STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525421	A. Building B. Wing	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 21855 Based on record review and interviews, the facility did not develop a comprehensive plan of care for assessed medical needs. This was discovered with 5 (R25, R3, R43, R32, and R39) of 21 medical record reviews. - R25 was admitted with medication of an antidepressant and anticoagulant. There was not a comprehensive plan of care developed for these medical concerns. -R3 was admitted with anticoagulant medication. There was not a comprehensive plan of care developed for this medical concern. -R43 eloped from the facility. There was no comprehensive plan of care developed for R43's elopement. -R39 is diabetic and receives hospice services. There was no comprehensive plan of care developed for diabetes and hospice care. -R32 receives oxygen for respiratory concerns. There was no comprehensive plan of care developed for oxygen use. Findings include: The facility's policy and procedure for Comprehensive Person Centered Care Plan, revised 8/10/23, was reviewed by Surveyor. The policy indicates the Comprehensive Person Centered Care Plan will reflect the individual's needs and preferences to facilitate care. The Procedure indicates: A. Within 48 hours after Admission; a Baseline Care Plan will be completed and reviewed with individual and/or representative. B. Within 21 consecutive days after admission, and in correlation with the Minimum Data Set, a comprehensive assessment will be completed and a written care plan will be developed based on the individual's history, preferences, and assessments from appropriate disciplines and the physician's evaluation and orders. C. Care Plan shall be reviewed and revised quarterly, upon change of condition, and/or as needed. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R25's medical record was reviewed by Surveyor. R25 was admitted on [DATE] with diagnosis of: history of pulmonary embolism, hip fracture, malignant cervix cancer and neuropathy. The Admission Physician Orders include: Duloxentine (classified as an antidepressant drug) 60 mg every day for neuropathy; Eliquis(anticoagulant/ blood thinner drug) 5 mg twice a day for anticoagulant. R25's Admission MDS (minimum data set) assessment completed on 12/19/23, indicates use of antidepressant, and anticoagulant. medication. R25's medical record did not contain a comprehensive care plan for antidepressant medication use and side effects; and anticoagulant medication use and side effects. On 01/04/24 at 9:31 AM Surveyor spoke with (Minimum Data Set; Registered Nurse) MDS RN-C. MDS RN-C indicated the Nursing RN should be developing the plan of care. MDS RN-C stated the facility is looking to change the care plan process to define who actually does them. MDS RN-C reported she will start a plan of care for basic resident problems however she is not on the units observing residents and nursing staff are responsible for the plan of care. On 01/04/24 at 1:21 PM Surveyor spoke with (Director of Nurses) DON-B via phone. DON-B indicated the MDS coordinator does the care plans. Surveyor shared R25's care plan concerns. DON-B did not know about the care plans not being developed. DON-B does the baseline assessments on the residents. On 1/4/23 at 1:43 PM at the facility Exit Meeting with Administrator-A, (Clinical Nurse Consultant) CNC-F and CNC-G, Surveyor shared the care plan concerns with R25. No further information was provided. 2. R3's medical record was reviewed for unnecessary medications. R3 was admitted to the facility on [DATE] for rehabilitation. R3 has a diagnosis of Permanent Atrial Fibrillation and receives Eliquis (blood thinner) to treat this medical condition. R3 was admitted with Eliquis (blood thinner) for Atrial Fibrillation prescribed. R3's comprehensive care plan did not have blood thinners identified with interventions specific to this medication. R3 is currently receiving Eliquis Oral Tablet 5MG as an anticoagulant due to atrial fibrillation. According to Poison Control- National Capital Poison Center (Poison.org) Eliquis is a blood thinner used to prevent serious blood clots from forming due to atrial fibrillation. Blood thinners can cause bleeding, which can be serious, and rarely may lead to death. You should avoid grapefruit, grapefruit juice, marmalades, limes, and pomelos; in addition to green leafy vegetables high in vitamin K while you are taking Eliquis. https://www.poison.org/articles/what-is-eliquis#:~:text=You%20can%20take%20Eliquis%C2%AE, and%20may%20increase%20side%20effects. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/03/24 at 10:39 AM the Surveyor reviewed R3's care plan and noted there was no person-centered comprehensive care plan to indicate use and side effects for the Eliquis R3 was admitted with. R3's comprehensive care plan did not have blood thinners identified with interventions specific to this medication. The CAA (Care Area Assessment) would indicate the Eliquis usage, and the facility should have developed a comprehensive care plan related to the risk of the medication to avoid a negative impact on the quality of care received. On 01/04/24 at 09:29 AM the Surveyor spoke with MDS (Minimum Date Set) RN (Registered Nurse)-C who is the MDS coordinator and has worked for the facility for six years. The MDS RN-C completes the MDS and collects data and merges it with the CAA (Care Area Assessment) to create a baseline care plan. After that the comprehensive care plan is updated by nursing. If a resident is on a blood thinner at admission the comprehensive care plan would be done by nursing. On 01/04/24 at 01:21 PM Surveyor spoke via phone to DON (Director of Nursing)-B who indicated the MDS coordinator does the baseline (admission) care plan. DON-B did not develop a comprehensive care plan for the Eliquis. On 01/4/24 at 1:42pm during the facility exit meeting with CNC (Clinical Nurse Consultants)-F and CNC-G and the NHA (Nursing Home Administrator)-A the Surveyor shared that there was no comprehensive care plan created for Eliquis related to use and side effects. 42037 3. R43 was admitted to the facility on [DATE] with cognitive communication deficit. R43 discharged from the facility on 5/19/23. On 5/7/23, R43 sustained a fall outside of the facility during an elopement. Surveyor reviewed R43's medical record. On 5/7/23, an elopement risk assessment was completed for R43 indicating they are at high risk for elopement. Surveyor noted R43 did not have an elopement risk comprehensive care plan completed after R43's elopement with fall on 5/7/23. On 1/04/24 at 9:50 AM, Surveyor spoke with MDS RN-C. Surveyor asked MDS RN-C who would be responsible for developing and updating resident care plans. MDS RN-C responded that they will initiate care plans if they are triggered through a resident's admission MDS. MDS RN-C added that if an issue arises with a resident such as skin issues, falls or accidents that the nursing staff would be responsible for any updates to care plans. On 1/4/24 at 1:25 PM, Surveyor conducted interview with DON-B via phone. DON-B indicated the MDS coordinator completes comprehensive care plans. On 1/4/23 at 1:43 PM, Surveyors met with Administrator-A, CNC-F and CNC-G. Surveyor shared concerns that R43's comprehensive care plan had not been updated after their elopement with fall on 5/7/23 and ongoing high risk for elopement. The facility did not provide any additional information at this time. 47094 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R39 was admitted to the facility on [DATE] and has diagnoses that include fracture of the fifth lumbar vertebrae, fracture of the sacrum, type 2 diabetes, urine retention, Chronic obstructive pulmonary disease (COPD), pleural effusion, atrial fibrillation, pacemaker, need for assistance with personal care, difficulty in walking, and history of falls. R39's admission minimum data set (MDS) dated [DATE] indicated R39 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R39 as needing extensive assist with 1 staff member for bed mobility, transferring, dressing, toileting, and personal hygiene. R39 had an indwelling catheter and was occasionally incontinent of bowel and wore adult briefs for protection. R39's physician orders included: - Novolog injection solution 100Units/ML- inject 4 units subcutaneously before meals for diabetes. - Insulin Glargine subcutaneous solution pen-injector 100unit/ML- inject 6 units subcutaneously at bedtime for diabetes mellitus (DM). - Blood Glucose Monitoring/Check- four times a day related to type 2 diabetes mellitus without complications. - Advair diskus inhalation aerosol powder breath activated 250/50- 1 puff inhale orally at bedtime for COPD. - Albuterol Sulfate HFA inhalation aerosol solution 108 (90 Base) MCG/ACT- 2 puffs inhale orally every four hours as needed for shortness of breath or wheezing. - Guaifenasin extended release tablet 12 hour- take 1 tablet by mouth every morning and at bedtimes for cough (initiated 3/1/2023, discontinued 3/8/2023) R39 was diagnosed with Pneumonia on 3/15/2023 with the following physician orders: - Cefuroxime Axetil oral tablet 500mg- Take 1 tablet by mouth every morning and at bedtime for Pneumonia for seven days. Surveyor reviewed R39's care plan and noted there was no diabetes care plan or respiratory care plan for R39 to manage R39's type 2 diabetes, COPD, and Pneumonia. On 1/4/2024 at 9:27 AM Surveyor interviewed MDS Registered Nurse MDS RN-C who stated that MDS RN-C initiated care plans with the basic problems the residents has and the day to day/ individualization of care plans would be up to the nursing team, there is not a designated person for care planning. On 1/4/2024 at 1:14 PM Surveyor interviewed Director of Nursing (DON)-B who stated when a resident is admitted the MDS nurse and supervisors will initiate a care plan, then managers will revise the care plans. DON-B was not employed with the facility at the time R39 was admitted and was not familiar with R39 so was not able to provide information as to why R39 did not have a diabetes or respiratory care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/4/2023 at 1:43 PM Surveyor informed nursing home administrator (NHA)-A, corporate nurse consultant (CNC)-F, and CNC-G of Surveyors concerns regarding R39 not having a diabetes or respiratory care. No further information was provided at this time. 5. R32 was admitted to the facility on [DATE] and has diagnosis that include palliative care, fracture of one rib on the left side, pneumothorax, hemothorax, myocardial infarction, non-rheumatic aortic valve disorder, paroxysmal atrial fibrillation, diastolic congestive heart failure, terminal prognosis related to lung nodule, type 2 diabetes mellitus, and emphysema. R32's admission MDS dated [DATE] indicated R32 had moderately impaired cognition with a Brief Interview Mental Score (BIMS) score of 12 and the facility assessed R32 needing moderate assist with 1 staff member for eating, toileting, showering, personal hygiene, and maximal assist with transferring using a Hoyer lift and assist of two staff members. On 1/2/2024 at 10:07 AM Surveyor observed R32 a with nasal canula in nose and an oxygen concentrator running at 4L with humidification. R32's current physician orders included: - Morphine Sulphate solution 20MG/ML- Give 0.5 ml by mouth every 1 hour as needed for pain/dyspnea (difficulty/labored breathing) and give 0.25ml by mouth every hour as needed for pain/dyspnea. - Hyoscyamine sulfate tablet, sublingual 0.125mg- Give 1 tablet sublingually every four hours as needed for increased secretions. - Change oxygen tubing and date tubing- every night shift every seven days. - Change humidified air canister- every night shift every seven days and as needed. - Oxygen at 2 liters per nasal canula to keep oxygen sats greater that 90% every shift. - Ipratropium- albuterol inhalation solution 0.5-2.5 (3) MG/3ML- 3Ml inhale orally every six hours as needed for shortness of breath. Surveyor reviewed R32's care plan and noted there was no respiratory care plan for R32 to manage R32's respiratory diagnoses/ concerns. On 1/4/2024 at 9:27 AM Surveyor interviewed MDS registered nurse (MDSRN)-C who stated that MDSRN-C initiated care plans with the basic problems the residents has and the day to day/ individualization of care plans would be up to the nursing team, there is not a designated person for care planning. On 1/4/2024 at 1:14 PM Surveyor interviewed director of nursing (DON)-B who stated when a resident is admitted the MDS nurse and supervisors will initiate a care plan, then managers will revise the care plans. DON-B was not sure why R32 did not have a respiratory care plan in place. On 1/4/2023 at 1:43 PM Surveyor informed nursing home administrator (NHA)-A, corporate nurse consultant (CNC)-F, and CNC-G of Surveyors concerns regarding R32 not having a respiratory care plan. No further information was provided at this time. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49011 based on 5 of 21 residents reviewed [NAME] based on Resident #3 Unnecessary Meds, Psychotropic Meds, and Med Regimen Review 01/03/24 01:20 Per 12/5 mds BIMS 15 Understand/understood Functional assess: independent Skin assess: none at admit 01/03/24 10:39 AM Care plan for diuretic and antidepressant. None for eliquis 01/04/24 09:29 AM [NAME] MDS coordinator - 6 years here. Does MDS. collects date and merges with CAA Anything skin tears, falls etc is assessed, done by floor nurse Fall elopement assessment done at admission Fall - staff interviews right away - root cause takes time Care plan update is done by someone in nursing At admission anticoagulant, antidepressant - who does plan of care for that person - should be nursing Looking to refine/define care plan process at process of admission she does basic problems - falls, pains, urine - after she does CAA if there is a care plan update she puts in very basic. Floor should be revising and updating as needed 01/04/24 01:21 PM DON the MDS coordinator does the care plan. Did not know about it. The DON does the baseline assessments. 01/04/24 01:14 PM Lachiquita [NAME] DON: (414-915-6894) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectations of care plans and fall investigations? when admitted , baseline CP- then managers or MDS coordinator. manager will revise care plans. supervisors follow up not sure why no care plans- will have to look-

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on interview and record review the facility did not ensure 1 (R43) of 7 residents reviewed for discharge received a thorough discharge summary in order to communicate necessary information to the resident *R43 discharged from the facility on 5/19/23. The facility did not complete a discharge summary or a recapitulation of their stay that was available to R43 or R43's representative upon consent. Findings include: R43 was admitted to the facility on [DATE] with cognitive communication deficit. On 5/19/23 R43 had a planned discharge from the facility into the community. A discharge- return not anticipated assessment dated [DATE] was completed by the facility. R43's Admission Minimum Data Set (MDS) dated [DATE] documents R43 has a BIMS (Brief Interview for Mental Status) score of 10, indicating R43's cognitive skills for decision making were moderately impaired. Surveyor reviewed R43's comprehensive care plan and could not identify any care plan addressing R43's discharge planning. Surveyor reviewed R43's physician orders and noted no discharge order documented by a physician. Surveyor reviewed R43's electronic medical record. R43 was discharged from the facility on 5/19/23. Surveyor could not identify a completed recapitulation of R43's stay at the facility or a completed discharge summary. On 1/4/24 at 9:50 AM, Surveyor conducted interview with Social Services-P. Social Services-P informed Surveyor that they were hired by the facility in July of 2023 in a Social Services role. Surveyor asked Social Services-P if a resident should be given a discharge summary and recapitulation of their stay at the facility upon discharge. Social Services-P responded Yes, that would be the expectation upon discharge. On 1/8/24 at 11:20 AM, Surveyor shared concerns with Administrator-A related to R43 discharging from facility on 5/19/23 without evidence of a discharge summary or recapitulation of R43's stay at facility being provided to resident or their representative. The facility did not provide any additional information at this time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, record review, and interview, the facility did not ensure residents at risk for pressure injuries received care consistent with professional standards of practice to prevent pressure injuries from developing for 5 (R137, R40, R41, R27, and R18) of 8 residents reviewed for pressure injuries. *R137 was admitted to the facility on [DATE] after sustaining a right femur fracture following a fall at home. R137 had a Braden score of 11 indicating high risk for development of pressure injuries. R137 developed a skin tear and a reddened area on 10/25/23 and 10/30/23 respectively. The facility did not have a Care Plan to address bed mobility, repositioning, or incontinence until 11/8/2023, when R137 developed an unstageable pressure injury to the coccyx. There was not a comprehensive assessment of the pressure injury nor was the dietitian alerted to address dietary needs. On 11/06/23, the nurse practitioner (NP) ordered an antibiotic for a wound infection and indicated the resident should be seen by the wound nurse practitioner. R137 was not seen by the wound nurse practitioner. Seven days later, R137 was hospitalized and found to have necrotizing fasciitis. The facility's failures to implement preventive interventions for a resident at risk of developing pressure injuries, to determine the etiology of skin tears to the coccyx, to comprehensively assess a pressure injury, to involve the Wound NP, and to notify the dietician of the development of a pressure injury created a finding of immediate jeopardy that began on 10/25/2023. Surveyor notified Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Clinical Nurse Consultant (CNC)-F of the immediate jeopardy on 1/8/2024 at 3:00 PM. The immediate jeopardy was removed on 1/12/24, however, the deficient practice continues at a scope/severity of G (actual harm/isolated) as evidenced by the following examples. R40 and R41 are being cited at severity level 3. * R40 developed an unstageable pressure injury to the coccyx on 6/11/2023 that was not comprehensively assessed until 6/14/2023. R40 did not have a comprehensive care plan that addressed pressure injury preventative measures. * R41 developed a Deep Tissue Injury (DTI) to the right heel and a DTI to the left heel on 10/12/2023 that were not comprehensively assessed until 10/16/2023. R41 did not have a comprehensive care plan that addressed preventative measures. * R27 developed a Deep Tissue Injury (DTI) to the left heel which was discovered on 12/16/2023. There was no RN (Registered Nurse) assessment until 12/18/2023 (two days later.) R27's care plan was not updated to reflect the use of heel boots until 12/18/23. The facility did not get treatment orders for the DTI until 12/18/23 when at that time, the physician and R27's representative were notified of the DTI. * R18 developed a Stage 2 pressure injury to the left buttock on 12/7/2023 that was not comprehensively assessed. Findings include: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy and procedure entitled Pressure Injury Prevention and Managing Skin Integrity dated 8/10/2023 states: I. Policy: Prevention measures are put in place to reduce the occurrence of pressure injuries. II. Procedure: 1. Risk Assessment a. Upon Admission: Braden Scale will be completed to evaluate individual's risk for developing a pressure injury at admission, and weekly for four weeks for all new admissions. b. Re-evaluation: Braden Scale will be completed upon change of condition and quarterly. c. Based on the individual's Braden Scale Score, pressure reduction interventions will be implemented by nursing and documented in the individual's medical record. 2. Identify Interventions and Care Plan a. Identify Interventions i. The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown. 1. There will be collaboration with the interdisciplinary team (IDT) regarding the presence of breakdown and the intervention plan. 2. When indicated, a referral to additional resources (ie. Wound Care Specialist, Registered Dietician, Physical Therapist, Occupational Therapist) may occur. 3. Identification of risk factors present or acquired that compromise skin integrity will be considered. b. Care Plan i. In developing a plan of care, the following will be considered: 1. Individual Pressure Injury History 2. Cognitive changes or impairment of the individual 3. Current state of skin integrity and personal hygiene practices of the individual that impact skin health 4. Any cultural practices that impact the health or integrity of the skin 5. Risk for pressure ulcer development (Braden Scale) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Skin Checks a. Skin check will be done upon admission, readmission or as clinically indicated. b. While providing routine care, a licensed nurse is to monitor the skin condition of each individual weekly and document the Skin Check in the medical record. 4. Weekly Wound Rounds a. Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concerns(s) will be added to weekly wound rounds. b. Registered Nurse (RN) or designee will: i. Conduct weekly skin evaluation. ii. Update the (PCP) with any decline in wound appearance, or as necessary iii. Update the Care Plan with any new interventions as applicable iv. Update Individual Representative as indicated 5. Administrative Review a. Interdisciplinary Team (IDT) reviews Pressure Ulcer/Abnormal Skin Findings through Quality Assurance Committee. 1. R137 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of the right femur, anemia, Type 2 Diabetes Mellitus, congestive heart failure, osteoarthritis, spinal stenosis, and osteoporosis. R137 had a fall at home, sustained the fracture to the right femur, and was admitted to the facility for Physical and Occupational Therapy. On 10/24/2023 at 4:57 PM in the progress notes, nursing charted R137 was admitted to the facility with a left hip fracture (Surveyor noted R137's right hip was fractured.) The Elopement Evaluation form on 10/24/2023 documented R137 was not an elopement risk because R137 was immobile. The Braden Scale score on 10/24/2023 was 11 indicating R137 was at high risk for skin breakdown. The Admit/Readmit Screener form on 10/24/2023 documented R137 had a pressure area to the sacrum that was red and blancheable and a rash under the left and right breast. On 10/24/2023 at 11:41 PM in the progress notes, nursing charted R137 was a new admission that day after a fall resulting in a right femur fracture. Nursing charted R137 was incontinent of bowel and bladder. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Baseline Care Plan initiated on 10/24/2023 was a tool for gathering information but did not implement any interventions. Bed mobility, toileting, and transfers were not assessed per the Baseline Care Plan. The Skin section of the Baseline Care Plan documented R137 had blancheable area to the coccyx and a rash under both breasts. Surveyor noted R137 did not have a Care Plan implemented to address Activities of Daily Living (ADLs) regarding the amount of assistance needed for bed mobility, incontinence care, or the prevention of pressure injuries such as developing a turning and repositioning program. R137 had limited mobility due to the healing right femur fracture. On 10/25/2023 at 10:18 AM in the progress notes, nursing charted R137 had a skin tear to the coccyx. Nursing charted the site was cleaned and Mepilex was applied per Nurse Practitioner (NP) verbal orders. Surveyor noted the treatment order was not entered into R137's Medication Administration Record (MAR) or Treatment Administration Record (TAR) and no etiology of how the skin tear developed was documented. No Care Plan preventative measures were initiated to prevent further skin breakdown. On 10/29/23, R137's ADL Care Plan was initiated with the following interventions: -Discuss with R137/family/POA (Power of Attorney) care any concerns related to loss of independence, decline in function. -Encourage R137 to discuss feelings about self-care deficit as needed. -Encourage R137 to participate to the fullest extent possible with each interaction. -Encourage R137 to use bell to call for assistance. -Monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. -Praise all efforts at self-care. -PT/OT evaluation and treatment as per physician orders. Surveyor noted R137's ADL Care Plan did not address the level of assistance needed for bed mobility, incontinence care, transfers, a turning and repositioning program or any other activity of daily living. On 10/30/2023 at 9:45 AM in the progress notes, nursing charted R137 had redness on the buttocks and a small skin tear. The documentation did not elaborate on the location of the skin tear and give the etiology of how the skin tear developed. No Care Plan interventions or preventative measures such as a turning and repositioning program were initiated to prevent further breakdown. On 10/30/2023 at 1:48 PM in the progress notes, Social Services charted a care conference was held for R137 and a medication list and care plan were given to R137 and family for review. Social Services charted R137 was non-weight bearing on leg and was working on standing and transfers. R137 did well with a slide board transfer and the plan was for R137 to discharge to home or an assisted living facility. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R137's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R137 had a severe cognitive deficit with a Brief Interview for Mental Status (BIMS) score of 6 and the facility assessed R137 as needing moderate assist for rolling in bed, was dependent for toileting, was always incontinent of bowel and bladder. The MDS indicates R137 was admitted with no unhealed pressure injuries and was at risk for a pressure injury with a pressure reducing device in the chair only. Surveyor noted the MDS was not checked for a turning/repositioning program. The MDS indicates R137 was checked for having a surgical wound. The Pressure Injury Care Area Assessment (CAA) stated R137 was at risk for impaired skin with incontinence exposing skin to moisture and waste. R137's admission Braden score was 11 placing R137 at high risk and proceed to plan of care to assist R137 with repositioning needs and peri hygiene. The CAA stated open wound or skin places R137 at risk for infection. Surveyor noted R137's skin tear was not indicated on the MDS assessment, and no care plan was developed to assist R137 with positioning or peri hygiene at that time. On 11/6/2023 at 10:36 AM in the progress notes, nursing charted R137 did not have any new skin concerns. Surveyor noted no further documentation was found on the skin tear to the buttocks/coccyx. On 11/7/23, R137's Impairment to Skin Integrity related to fragile skin Care Plan was initiated with the following interventions: -Encourage good nutrition and hydration in order to promote healthier skin. -Keep skin clean and dry; use lotion on dry skin. Surveyor noted R137's Impairment to Skin Integrity care plan did not include a turning and repositioning program. On 11/8/2023 at 1:10 PM in the progress notes, Social Services charted a care conference was held for R137 and R137 had been working on slide board transfers but due to redness on bottom, they put the slide board transfers on hold. On 11/8/2023 at 4:13 PM in the progress notes, Director of Nursing (DON)-B charted R137 had an unstageable pressure injury to the sacrum that measured 3 cm x 3 cm with slough, eschar, and a slight odor. Surveyor noted no depth was measured and the wound bed did not have percentages of tissue type documented to accurately describe the wound bed; this pressure injury did not have a comprehensive assessment. DON-B notified NP-J and the physician of the new pressure injury. An order was obtained to cleanse the wound with Puracyn, apply Medihoney, and cover the wound with Allevyn daily. Surveyor noted the Dietician was not notified of the new pressure injury. No supplements were ordered to address the increased protein need. On 11/8/23 R137's Pressure Ulcer to sacrum Care Plan was initiated with the following interventions: -Administer medications as ordered; monitor/document for side effects and effectiveness. -Administer treatments as ordered and monitor for effectiveness. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Assess/record/monitor wound healing; measure length, width, and depth where possible; assess and document status of wound perimeter, wound bed, and healing progress; report improvements and declines to the physician. -Bed rest; up with therapy only. -Educate R137/family/caregivers as to causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. -Follow facility policies/protocols for the prevention/treatment of skin breakdown. -If R137 refuses treatment, confer with R137, IDT (Interdisciplinary Team), and family to determine why and try alternative methods to gain compliance; document alternative methods. -Inform R137/family/caregivers of any new area of skin breakdown. -Monitor dressing to ensure it is intact and adhering; report loose dressing to treatment nurse. -Monitor nutritional status; serve diet as ordered. -Monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length x width x depth), stage. -Obtain and monitor lab/diagnostic work as ordered; report results to physician and follow up as indicated. -Staff to assist with routine toileting and skin care for incontinence. -Treat pain as per orders prior to treatment/turning to ensure R137's comfort. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. On 11/9/2023 at 10:46 AM in the progress notes, nursing charted wound care was completed to the pressure injury which was yellow odorous eschar with pain to the touch. The DON and NP-J were aware and R137 was repositioned as needed. On 11/9/2023 at 11:29 AM in the progress notes, nursing charted R137 complained of chills and body aches; R137 was warm to the touch with a temperature of 102.4. Nursing charted NP-J was notified of the fever, Tylenol was given, and the rechecked temperature was 100.8. On 11/9/2023, R137 was evaluated by NP-J. NP-J documented R137 complained of occasional right hip pain and pain secondary to a wound on the sacrum which was being treated with daily local wound care. NP-J documented the Unstageable sacral wound had necrotic edges and the peri wound area was erythematous. NP-J documented the treatment plan for the Unstageable sacral wound was to start doxycycline (antibiotic) 100 mg twice daily for seven days for wound infection, continue daily local wound care with Medihoney, and resident will be followed by the facility Wound NP. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted with record review the Wound NP did not evaluate or treat R137. On 11/9/23, R137's Pressure Ulcer to sacrum Care Plan was revised with the following interventions: -Avoid positioning R137 on back. -Staff to assist with turning and repositioning every 2-3 hours. -R137 requires air mattress; check function every shift and as needed. On 11/10/2023 at 9:17 PM in the progress notes, nursing charted oxycodone 5 mg was administered for pain to the sacral/coccyx area from sitting and repositioning and rest were ineffective. Surveyor noted R137 was to be on bedrest, yet pain was caused from sitting. On 11/11/2023 at 9:17 PM in the progress notes, nursing charted R137 had poor appetite and oral fluids were offered and accepted. Nursing charted incontinence rounds and wound care were completed; R137 had an air mattress and was repositioned frequently. R137 was currently resting in bed and in no distress with call bell and oral fluids in reach. Surveyor noted there was no dietician reassessment of R137's nutritional needs after R137 developed an unstageable pressure injury and was charted as having a poor appetite. On 11/13/2023 at 12:48 PM in the progress notes, nursing charted oxycodone 5 mg was administered for pain prevention prior to wound care. On 11/14/2023, R137 was evaluated by the physician. The physician documented R137 had an Unstageable sacral pressure ulcer with eschar and was tolerating doxycycline. The physician documented daily wound care was in progress with Medihoney and pressure relief and position changes were the treatment plan. On 11/16/2023, R137 was evaluated by NP-J at the request of R137's family for depressed mood and decreased appetite. On assessment, R137 was lying in bed and participated minimally in the conversation. The family reported R137 was more depressed that week, was lying in bed a lot, and sleeping more during the day. Family reported R137 was not eating unless the family fed R137, and the family requested a medication for depression. NP-J documented the Unstageable pressure injury to the coccyx had improved since the previous exam (on 11/9/2023). NP-J documented the treatment plan for the Unstageable sacral wound was to continue daily local wound care with Medihoney and will be followed by the facility Wound NP. Surveyor noted with record review the Wound NP did not evaluate or treat R137 and no weekly comprehensive assessment of the pressure injury to include measurements of the area (width, length, depth, type of tissue and exudate) was completed. On 11/16/2023 at 3:29 PM in the progress notes, DON-B charted R137 was assessed by NP-J with a new order received for Mirtazapine 7.5 mg every evening for depression/appetite. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/16/2023 at 3:51 PM in the progress notes, DON-B charted R137's family member was at bedside and stated R137 had increased confusion. DON-B charted DON-B attempted to ask R137 questions, but DON-B was unable to understand R137's answers. Per the family member, this was a change for R137. DON-B charted NP-J was made aware and new orders for labs were obtained. On 11/16/2023 at 10:47 PM in the progress notes, nursing charted R137's vital signs at 9:55 PM were as follows: blood pressure 95/48, pulse 101, temperature 99.7, respirations 30, oxygen saturation 91% on room air, and blood sugar 507. Nursing charted R137 was crying and whimpering at that time and was confused and disoriented. The NP was notified of the findings and an order was given to send R137 to the emergency room for further evaluation. Surveyor noted R137's blood sugar readings from 11/2/2023-11/16/2023 ranged from 115 to 507 with an average reading of 282 and only three of the 29 blood sugar readings were less than 200. On 11/17/2023 at 5:49 AM in the progress notes, nursing charted R137 was admitted to the intensive care unit for possible necrotizing fasciitis. R137 did not return to the facility and passed away on 11/19/2023. In an interview on 1/4/2024 at 8:54 AM, NP-J stated NP-J remembered seeing R137's sacral wound at least twice and was aware the physician saw R137's wound once, maybe twice. NP-J stated NP-J first saw R137's sacral wound on 11/9/2023. Surveyor asked NP-J if NP-J took any measurements of the wound. NP-J stated facility nursing staff was responsible for measuring the wound. NP-J recalled ordering an antibiotic for the wound on 11/9/2023 because the wound was foul smelling, and the peri wound was reddened and inflamed. NP-J stated the physician comes to the facility on Tuesdays and NP-J had the physician look at the wound on 11/14/2023 for a follow up visit. NP-J stated NP-J saw R137 on 11/16/2023 because the family said R137 was depressed and not eating. NP-J stated that was the initial reason NP-J saw R137 that day and since NP-J was there, NP-J checked on everything else including the pressure injury. NP-J stated the pressure injury looked better at that time compared to the previous week when NP-J had ordered the antibiotic. NP-J stated the skin around the wound and the wound itself had improved with the antibiotic and Medihoney. NP-J stated there was no visual presentation of anything brewing underneath the wound. NP-J stated NP-J would not have guessed necrotizing fasciitis was present and was shocked when that was reported to NP-J from the hospital. In an interview on 1/4/2024 at 9:34 AM, Surveyor asked MDS Registered Nurse (RN)-C what the process was for a resident that develops a pressure injury while a resident at the facility. MDS RN-C stated the floor nurse does the initial assessment and notifies the Assistant DON (ADON) or the DON of the new area; the DON or ADON will do a complete assessment and document the new areas in either the progress notes or in the assessment tab of the computer charting system. Surveyor asked MDS RN-C how the Wound NP was notified of a resident that needed an assessment and where that assessment would be documented. MDS RN-C stated the Wound NP is notified by either the DON or ADON and will put their own note into the computer charting system. Surveyor noted R137 did not have an initial comprehensive assessment on 11/8/2023 of the new pressure injury, was not comprehensively assessed weekly, and was not seen by the Wound NP. On 1/4/2024 at 10:16 AM, Surveyor shared with Clinical Nurse Consultant (CNC)-F the following concerns regarding R137: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-R137's baseline care plan did not have any interventions to address R137's bed mobility with the right hip fracture. -R137 had a Braden score of 11 on admission placing R137 at high risk for a pressure injury and no preventive interventions were implemented. -R137 had a skin tear to the coccyx on 10/25/2023 and 10/30/2023 that were not assessed for etiology of the wounds to prevent future skin breakdown. -The skin tear on 10/25/2023 had a treatment applied that was not documented in the MAR/TAR. -When the ADL care plan was initiated on 10/29/2023, bed mobility and repositioning were not addressed. -On 11/8/2023 a pressure injury to the sacrum was discovered and the wound measurements did not include a depth or a complete description of the wound bed. -The dietician was not notified of the new pressure injury. -An air mattress and repositioning were not implemented on the care plan until after the development of a pressure injury. -On 11/9/2023 the pressure injury required antibiotics for an infection. -On 11/9/2023, NP-J requested the Wound NP be involved in R137's care; no documentation was found by the Wound NP of any assessment of R137's pressure injury. -R137 required opioids for pain control due to the pressure injury. -The pressure injury was not assessed weekly, and no documentation was found of the pressure injury being comprehensively assessed. -R137 was sent to the hospital on 11/16/2023 due to unstable vital signs and was admitted with necrotizing fasciitis. Surveyor shared with CNC-F no documentation was found for a comprehensive assessment or a weekly assessment of the pressure injury. CNC-F stated CNC-F had looked for that documentation the day before and did not see any but would look again. On 1/4/2024 at 10:54 AM, CNC-F stated CNC-F was not able to find any comprehensive skin assessments for R137 other than the admission assessment when R137 did not have any skin concerns for pressure injuries. CNC-F stated the DON at that time (November 2023) simply walked out on the job and they did not know if the DON had a wound log at that time; if the DON did have a wound log, they were not able to find it. CNC-F stated the Wound NP was not involved with R137 like NP-J wanted. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/4/2024 at 11:20 AM, Surveyor asked Licensed Practical Nurse (LPN)-E what the facility protocol was for a resident with a new pressure injury. LPN-E stated the staff nurse that discovers the wound gets the measurements and does the Skin Only Evaluation in the computer charting system. LPN-E stated the previous DON wanted to be notified of any new skin concerns, but there have been multiple DON changes, so it was changing all the time. LPN-E stated the current DON wants the nurse on the floor to get a measurement of the wound and let the NP and DON know about it so the DON will look at the area right away and the Wound NP can look at it on Mondays when the Wound NP assesses all wounds except the surgical wounds. In an interview on 1/4/2024 at 1:18 PM, Surveyor asked Registered Dietician (RD)-K how they are notified of residents with pressure injuries. RD-K stated the facility has wound meetings every week, but with the change in management, those meetings were changing all the time. RD-K stated they are starting to get into a routine with wound rounds on Mondays followed by a wound and nutrition risk meeting right after that on Mondays. RD-K stated that started in the last month. RD-K stated they have a new DON, so things have changed with meeting times and days. RD-K stated RD-K gets a list or report on Mondays of all the residents with skin issues; in the past RD-K had to hound them to get that information. Surveyor asked RD-K if RD-K was aware of R137 having a pressure injury. RD-K stated RD-K was not aware of R137 having a pressure injury. RD-K stated RD-K did the initial nutrition assessment upon admission and R137 was eating well so did not order supplements at that time. RD-K stated RD-K reviewed their notes to see if RD-K was ever told of R137's pressure injury and RD-K did not have any notes so was not aware of the pressure injury. In a phone interview on 1/4/2024 at 1:18 PM, Surveyor asked DON-B if DON-B recalled R137, a resident in the facility 10/24/2023-11/16/2023. DON-B denied having any knowledge of R137 because DON-B had just started working at the facility on 11/6/2023. Surveyor shared with DON-B that DON-B had documented in R137's record on 11/8/2023 of a new pressure injury to the sacrum. DON-B did not recall any information regarding R137 and DON-B did not have R137's medical record available for review at that time. Surveyor asked DON-B what documentation would be expected for a resident that sustained a skin tear. DON-B stated the skin tear should be documented in the progress notes and should include a treatment if that was ordered and the notification of the skin tear to the physician and the family. Surveyor asked DON-B if a treatment was ordered, where would that treatment be documented. DON-B stated the treatment would be on the TAR. Surveyor noted the treatment to the skin tear on 10/25/2023 was not entered onto the TAR. Surveyor asked DON-B where a comprehensive assessment would be documented of a new pressure injury. DON-B stated pressure injuries are documented in the Wound Skin Only assessment in the computer charting system. Surveyor asked DON-B how the Wound NP is notified of a resident that has a new pressure injury. DON-B stated either the nurse on the floor or NP-J lets the Wound NP know of a new area. DON-B stated wounds are assessed by the Wound NP weekly and the treatments are done as prescribed. Surveyor asked DON-B who does wound assessments if the Wound NP was not involved with the resident. DON-B stated the in-house NP and the nurse on the floor would look at the wound and document in the Skin Only form in the computer charting system and then DON-B or the nurse manager should document on the wound. Surveyor asked DON-B how the RD is notified of skin issues. DON-B stated the RD is aware of the residents with skin issues at the weekly meeting. Surveyor attempted to interview other staff that cared for R137, but all staff that documented on R137 were no longer employed at the facility. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/4/2023 at 1:42 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and CNC-F R137's timeline while at the facility and the concerns no preventive measures were implemented on admission to address R137's immobility and incontinence, development of skin tears with no etiology to prevent future skin breakdown, missing comprehensive assessments of the sacral Unstageable pressure injury, and no Wound NP or RD involvement in R137's care after the development of the pressure injury. R137 was placed on antibiotics for an infected pressure injury and was hospitalized with necrotizing fasciitis. NHA-A and CNC-F agreed no comprehensive assessments were completed, the Wound NP was not involved in R137's care, and RD-K was not informed of R137's pressure injury. No further information was provided at that time. The failure to implement preventive interventions for a resident at risk of developing pressure injuries, determine the etiology of skin tears to the coccyx, comprehensively assess the pressure injury, involve the Wound NP, and notify the dietician of the development of a pressure injury led to serious harm for R137 which created a finding of Immediate Jeopardy. The facility removed the jeopardy on 1/12/24 when they completed the following: A facility skin sweep was completed on 1/8/24. All facility residents who are at risk for the development of pressure injuries had their care plans reviewed and updated as needed. All in facility residents with current skin alterations had their care plans reviewed, had an RN comprehensive skin evaluation, and ensured interventions and treatments are place. The facility including the Medical Director reviewed their Pressure Injury Prevention and Managing Skin Integrity Policy and completed a root cause analysis on 1/8/24. All nurses were educated on the facility's skin prevention policy and procedure. All nurses were educated on pressure relieving interventions for residents identified to be at risk for the development of pressure injuries. All nursing staff were educated on notification process of skin changes to be communicated to resident provider and to clinical leadership who then coordinates with the wound NP, dietitian, and provider as needed. Daily at stand up, DON or designee will review progress notes, risk management and 24 hour boards for any resident alterations of skin integrity. All training was completed by staff before their next working shift. Any nurses who did not complete the competency are not scheduled until the training is completed. Competencies and education were conducted by nursing management and/or a nurse who has passed the competency education and has been designated to give an education. The Interdisciplinary Team (IDT) conduct weekly wound meetings to review the status to include: pressure injury Policy and Procedure compliance with findings report to the Quality Assurance Performance Improvement committee (QAPI). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON or designee will audit 5 new admission medical records to ensure that the skin policy and procedure is followed weekly X 4, then monthly X 3 with findings reported to QAPI. The deficient practice continues at a scope/severity of G (actual harm/isolated) based on the following examples: 20025 2. R40 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, bipolar, depression, and spinal stenosis and osteoarthritis. R40 was discharged from the facility on 7/28/23. R40 had a Braden Score completed on 3/14/23 which indicated a score of 20, which is not at risk for pressure injuries. R40 had no other Braden Score completed. The admission MDS (Minimum Data Set) dated 3/30/23 indicates R40 needed extensive assistance with bed mobility, transfers, dressing, and hygiene. It also indicates R40 is occasionally incontinent of urine. It also indicates R40 is at risk for pressure injuries, and has no unhealed Pressure injuries. The MDS indicates R40 only has a pressure r [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on interviews and record reviews the facility did not conduct a root cause analysis of resident falls in order to determine whether current interventions were implemented at the time of the fall, whether current interventions were effective and to determine appropriate ongoing interventions and supervision needed for 2 (R43 and R39) of 6 residents reviewed for falls. *R43 sustained a fall on 5/7/23. The facility did not thoroughly investigate R43's fall. *R39 sustained a fall on 2/28/23. The facility did not thoroughly investigate R39's fall. Findings include: 1. R43 was admitted to the facility on [DATE] with cognitive communication deficit. R43 discharged from the facility on 5/19/23. Surveyor reviewed R43's closed medical record including progress notes. Per medical record, R43 sustained a fall outside of the facility on 5/7/23 without injury. Surveyor noted a progress note dated 5/7/23 which reads Resident exited building and was found by hospital staff on the ground appeared to have abrasion on forehead, no noted active bleeding. R43's fall care plan with initiation date of 3/6/23 and a revision date of 4/19/23 reads The resident is at risk for falls r/t (related to) gait/balance problems. Interventions initiated 3/6/24 include be sure resident's call clight is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests of assistance, encourage the resident to participate in activities ., PT/OT (Physical Therapy/Occupational Therapy) evaluate and treat as ordered or PRN (as needed). Surveyor did not note any care plan intervention updates related to R43's fall on 5/7/23. On 1/4/24 at 3:15 PM, Surveyor requested facility's fall investigation for R43's 5/7/23 fall including root cause analysis and staff statements. No current staff members had knowledge of R43's fall on 5/7/23. On 1/8/24 at 11:35 AM, Administrator-A informed Surveyor that there was no fall investigation that they could identify for R43, including root cause analysis and staff interviews or revisions done for R43's fall care plan. Administrator-A added that they were not employed by the facility at the time of R43's fall and did not have any additional information to supply Surveyor at this time. 47094 2. R39 was admitted to the facility on [DATE] and has diagnoses that include fracture of the fifth lumbar vertebrae, fracture of the sacrum, type 2 diabetes, urine retention, Chronic obstructive pulmonary disease, need for assistance with personal care, difficulty in walking, and history of falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's admission minimum data set (MDS) dated [DATE] indicated R39 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R39 needing extensive assist with 1 staff member for bed mobility, transferring, dressing, toileting, and personal hygiene. R39 had an indwelling catheter and was occasionally incontinent of bowel and wore adult briefs for protection. R39 did not have impairments to R39's upper and lower extremities and was not steady and able to be stabilized with staff when standing. R39 used a walker for short distance and when working with physical therapy and occupational therapy and a wheelchair for long distance. R39's admission falls risk score dated 2/23/2023 indicated R39 was at risk for falls with a score of 17. R39's Risk for Falls Care Plan was initiated on 2/23/2023 with the following interventions: - Encourage R39 to self-propel wheelchair on unit. - Individualized fall prevention measures on R39's care card. - Footwear will fit properly and have non-skid soles. - Keep areas free of obstructions to reduce the risk of falls or injury. - Place call light within easy reach. - Provide reminders to use ambulation and transfer assist devices as needed. - Remind R39 to call for assistance. - Respond promptly to calls for assist to the toilet. - Complete fall risk assessment per policy. R39's certified nursing assistance (CNA) care card dated 2/27/2023 indicated R39 used a four wheeled walker and needed assistance of 1 person and use of a gait belt for transfers, R39 was forgetful at times, and needed assistance of 1 person and gait belt when ambulating to and from R39's bed to R39's bathroom. On 2/28/2023 at 10:44 AM in the progress notes nursing charted nursing was called to R39's room. Nursing observed R39 lying on the floor on R39's side. R39 stated R39 was trying to go to the bathroom and got tangled in the bed sheets. Nursing charted R39's vital signs were stable and R39 stated R39's knees and head hit the ground. Nursing charted that R39's family was contacted and denied R39 to go to the hospital. Nursing charted R39 did not have visible injuries and R39 denied having pain. Surveyor reviewed the fall investigation for R39's fall on 2/28/2023 and noted that nursing did not indicate if R39's physician or facility administration was contacted regarding R39's fall. The fall investigation also did not include staff interviews regarding when R39 was last toileted by staff, did not indicate what R39's surroundings looked like at time of fall and does not indicate if the interdisciplinary team discussed the root cause of the fall or if the fall was reviewed to determine contributing factors to R39's fall or if interventions were in place and appropriate for R39. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/4/2024 at 10:03 AM Surveyor interviewed licensed practical nurse (LPN)-L who stated LPN-L did not recall R39 as a resident at the facility or R39's fall on 2/28/2023. Surveyor asked what the policy is for if a resident falls. LPN-L stated that if a resident fell nursing would do an assessment to determine if the resident had to go to the hospital for further evaluation or if the resident is ok to be transferred to another surface. LPN-L stated that vital signs are gathered, notification to the doctor, director of nursing (DON), and family regarding the residents fall, the residents get put on the 24 hour board for monitoring for 3 days, and the fall gets documented in point click care. Surveyor asked LPN-L if LPN-L recalls contacting R39's physician or the DON for R39's fall on 2/28/2023. LPN-L replied LPN-L does not recall R39's fall on 2/28/2023 so is not sure if LPN-L contacted R39's physician or the DON. LPN-L stated LPN-L would have documented on the fall investigation if LPN-L did contact the physician or DON. On 1/4/2024 at 11:20 AM Surveyor interviewed LPN-E who stated when a resident falls the interdisciplinary team (IDT) will review the falls from the 24 hour boards and discuss what interventions would need to be put in place for the resident. Surveyor asked LPN-E if the team goes over why or how the fall happened or interview staff that was on at time of fall to determine when the resident was last seen, toileted, what the environments looked like. LPN-E stated they do not discuss that in the morning meetings. LPN-E stated if they need more information then the nurses will ask questions otherwise, they just talk about an intervention. On 1/4/2024 at 1:14 PM Surveyor interviewed DON-B who stated the IDT discuss the falls in the morning meeting and go over what happened during the fall and what interventions should be put in place. DON-B stated that the IDT team meeting does not get charted anywhere, the team just has a discussion. On 1/4/2024 at 1:43 PM Surveyor informed nursing home administrator (NHA)-A, corporate nurse consultant (CNC)-F, and CNC-G of Surveyors concern that R39's fall on 2/28/2023 did not have a thorough investigation of the fall. No further information was provided at this time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46517 Based on observation and interview the Facility did not ensure eye drops and insulin were dated when opened, medications were not expired, medications belonging to residents who no longer resided in the facility were disposed of properly, and the medication refrigerator was being monitored for appropriate temperature. This deficient practice has the potential to affect R1, R29, R4 and a pattern of residents residing on the first floor who utilize refrigerated medications and/or stock medications. *R1, R29 and R4 had medications in the Unit D medication cart that were either not dated and/or expired. *The first-floor medication room contained expired stock medications. *The first-floor medication room refrigerator contained medications belonging to residents no longer in the facility and insulin that was opened but not dated. *The first-floor medication room refrigerator temperature log was not filled out. Findings include: Surveyor reviewed the facility policy entitled Medication Storage in the Facility, dated May 2018, stated: Medications and biologics are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . H. Outdated, contaminated, or deteriorated medications .are immediately removed from inventory, disposed of according to procedures for medication disposal . K. Refrigerated medications are kept in closed and labeled containers . Temperature . C. Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 degrees Celsius (C) (36 Fahrenheit) and 8 degrees C (46 Fahrenheit) . D. The facility should maintain a temperature log in the storage area to record temperatures at least once a day . Expiration dating . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1.The nurse shall place a date opened sticker on the medication and enter the date opened and the new expiration date .the expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating. G. All expired medications will be removed form the active supply and destroyed in the facility, regardless of amount remaining . 1. On 1/03/24 at 9:30 AM, Surveyor reviewed the Unit D medication cart and noted the following: R4 had an opened container of Latanoprost eye drops which were not dated. The eye drops were sent on 12/19/23; an opened vial of Insulin Glargine which was not dated and sent on 12/24/23; an opened vial of Insulin Lispro which was dated either 8 or 9/25. Surveyor could not determine whether it was an 8 or a 9. Surveyor reviewed the above medications with Licensed Practical Nurse (LPN)-O. LPN-O could not find a date on the first two and informed Surveyor the third medication was dated with an expiration date of 8/25, 25 being the year. Surveyor questioned how could the expiration date be 2025 when this medication was sent on 8/2023 and the medication was used? LPN-O was uncertain and stated she would get back to Surveyor. R1 had a bottle of Polyvinyl eye drops which were opened and dated 09/01/23. Surveyor showed LPN-O the bottle and LPN-O informed Surveyor she did not think the bottle was expired because the expiration date on the bottle was 4/25. R1 also had an opened bottle of Systane eye drops which were not dated. Surveyor showed the bottle to LPN-O. R29 had two boxes that contained Bausch and Laumb Sodium Chloride Hypertonicity ophthalmic ointment 5%. One of the boxes contained one opened and used container of eye drops and the box had a red circle with a date 11/23. The other box contained an opened and used container of eye drops and did not have a circled date. Surveyor noted neither box/container of eye drops were dated with an opened date. Per LPN-O she thought the box with the red circled date of 11/23 was expired but the other box was not. Surveyor asked LPN-O how long are opened eye drops good for? LPN-O thought until the expiration date on the container. Surveyor explained some medications might expire sooner after opening. LPN-O informed Surveyor she would look into it and get back to Surveyor. On 01/03/24 at 10:15 AM, LPN-O informed Surveyor eye drops expire after 30 days of opening and insulin expires after 28 days of opening. 2. On 01/03/24 at 8:40 AM, Surveyor reviewed the first-floor medication room. Surveyor noted the medication cabinet contained two opened expired medications: Bisacodyl with an expiration date of 9/23 and an Antacid bottle with an expiration date of 12/2023. Surveyor showed LPN-L the expired medications and LPN-L stated they should be destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 01/03/24 at 8:45 AM, Surveyor reviewed the first-floor medication refrigerator and noted four residents had insulins that were opened and either expired or not dated, and there was one opened and used bottle of insulin lispro that was not labeled with a resident's name but had an opened date of 11/27. Surveyor showed LPN-L all the expired/unlabeled insulins in the refrigerator. Per LPN-L, the four residents with the expired/not dated insulins were no longer at the facility and those medications should have been disposed of when the residents left. LPN-L stated the bottle of insulin lispro was dated with an opened date. 4. On 01/03/24 at 8:50AM, Surveyor reviewed the first-floor medication refrigerator and noted a temperature log on the door. The temperature log had not been filled out for January and December 2023 only contained nine temperatures. Besides the above medications this refrigerator contained medications for four other residents still in the building, two tuberculosis vials and three boxes of influenza vaccines. Surveyor could not locate a thermometer. Surveyor asked LPN-L where the thermometer was located, and LPN-L could not locate it either. On 01/03/24 at 8:57 AM, LPN-L found Surveyor and showed Surveyor the thermometer which was located on the wall the refrigerator was against. The temperature was above the recommended range; however Surveyor had the refrigerator door open prior to reading the temperature. Surveyor rechecked the refrigerator temperature two hours later and it was within the designated range. Surveyor noted a typed memo placed on the medication room door which stated, AM and PM nurses are to check the refrigerator temps located in the med room on the refrigerator daily on am and pm shift. On 01/04/24 at 12:43 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Per NHA-A the refrigerator temperatures should be checked twice a day if it houses a vaccine. Surveyor relayed the above concerns relating to medications not being dated, expired medications, medications belonging to discharged residents still in storage and the refrigerator temperature not being recorded. No additional information was provided.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 47094 Based on observation, interview, and facility policy review the facility did not ensure the garbage and refuse were properly disposed in the outside garbage storage receptacles. This deficient practice had the potential to affect all 38 residents residing at the facility. Findings include: On 1/2/2024 at 8:22 AM Surveyor took an initial tour of the kitchen and outside garbage receptacles with Head Chef-I. Surveyor observed 2 large dumpsters, 1 dumpster was for recyclables and the second dumpster was for garbage. The Garbage receptacle lid was open because it was full of garbage bags. There were garbage bags all along the back of the garbage receptacle on the ground. Surveyor was not able to determine what was inside the garbage bags. Surveyor asked Head Chef-I how often the dumpsters get emptied. Head Chef-I replied the dumpsters get emptied two times a week and both dumpsters should be emptied today (1/2/2024). Surveyor asked Head Chef-I who maintains the outside around the dumpsters to see if it is clean. Head Chef-I replied that maintenance manages the outside grounds. On 1/3/2024 at 12:30 PM Surveyor went to look at the outside garbage receptacles again with Head Chef-I. The garbage receptacle lid was open, the garbage receptacle was emptied, and there were still several bags of garbage on the ground along the back of the garbage dumpster. On 1/3/2024 Surveyor requested the policy for waste management for the facility. Surveyor was handed the contract with the Pest Management company and the facility. The contract did not explain how often or when the outside dumpster area should be checked and maintained by facility maintenance staff. On 1/4/2024 at 12:14 AM Surveyor interviewed the Maintenance Lead-H who stated he checks the outside dumpster area once a month. Surveyor asked Maintenance Lead-H when the last time he checked the dumpster area was. Maintenance Lead-H stated he last checked mid- December. Surveyor asked Maintenance Lead-H if he has checked the area lately. Maintenance Lead-H stated he checked it this morning and will be going out later to clean the area up. On 1/4/2024 at 1:43 PM Surveyor informed nursing home administrator (NHA)-A, Corporate Nurse Consultant (CNC)-F, and CNC-G of Surveyors observations of the outside garbage receptacle area was dirty with garbage bags along the back of the dumpster. Surveyor informed NHA-A that the pest control contract did not specifiy how often the dumpster area should be managed and that Maintenance Lead-H looks at the dumpster area monthly. Surveyor asked NHA-A what facility expectations are of managing the dumpster area. NHA-A stated NHA-A would expect the area to be looked at least every other day if not daily to check for garbage in the area. No further information was provided at this time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46517 Based on observation and record review, the facility did not maintain documentation of a comprehensive infection control program including infection surveillance and the facility did not have a comprehensive water management plan. This deficient practice has the potential to affect 38 of the 38 residents residing in the facility at the time of the survey. * The facility was not able to show evidence of an infection control surveillance system designed to identify infections before they can spread to others in the facility, prior to December 1, 2023, when the facility identified the deficit and implemented a Performance Improvement Plan. While on survey, the facility was able to provide a line list about the Covid outbreak that occurred around August 7 & 8, 2023. * The facility had a water management policy entitled Water Management Program which listed components of what needed to be included in the water management program. The facility's water management program consisted of a water flow diagram with 4 sheets of paper entitled logbook documentation: flush all toilets and hoppers not being used, all dated December 2023. The facility's water management program did not include the roles and responsibilities of the water management team, a written description of the building's water system and all the areas where Legionella could potentially grow and the corresponding control measures. Findings include: The facility policy entitled Infection Control, last reviewed date 09/20/23, stated: 1. Prevention and Surveillance the facility will: i. Perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection . 4. Investigating i. Trends and patterns will be discussed with the Quality Assurance Performance Improvement (QAPI) committee. Process Improvement Projects (PIP) will be chartered and managed around identified opportunities for improvement, resulting in countermeasures . 1. During Surveyor's record reviews it was noted that the facility had a possible Covid outbreak sometime in August/September of 2023. Surveyor asked for any infection control documentation to review such as infection surveillance. Surveyor did not receive any documentation relating to infection control to review prior to interviewing staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/03/24 at 1:02 PM, Surveyor interviewed Clinical Nurse Consultant (CNC)-F. Per CNC-F infection control now is managed as a joint effort with herself and the Director of Nursing (DON)-B managing infection control. CNC-F informed Surveyor the facility's infection control program is not where it should be, and the facility was attempting to switch from one infection control program to Point Click Care (PCC). Surveyor asked to see infection surveillance for the last year. CNC-F stated she did not have anything and could not get access to the old system. Per CNC-F the facility had a lot of turnover and the staff that handled the infection control program previously only had access to the old system. CNC-F stated the facility was aware of the deficits with the infection control program and started a PIP in the beginning of December 2023 when the issue was realized. CNC-F stated the facility has mapping and tracking from December 2023 to present but nothing prior to December 2023. CNC-F stated she reviews the PCC module daily and it is up to date with monitoring infections, and she feels that surveillance was happening but the facility is not capturing it/or documenting it appropriately. Surveyor asked if the facility had any outbreaks during the previous year? CNC-F was uncertain. Surveyor asked if the facility had any covid outbreaks the previous year? CNC-F informed Surveyor she thought there might have been one positive in November, but that resident came to facility with Covid or was sent out to the hospital and then diagnosed with Covid. Surveyor asked if there was a Covid outbreak around the month of August 2023? CNC-F was uncertain. Surveyor asked for any additional information on a Covid outbreak that might have happened last year and any additional information regarding the facility's infection control program. Per CNC-F she would search and see what she could find. CNC-F also provided Surveyor a copy of the facility's PIP which documented: Project: Infection control Purpose: Facility has completed the following worksheet for the purpose of quality assurance and health care service review to improve the quality of care of the residents served. Many times this is a living document and is continuously added to until 100% improvement is sustained. Background I. Background a. Date of Discovery: 12/1/2023 b. Was a self-report necessary to be submitted to DA? NO If yes, Date: Summary of Critical Event II. Summary of Critical Event a. Prior DON was covering as Infection Control Nurse; she left position. New ADON will assume infection control nurse duties. For time between new RN assuming role the CNC and DON attempted to run the infection control program in the manner that previous DON was. The tracking method and data provided did not prove to be consistent or accurate. At the same time, IP Module within Point Click Care (PCC) became available to track infections. b. Decided that it would be best if the facility started fresh and began tracking infections through the PCC program, and through spreadsheets modeled after infection control programs used by [facility corporation]. c. Most infections were tracked, but specific start dates, resolution dates and symptoms were not always clearly tracked. Relevant Facility policies, and contributing factors if any: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	III. Relevant Facility policies and contributing factors if any: a. All infection control is to follow F882 c. Facility is at risk for citation for infection control, no observed negative outcomes however tracking and auditing to be put into place. The root cause was that the DON handled infection control, wounds, and her duties as the DON. It is not possible to handle all these areas effectively . During the end of the day meeting on 01/03/24 at 3:13 PM with Nursing Home Administrator (NHA)-A, CNC-F, and CNC-G, Surveyor reviewed the above concern regarding a lack of documentation of infection surveillance and asked for any information on a possible Covid outbreak around August of 2023. On 01/04/24 at 10:14 AM, CNC-F informed Surveyor she found evidence of an outbreak of Covid around August 7th/8th of last year. Per CNC-F there were around 6 positive cases. CNC-F stated the facility was testing and masking. Surveyor asked for documentation on when and who was tested for Covid. CNC-F stated she had found this information by going through progress notes and the staff here were trying to piece it all together. CNC-F stated she will find additional information and get back to Surveyor. On 01/04/24 at 10:50 AM, CNC-F informed Surveyor Licensed Practical Nurse (LPN)-E was printing the line listing for the August outbreak and LPN-E could speak with Surveyor. On 01/04/24 at 12:29 PM, Surveyor interviewed LPN-E. LPN-E was agency staff at the facility and worked during the Covid outbreak. LPN-E provided Surveyor a completed line listing, communication with the health department and testing information. Per LPN-E the Covid outbreak was confined to one hall. Surveyor noted the facility appeared to have done everything correctly during the outbreak and there appeared to be no negative resident outcome; however, the facility did not maintain proper documentation of the outbreak. On 01/04/24 at 12:51 PM, Surveyor interviewed NHA-A and CNC-F. Surveyor shared infection control concerns related to lack of documentation of infection surveillance. Per CNC-F she was aware of the infection control deficient and NHA-A agreed. No additional information was provided. 2. The facility's policy entitled Water Management Program, (facility reviewed) on 12/13/23, stated: Policy: Entity shall identify and manage risks arising from exposure to Legionella bacteria in water systems. The standards identified below will be followed in order to prevent and control Legionnaires' disease and outbreaks. Procedure: A. Water Management Team i. Entity's Water Management Program is overseen by the Water Management Team. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ii. The team consists of, at a minimum, the Executive Director, Environmental Services Lead, and Infection Preventionist. iii. Other members of the team may include Medical Director, Director of Quality and Risk Management, Contractual Microbiologist, Consultant Industrial Hygienist, Local Water Department Representative, Water Maintenance Contractor Representative. B. Facility Risk Assessment i. Legionella Environmental Assessment will be conducted by the Water Management Team annually and periodically as changes in the environment conditions dictate. ii. The following will be included within the assessment: 1. Water Flow Mapping diagrams (describing the building water systems and areas where Legionella could be present) 2. Areas of risk of stagnation, temperature becoming ideal for growth, devices with standing water, decorative fountains, etc. iii. Water Management Team will review the assessment within Quality Assurance and Process Improvement (QAPI) team annually. C. Monitoring i. The Water Management Team will be responsible for monitoring risk and identifying potential cases or breaches of control measures of concern. ii. If facility is in a municipality, said water department will monitor water parameters (residual disinfectant, temperature, PH) iii. If facility is rural and on a well system, facility will monitor water parameters following CDC guidelines biofilm, scale, buildup, etc. iv. Facility will monitor temperature of hot water and visually check for biofilm, scale, buildup, etc. v. All positive results of Legionella are reported to the local health department and the positive device is removed from service. vi. Areas of the water system found outside of normal limits will be flushed and serviced. vii. If rooms are closed due to low census or put out of use, a routine process will be implemented to run faucets, showers, and to flush toilets. viii. Documentation will be retained. ix. Corrective actions taken when control limits are not maintained will be documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525421	A. Building B. Wing	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Water Management Plan i. The Water Management Plan will be reviewed annually or more often as indicated. E. Contingency Response i. If there is an implication of an outbreak of Legionellosis, decontamination of the hot water system may be necessary. Thermal shock or shock chlorination methods of decontamination for the hot water system may be used. ii. Based on the findings, Water Management Team or designee will reevaluate the disinfection processes and make appropriate corrections. iii. Entity shall flush dead legs, water heaters, and plumbing fixtures with chlorine. iv. If a water main break occurs, the main water valves will be closed, and the Water Emergency Plan will be activated. v. For potable water systems that were opened for repair, other construction or subjected to water pressure changes associated with construction, it is recommended that at a minimum the systems be thoroughly flushed During the end of the day meeting with NHA-A, CNC-F and CNC-G, Surveyor asked to review the facility's water management plan. NHA-A informed Surveyor she would arrange for the Maintenance Lead (ML)-H to speak with Surveyor regarding the water management plan. Surveyor asked to review any documentation the facility had prior to this interview. NHA-A informed Surveyor she would speak with ML-H. On 01/04/24 at 11:26 AM, Surveyor interviewed MN-H. Surveyor was not given a water management plan prior to review and MN-H gave Surveyor a handful of papers containing a document entitled [NAME] Grove Water Flow Diagram which contained a diagram of the facility's water flow; four sheets of paper entitled Logbook Documentation: Flush all toilets and hoppers not being used (all dated in December); an Emergency Disaster plan which documented what the food service staff would do in an emergency and an invoice from a food service company. Surveyor asked MN-H if there was any other documentation he had for the water management plan. Per MN-H what he gave Surveyor was all he had. MN-H explained he flushes the empty rooms and areas once a week. Per MN-H he created an order work form in the facility's system but was not documenting this until December 2023. MN-H informed Surveyor he checks the water temperatures weekly, and a company comes to inspect the ice machines quarterly. Surveyor asked for documentation. Surveyor asked MN-H who is part of the Water Management team and what are their assignments? Surveyor explained the needed parts of Water Management plan such as members names and assignments; a written description of the buildings water system and all the areas where legionella could potentially grow and the corresponding control measures. MN-H said he did not have any other plan, but informed Surveyor his boss was working on a new plan. On 01/04/24 at 12:51 PM, Surveyor interviewed NHA-A and CNC-F. Surveyor explained the Water Management Plan concerns and asked for any additional information. No additional information was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46517 Based on interview and record review the facility did not offer the pneumonia vaccine for two (R11 and R12) of five residents reviewed for vaccinations. Findings include: Facility policy entitled, Individual Immunizations, last reviewed 09/20/2023, stated, Prophylactic immunizations will be offered to individuals to promote the absence of Health Care Acquired Infections. Procedure: 1. Immunization a. Upon admission, the organization will verify the individual's immunization status, update the Primary Care Provider (PCP) as indicated, and administer immunizations as ordered. b. Individuals will be offered immunizations based upon the Center for Disease Control (CDC) recommendations and guidelines and as prescribed by their PCP . 3. Documentation .b. Immunization consent and or refusal shall be documented within the Electronic Medical Record . 1. Surveyor reviewed R12's Electronic Medical Record (EMR) for immunization status and noted R12 did not have documentation of any pneumonia vaccines. Surveyor reviewed R12's admission Minimum Data Set assessment (MDS) dated [DATE] which documented R12 was not offered the pneumonia vaccine. Surveyor continued to review R12's EMR and noted there was no documentation that R12 was offered the vaccine, received the vaccine, or refused the vaccine. 2. Surveyor reviewed R11's EMR for immunization status and noted R11 did not have documentation of any pneumonia vaccines. Surveyor reviewed R11's admission Minimum Data Set assessment (MDS) dated [DATE] which documented R11 was not offered the pneumonia vaccine. Surveyor continued to review R11's EMR and noted there was no documentation that R11 was offered the vaccine, received the vaccine, or refused the vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/03/24 1:02 PM, Surveyor interviewed Clinical Nurse Consultant (CNC)-F. Per CNC-F upon admission the nurse verifies the immunization and have the resident sign a declination or acceptance of the vaccine; education is given to the resident at that time. CNC-F informed Surveyor the facility is offering the pneumonia vaccines and the influenza vaccines but would have to check on the Covid vaccines. Surveyor asked if R11 and R12 were offered the pneumonia vaccines? CNC-F stated she would have to get back to Surveyor. Surveyor explained a lack of documentation as to whether R11 and R12 were offered the vaccine and refused or not offered the vaccine at all. CNC-F stated she would look into it and get back to Surveyor. On 01/04/24 at 10:50 AM, CNC-F informed Surveyor staff told her they are offering the vaccines but there is no documentation/evidence. On 01/04/24 at 12:51 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and CNC-F. CNC-F stated she could not find any additional information as to whether R11 or R12 was offered the pneumonia vaccine. Per CNC-F the facility needs to do a better job with offering vaccines upon admission and documenting acceptances and refusals. No additional information was provided.