). According to this assessment, R25 requires extensive assistance of staff to meet her most basic needs of bed mobility, personal hygiene, toileting, bathing and dressing. R25 is also incontinent of bowel and bladder status. Note: Following discussions with facility staff, the facility did submit a delayed SCS MDSA with ARD of [DATE]. There were no changes noted to the above listed areas of physical functioning of R25 in this new assessment. Observations were made throughout the survey ([DATE] - [DATE]) in which R25 remained on bedrest. Surveyor reviewed the Care Plan (CP) developed for R25 and noted the following plans: 1. Urinary Tract Infection, potential or actual due to: History of urinary tract infections (Initiated [DATE] and last revised [DATE]). The goal for this plan was Urinary tract infection will resolve without complication. Interventions for this plan included: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assist with toileting or incontinence care as needed 2. I have a physical functioning deficit related to: Self care impairment (Initiated [DATE] last revised [DATE]). Interventions for this plan included: - Assist of one for bed mobility. Provide reminders/cueing to turn and reposition with routine cares, during rounds, as needed and per request. (Initiated [DATE] and last revised 5/ ,d+[DATE]) - Incontinent of bladder. - Sometimes incontinent of bowel - Toilet with assist of two. She isn't always able to make toileting needs known and frequently declines help to use bathroom Offer toileting assistance with routine cares, during rounds, as needed and per request. 3. Alterations in genitourinary system AEB (as evidenced by): Urinary incontinence r/t (related to): impaired mobility & CKD (Initiated [DATE] last revised [DATE]) Interventions for this plan included: - Adjust toileting times to meet resident's needs - Provide assistance with toileting - Provide incontinent care as needed 4. Actual infection UTI (Initiated [DATE]). Interventions for this plan included: - Monitor for side effects from antibiotic therapy and report to physician if present. - Offer and encourage adequate intake of fluids. - staff to use good clean hygiene techniques when providing peri care. Further review of R25's Medical Record revealed the development of Moisture Associated Skin Damage to the Right Buttock on [DATE] On [DATE], Surveyor observed R25 from 6:40 AM - 10:29 AM in which no offers or attempts were made to reposition resident (3 hours 49 minutes). The observation was as follows: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 6:40 AM, R25 was noted to be lying in bed on her back with the upper part of her body, waist to neck, leaning to her left side. She was asleep and remained in this position until 7:48 AM, when DON B (Director of Nursing) entered the room with R25's meal tray. There was no offloading or toileting completed at that time. Surveyor noted R25 to be at 90 degrees with the meal tray positioned over the bed and in front of the resident. She had a waffle with syrup, scrambled eggs, a bowl of oatmeal, 4 ounces of orange juice, 8 ounces of milk and coffee on the tray in front of her. - At 8:12 AM, R25 was nearly finished with her meal. - At 9:26 AM, Speech Therapy and Occupational Therapy entered the room to work with R25. They were both in the room together and left at 9:36 AM. There was no repositioning of R25 at that time and she was again noted by Surveyor to still be in the 90 degree position in bed. - No additional staff entered the room after the two therapy staff left the room. At 9:10 AM, Surveyor approached CNA D (Certified Nursing Assistant) and asked what R25's care needs were. CNA D stated that R25 is able to perform some of her cares but relies on staff cues. She requires staff assistance for toilet changes and repositioning. When asked if she assisted R25 yet on this date, CNA stated that she did not. She reported to duty at 9:00 AM and was not sure yet, what tasks needed yet to be completed on the unit. At 10:10 AM, Surveyor approached CNA C and asked her what R25's care needs were. CNA C also stated that R25 requires assistance of staff to toilet her, often refuses and is currently being transferred with a mechanical lift related to the recent hip fracture. CNA C stated R25 is incontinent of bowel and bladder and does not inform staff of the need to be changed. CNA C stated R25 was to be repositioned every two hours. Surveyor then asked her why R25 was not yet toileted or given incontinence care for the morning. CNA C stated that when she first came on duty at 6:00 AM, she was told there were staff on the unit doing cares. She learned at 6:20 AM that no staff was actually on the unit so she came down to the unit to work. She indicated she was behind schedule as a result. She had not yet been able to assist R25. After learning that R25 had not yet received toileting or incontinence cares for this morning, CNA C stated she would take care of R25 now. She entered R25's room at 10:15 AM along with CNA D. Upon rolling R25 onto her left side at 10:29 AM, Surveyor noted the incontinent brief was wet with urine, causing a potential for further urinary tract infection issues.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, interview and record review, the facility did not ensure a resident maintains acceptable parameters of nutritional status and weight. This affected one of four residents Resident (R) 9, reviewed for nutrition and hydration. R9 was not provided the ordered supplement to maintain nutritional pararmeters, adaptive equipment was not provided as indicated on the care plan, facility did not follow up on dietician recommendations for multi-vitamin, nor was R9's intake accurately recorded by staff to ensure adequate nuritional intake. This is evidenced by: R9 admitted to facility 12/11/2017. Diagnoses include dementia, seizures, stroke affecting left side, depression, and anxiety. R9 has an activated Power of Attorney (POA) to assist in making healthcare decisions. Minimum Data Set (MDS), dated [DATE], confirmed R9 is understood and understands others. R9 scored an 8/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R9's care plan includes the following: At risk for nutritional status change, interventions include: -11/25/22, Adaptive equipment: red handled silverware, black handled knife, regular soup spoon. -2/9/23, Provide supplements as ordered: Sysco shake 4o.z or NJ supplement 6o.z daily for nutritional support. Nurses notes 12/28/22, R9 needing more assistance with breakfast and lunch meals. 1/1/23, weight #195.2. 1/26/23, nutritional assessment completed, no recommendations. 2/3/23, nutritional assessment, coccyx is worsening, overall downward weight trend. Sysco shake once daily added for nutritional support. 2/9/23, Weight #190.7, -2.31% from 1/1/23. 2/20/23, Weight #184.3, -5.58% from 1/1/23. 2/22/23, Nutritional assessment, significant weight change present. 2.5% weight decrease x 30 days (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8.2% decrease x 90 days, 7.3% decrease x 180 days. Consider multi-vitamin with minerals. Unable to locate documentation that recommendation for multi-vitamin with minerals was considered. Surveyor noted no follow through with the multivitamin was completed, to maintain R9's nutritional status. 3/11/23, Weight #184.2, -5.64 from 1/1/23. 3/23/23, Nutritional assessment, -5.8% in one month. Sysco shake three times daily. Surveyor notes this is the first nutritional intervention added since 2/9/23, as R9 has continued to lose weight. 6/6/23, Weight #175.4, -10.14% from 1/1/23. 6/8/23 Nutritional assessment, weight down -10.3% in 6 months. Recommend staff provide assistance and encouragement with meals. 6/19/23, Weight #183.2 6/26/23 at 12:26 PM, Surveyor observed R9 eating in dining room. Certified Nursing Assistant (CNA) C was exiting the dining room. CNA C stated that she was assisting R9, but today he is doing well with eating independently. CNA C exited the dining room. Surveyor observed R9 ate approximately 25% of his meal, including a portion of chopped steak and a chocolate eclair. R9 had a coffee cup with chicken broth, a coffee cup with hot chocolate, and a glass of milk on his tray. R9's utensils were a black handled fork, regular spoon, and regular knife. R9's meal ticket showed he should be using a black handled knife and red handled silverware. His drinks should also include fruit punch and house shake; these were not noted on R9's tray. 6/26/23, review of record, staff documented that R9 ate 51-75% of meal, and MAR indicated 100% intake of Sysco shake. This is not accurate, as Surveyor observed actual intake for this meal of 25%. 6/27/23 at 7:48 AM, staff brought R9 to the dining room. R9's tray consisted of a black handled fork, regular spoon, and regular knife, and should be using black handled knife and red handled silverware. No Sysco or house shake was noted on R9's tray. MAR indicated 100% intake of Sysco shake. Again, this meal intake for the Sysco shake is inaccurate as Surveyor observed that it was not provided. During dining room observations, it was noted that administrative staff completed meal supervision in the dining room. Nursing Home Administrator (NHA) A confirmed and provided the schedule of staff including NHA, DON, Maintenance, Business Office Manager, and Social Worker. Surveyor did not observe staff documenting intakes during observations. 6/27/23 at 2:56 PM, interview with Director of Nursing (DON) B, stated that that R9's Sysco shakes come on his meal tray. Surveyor noted that these had not been observed on R9's meal tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/27/23 at 4:29 PM, interview with Registered Nurse (RN) L, stated that R9 receives Sysco shake on his meal tray. Surveyor asked how a nurse knows what R9's intake of shake was, and she stated a nurse would have to check his tray in dining room. Surveyor reported to RN L that during dining observations, noted no nurse checked R9's tray for intake of shake. RN L stated that she was very busy and needed to check residents at this time. 06/27/23 at 4:36 PM, interview with DON B, reported that kitchen staff is pouring shake into a glass and that is why Surveyor did not see Sysco shake on tray. Surveyor stated to DON B that observations for both meals included hot chocolate, milk, and broth, which were also on R9's meal ticket. Surveyor observed no Sysco shake provided on the tray at the observed meals. Surveyor asked DON B how nurses are signing the MAR for administration and documenting intake if it comes on R9's tray from kitchen staff. DON B reported that nurses could ask nursing assistants. Surveyor asked how nutritional status parameters can be met, if intakes are not recorded accurately. Surveyor observations of dining indicated that administrative staff provide supervision in dining room. CNAs were not present in dining room at all times, so would not be able to assist or document intakes accurately. Nutritional interventions for R9 were not followed consistently to maintain parameters of nutrtional status and weight.

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F 0697 Level of Harm - Minimal harm or potential for 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** 47284 Based on observations, interviews and record review, the facility did not ensure pain management was achieved for 1 of 1 resident (R) reviewed for pain (R10). R10 had pain in the perineal area related to vulvar (the outer surface area of female genitals) cancer with radiation burn to the area. The perineal area is the layer of skin between the genitals (vaginal opening) and the anus / sacral area. There was no current pain assessment or care plan to direct staff on managing R10's pain. This is evidenced by: Review of the facility policy, entitled Pain Management, dated 8/09/22, states: .The facility will utilize a systematic approach for recognition, assessment, treatment, and monitoring of pain .Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated .Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences .Observe for nonverbal indicators of pain . The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in the consistent assessment of a resident's pain .Based on the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals, hospice providers and the resident and/or the resident's representative will develop, implement, monitor, and revise as necessary the interventions to prevent or manage each individual resident's pain beginning at admission. The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal .Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences and revise the plan of care as needed . On 6/27/23, Surveyor reviewed R10's medical record to find the following: On 2/03/23, R10 was admitted to the facility with medical diagnoses that include but not limited to, malignant neoplasm of the vulva with radiation burn to the vulva area. R10's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 10. BIMS score ranges from 00-15. 13-15: cognitively intact. 08-12: moderately impaired. 00-07: severe impairment. Surveyor reviewed R10's current pain regimen. According to the physician's orders, R10 had the following orders related to pain control: *Observation: Pain - Observe every shift. If pain is present, complete the pain flow sheet and treat it by trying non-pharmacologic interventions prior to medicating if appropriate. Document in the progress notes. Start date 2/03/23. *Apply a frozen perineal pad to the perineal area for discomfort as needed (PRN) every 3 hours. Start date 3/16/23. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Saline gauze to the perineal area for comfort PRN 3 times daily. Start date 3/16/23. *Gently wash the vulvar and sacral area daily with soap and water, rinse, and pat dry. Apply the Silvadene cream to the vulva one time a day related to burn of unspecified body region, unspecified degree. Start date 3/27/23. *Prophylactic wound care to sacrum - Keep the sacral area covered with sterile bordered gauze wound dressing with an adhesive border 4 x 4 every 3 days and PRN. Apply a thin layer of Vaseline or Aquaphor to the vulvar/vaginal area to protect the skin from urine. Change undergarments frequently throughout the day. Start date 6/26/23. *Monitor areas of impaired skin integrity (perineal area and left lower extremity) - Monitor areas for redness and report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Start date 6/26/23. *Medicated Pads External Pad (Witch Hazel (Hamamelis Virginiana)) Apply to vaginal area topically PRN for burns related to burn of unspecified body region, unspecified degree. Start date 4/13/23. *Silvadene External Cream 1 % (Silver Sulfadiazine) Apply to the vulva topically everyday shift related to malignant neoplasm of overlapping sites of the vulva. Apply a very thin layer to the vulva daily. Start date 3/16/23. *Tylenol 1000mg every 12 hours PRN for pain. Start date 4/28/23. *Tylenol 500mg two times a day for pain. Start date 2/03/23. *Tramadol 12.5mg every 4 hours PRN for pain related to malignant neoplasm of the vulva. Start date 6/27/23. A review of R10's treatment administration record for the frozen perineal pad to the perineal area as needed and saline gauze to the perineal area as needed both show no documentation of perineal pad or saline gauze being administered since it was ordered in March 2023. A review of R10's medication administration record shows PRN Tylenol was administered two times in April and two times in May. No administration in June. There were no medicated pads administered since ordered on 4/13/23 except for one time on 4/15/23. Tramadol was just ordered on 6/27/23, so no administration yet at this time. A review of R10's care plan revealed no comprehensive care plan developed to direct staff in R10's care and needs concerning pain control. A review of R10's Certified Nursing Assistant (CNA) Kardex (care plan) also revealed no information on how to specifically care for R10 during perineal cleaning or information about R10's pain control. A review of R10's pain assessments shows on 2/5/23 pain to bilateral heels with a score of 5 out of 10 pain at its worst. On 2/8/23 pain in the legs with a score of 3 out of 10 pain at its worst. On 6/27/23 pain to the vaginal area/radiation burn with a score of 5 out of 10 pain at its worst. These are the only pain assessments completed for R10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/23 at 2:59 PM, R10 told this Surveyor that she had pain in the private area. R10 said it hurts her at times while sitting and is worse with having to be cleaned up. R10 said she had pain at this time while sitting up in her wheelchair. R10 had a grimacing facial expression during this time. On 06/27/23 at 11:10 AM, R10 was in the physical therapy room working with physical therapy assistant (PT) I. Surveyor asked R10 if she had any pain in the private area at this time. R10 stated she had some pain in the area now. Surveyor asked PT I if R10 had pain often in that area. PT I said yes, that is where her cancer is located. On 06/27/23 at 12:25 PM, Surveyor interviewed Certified Nursing Assistant (CNA) D concerning R10's pain in the private (perineal) area. CNA D stated R10 had told her it was painful in the area. CNA D stated R10 appeared to be in pain when cleaning the perineal area. Surveyor asked what did CNA D do if R10 was in pain. CNA D said she would tell the nurse that R10 was in pain to see if there was anything the resident could get for the pain. On 06/27/23 at 12:30 PM, Surveyor spoke with Registered Nurse (RN) H concerning R10 being in pain. RN H stated she received in report that R10 had a painful perineal area due to cancer. R10 was getting Silvadene treatment for the area of the pain. RN H said she was unaware of anything else specifically used for R10's perineal pain. RN H said R10 does get scheduled Tylenol for pain. On 06/27/23 at 12:35 PM, Surveyor spoke with the Director of Nursing (DON) B concerning R10's pain in the perineal area. DON B said the pain for R10 was not constant. It was worse when sitting for a long time or during cares. Silvadene was applied as scheduled and medicated pads have been ordered for the pain if needed. DON B stated the area had improved. On 06/28/23 at 7:53 AM, Surveyor spoke with CNA C about how perineal care went for R10 regarding pain. CNA C stated R10 did not have much pain during perineal care, but more so when R10 was sitting. CNA C stated she was extra gentle when doing perineal care to R10 due to vulvar cancer with radiation burn. On 06/28/23 at 8:04 AM, Surveyor spoke with the Nursing Home Administrator (NHA) A to obtain the reviewed documentation for R10. Surveyor asked for R10's care plan concerning pain, CNA Kardex, facility policy on pain management, physician orders, administration records, and pain assessments for a comprehensive pain management program for R10. On 06/28/23 at 11:22 AM, NHA A provided the requested documentation for R10 to this Surveyor. NHA A acknowledge there was no comprehensive pain management plan in place for R10.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, interview and record review, the facility did not ensure that a resident's drug regimen was free from unnecessary medications in the presence of adverse consequences which indicate the dose should be reduced or discontinued for 1 of 5 residents (R) reviewed for unnecessary medications (R9). Facility did not follow up with provider after request to reduce laxative related to R9 having loose bowel movements. R9 continued to have loose watery stools with no change in laxative medications. Findings include: R9 admitted to facility 12/11/2017. Diagnoses include dementia, seizures, stroke affecting left side, depression, and anxiety. R9 has an activated Power of Attorney (POA) to assist in making healthcare decisions. Minimum Data Set (MDS), dated [DATE], confirmed R9 is understood and understands others. R9 scored an 8/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R9's care plan includes the following: Activities of Daily Living (ADLs), interventions include: -1/21/23, Toilet use: requires staff assist x 2. He is to be helped to the TOILET in the shower room per his request, with routine cares, during rounds and as needed. OK for check and change while in bed if he desires. Resident has actual skin integrity break - MASD to coccyx and open area to left buttocks secondary to incontinence-associated dermatitis, interventions include: Potential for Constipation related to medications, interventions include: -9/3/20, Auscultation of bowel sounds in all four quadrants: noting hyperactive, hypoactive, or absence of sound. Report any significant change to physician. -9/3/20, Monitor for frequency of bowel movements and administer softeners and laxatives as needed per MD orders. -12/4/20, Encourage to sit on toilet to evacuate bowels. Orders Related medications: Miralax 17 grams twice daily for constipation, Milk of Magnesia 30 mL once daily for constipation, docusate sodium 100 mg give two tablets at bedtime, Senna Plus 8.6-50 mg twice daily for constipation. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/26/23 Bowel and bladder tracking, no trends noted. 5/7/23, request to medical provider to decrease Miralax (laxative) to once daily related to explosive bowel movements. Provider faxed response that bowel routine will be addressed on rounds, goal visit 5/10 or 5/17. Unable to find documentation that bowel routine was addressed. No medication changes. R9's bowel medications: Miralax 17 grams twice daily for constipation, Milk of Magnesia 30 mL once daily for constipation, docusate sodium 100 mg give two tablets at bedtime, Senna Plus 8.6-50 mg twice daily for constipation continue after the 5/7/23 fax to the provider. 5/1/23-5/31/23, 26 of 29 bowel movements coded as watery/diarrhea. 06/27/23 at 9:18 AM, interview with CNA E, reported R9's, butt is horrible, but it has been a problem. Staff are changing and repositioning him every hour. 6/1/23-6/28/23, 11 of 24 bowel movements coded as watery/diarrhea. 6/28/23 at 8:57 AM, interview with CNA F, stated that he works with R9, and he is aware that R9 is on several medications for bowel regulation. CNA F reported that R9 has a bowel movement every few days, maybe every other day, and bowel movements are watery, like diarrhea, and explosive. 6/27/23 at 2:51 PM, interview with DON B regarding request to provider to decrease Miralax to once daily. DON B stated that she did not think provider had completed rounds. 6/27/23 at 4:51 PM, interview with Medical Records (MR) G, reviewed provider schedule. Schedule indicated rounds were completed on 5/13/23. MR G reported that she thinks provider was present in facility 5/13. Review of R9's record showed no new orders on 5/13/23. MR G stated that this provider comes at different times, does not always round with a staff present, and sometimes staff are unsure when he has been to facility or if provider identified any changes. DON B requested provider documentation of most recent nursing home rounds. Documentation supports provider completed rounds on 5/18/23 and 6/16/23, with no new orders to address the needed change in bowel medication to prevent diarrhea (adverse consequence of the laxative medication) that contributed to MASD worsening. 6/27/23 at 2:56 PM, interview with Director of Nursing (DON) B, who stated that she believes R9 is having increased incontinence, and this is causing his MASD. On 7/6/23 at 2:00 PM, Surveyor interviewed MD N (Medical Doctor for R9). MD N stated that he had several conversations over the past few months regarding the skin damage. He stated that he received a fax from the facility regarding the loose stools and facility wanting to decrease the bowel meds. He added that R9 has long-standing constipation and any changes to the bowel medication routine will cause a potential issue. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MD N stated that he dislikes fax messages as they do not allow discussion, so he telephoned the facility and spoke with the nurse on duty at the time a few months back. He stated they discussed R9's history of constipation and his normal pattern. MD N stated that R9's normal pattern is that his bowels are loose for 6-7 days then he goes 2-3 days without any bowel movements. He then indicated that he thought the loop was closed on the matter, but it appeared to go sideways and he learned that the loop really wasn't closed after the State Surveyors were in the building. On 6/29/23, he telephoned DON B and discussed R9's bowel program further after Surveyors left the building. MD N stated that he made a small change in R9's bowel program and doesn't want to do any dramatic changes.

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Ashland Health Services	1319 Beaser Ave Ashland, WI 54806

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47284 Based on observations and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This practice had the potential to affect 13 residents residing in the facility. The facility did not provide hand hygiene to the residents before eating meals. This is evidenced by: The facility policy, entitled Dining Experience, dated 07/27/22, states: .Individuals will be provided with proper hand hygiene prior to each meal or snack . On 06/26/23 at 11:40 AM, Surveyors observed hall service meals. No hand hygiene was offered to the residents who ate in their rooms. R25, R27, R19, R7, R20, R10. On 06/26/23 at 11:50 AM, Surveyors observed staff assisting residents in the main dining room with lunch. No observation of staff offering hand hygiene to the residents before eating. No hand wipes or hand sanitizer in the dining room. R29, R9, R13, R15, R3, R6, R17. On 06/27/23 at 7:35 AM, Surveyor observed residents in the dining room getting ready for breakfast. Staff did not offer hand hygiene to the residents before eating breakfast. No hand wipes or hand sanitizer in the dining room. On 06/27/23 at 7:44 AM, Surveyor spoke with R15 who was in the dining room at the time to see if staff help with providing hand cleaning before eating meals. R15 stated the staff cleaned my face and my hands this morning. Surveyor asked if the staff cleaned the resident's hands before eating each meal. Resident stated I'm not sure, but we will see if they do. On 06/27/23 at 7:56 AM, Surveyor continued to observe breakfast being served to the residents in the dining room. No hand hygiene was offered to the residents before starting to eat. On 06/27/23 at 8:32 AM, Surveyor observed the medical records coordinator (MR) G offering disposable towels to the resident to clean their hands and faces after eating. On 06/27/23 at 8:58 AM, Surveyor spoke with MR G and asked if the residents are offered hand hygiene before eating. MR G stated that sometimes residents are provided hand hygiene before eating, but sometimes the hand wipes are not stocked. MR G stated she had to look for the wipes today as they were not in the dining room like they are supposed to be. On 06/27/23 at 10:25 AM, Surveyor interviewed family member (FM) J who is here daily from 8 am until 6 pm. Surveyor asked FM J if he had seen staff offer hand hygiene to the residents before eating. FM J said no, they do not offer hand hygiene to the residents before eating. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/28/23 at 8:00 AM, Surveyor asked the Nursing Home Administrator (NHA) A, for the facility's policy on hand hygiene for the residents before eating. On 06/28/23 at 9:05 AM, the NHA A provided the facility policy on the dining experience. NHA A stated they realized hand hygiene was not being offered to the residents before eating, so they started a performance improvement to make sure this was completed. This was started yesterday.