STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 000}	Initial Comments On 05/21/2024, with information gathered through 05/31/2024, Surveyors conducted a verification visit, a standard survey and 3 complaint investigations at Country Terrace Appleton. Two (2) of 3 complaints were substantiated. As a result of the survey, 7 deficiencies were identified. One (1) of the 5 deficiencies was a repeat violation. See Statement of Deficiency (SOD) 5DF711, dated 06/26/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 12	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 (Residents 3 and 8) residents reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 3 was prescribed Diclofenac Sodium 1 % (percent) external gel to be applied to two	{N 352}		

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

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{N 352}	Continued From page 1 finger joints 4 times daily. During review of Resident 3's May 2024 MAR (Medication Administration Record), it was discovered Resident 3 did not receive the gel at 4:00PM from 05/01/2024 through 05/20/2024 and at 8:00PM on 05/04/2024 and from 05/07/2024 through 05/19/2024 due to the medication not being in the cart. Resident 8 was prescribed Citalopram Hydrobromide 10 MG (milligram) oral tablet to be taken by mouth once daily. During review of Resident 8's February 2024, March 2024 and April 2024 MAR, it was discovered Resident 8 received 1 tablet of Citalopram on 04/24/2024, but did not receive any other doses in February, March or April. Findings Include: On 12/04/2023, the department received a complaint regarding medication administration. A facility policy titled, "Medications Storage/Administration/Documentation" dated 12/12/2012 stated, "The resident's MAR is initialed by the person administering a medication in the space provided under the date, and on the line for that specific medication dose administration...If a dose of a regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage is initialed and circled. An explanatory note is entered on the back of that same page." On 05/21/2024, Surveyor made an onsite visit to the facility. A sample of residents was selected including the resident records of Residents 3 and 8.	{N 352}		

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{N 352}	Continued From page 2 RESIDENT 3 Resident 3's record contained an order dated 07/05/2023 for Diclofenac Sodium 1 %(percent) external gel to be applied topically to two finger joints 4 times daily for joint damage causing pain and loss of function. Surveyor reviewed Resident 3's May 2024 MAR. Resident 3 was to receive the gel at 8:00AM, 12:00PM, 4:00PM and 8:00PM every day. Resident 3's May 2024 MAR indicated by medication passer's initials being circled that Resident 3 did not receive the gel at the following times/days: -4:00PM from 05/01/2024 through 05/20/2024. (It should be noted that on 05/04, 05/07 and 05/19 there is a note on back of MAR that says, "Not in cart," there are no notes for the other days the gel was not administered.") -8:00PM on 05/04/2024, 05/07/2024 through 05/19/2024. (No notes were written regarding the medication not being administered.) On 05/21/2024 at approximately 11:45AM, Surveyor observed the medication cart and MAR with Assistant Director B. Assistant Director B indicated s/he initials the MAR after giving a resident their medications, if initials are circled this means the resident did not receive medication. Assistant Director B indicated the reason for not giving the medication should be written on the back of the MAR. Surveyor reviewed the medication cart. Surveyor was unable to locate the Diclofenac gel for Resident 3 in the medication cart. Surveyor requested Assistant Director B's assistance in locating the gel. Assistant Director B was unable to locate the gel. Assistant Director B indicated s/he needed to go get Director A. Director A was informed	{N 352}		

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{N 352}	Continued From page 3 Surveyor and Assistant Director B were unable to locate the Diclofenac gel for Resident 3. Director A stated s/he would be calling the pharmacy to get another tube. Director A and Assistant Director B verified the MAR indicated Resident 3 did not receive the Diclofenac gel at 4:00PM and 8:00PM as prescribed. On 05/22/2024 at 9:00AM, Surveyor interviewed Pharmacist D. Pharmacist D verified the facility contracts with the pharmacy for pharmacy services. Pharmacist D stated the facility had called yesterday to request a refill of the gel. Pharmacist D stated prior to that the facility had not requested a refill since March 2022. Pharmacist D did indicate the gel can be bought over-the-counter. On 05/22/2024, Surveyor emailed Director A. Surveyor inquired about who was responsible for ordering, purchasing and delivering the Diclofenac gel for Resident 3. Director A responded to the email, "...I found no evidence that it was reordered by staff. Will now be covering med [medication] re order [sic] process as employee training." RESIDENT 8 Resident 8's record contained an order dated 12/26/2023 for Citalopram Hydrobromide 10 MG oral tablet to be taken by mouth once daily for generalized anxiety disorder. Surveyor reviewed Resident 8's February 2024 MAR. The entry for Citalopram had a handwritten note stating, "Dc'd [discontinue] 1.18.2024." Resident 8 received no doses of Citalopram in February. Surveyor reviewed Resident 8's March 2024	{N 352}		

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{N 352}	Continued From page 4 MAR. The entry for Citalopram had a handwritten note stating, "Dc'd 1.18.24." Resident 8 received no doses of Citalopram in March. Surveyor reviewed Resident 8's April 2024 MAR. The entry for Citalopram had a handwritten note stating, "Dc'd 1.18.24." Resident 8 received 1 dose of Citalopram on 04/24/2024. On 05/30/2024 at 9:15 AM, Surveyor interviewed Pharmacist E. Pharmacist E verified they provide pharmacy services to the facility. Pharmacist E verified there is an order dated 12/26/2023 for Resident 8 to receive Citalopram 10 mg once a day. Pharmacist E stated the pharmacy sent Citalopram unit dose packs to the facility on 01/12/2024, 02/09/2024, 03/08/2024, 04/05/2024 and 05/03/2024. Pharmacist E stated s/he did not see any documentation of a discontinue order for the use of Citalopram for Resident 8. Pharmacist E stated there was a note from Resident 8's physician regarding the facility discontinuing Citalopram and the need for Resident 8 to continue to receive it. Pharmacist E stated s/he would send a copy of the note to Surveyor. On 05/30/2024, Pharmacist E sent a letter from Resident 8's physician stating, "...Med list says citalopram was discontinued 1/18/24 but I am not seeing any note that says to discontinue it. I am wondering if Country Terrace inappropriately discontinued it after [him/her] HVI cardiology appointment on 1/18 because instructions were to discontinue Plavix (clopidogrel). Maybe citalopram was mistaken for clopidogrel. Would recommend restarting citalopram." On 05/30/2024 at 10:40 AM, Surveyor interviewed Director A who acknowledged Surveyors findings. Director A stated, "I can't say	{N 352}		

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{N 352}	Continued From page 5 [Resident 8] got Citalopram. The MARs were discontinued. I am looking into this and trying to figure out why they were discontinued."	{N 352}		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation, staff interview and record review the provider did not establish an effective procedure for the proper destruction and disposal of unused, discontinued, or outdated medications. In 1 of 1 medication carts in the facility, medications for 4 of 12 (Resident 1, 2, 3 and 4)	N 406		

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residents were discovered as expired.

Resident 1 had the following medication cards which contained a prescription for:
-Acetaminophen 500 mg (milligrams) with an expiration date of 05/04/2024.
-Acetaminophen 500 mg (milligrams) with an expiration date of 04/25/2024.
-Famotidine 20 mg (milligrams) with an expiration date of 04/14/2024.
-Famotidine 20 mg (milligrams) with an expiration date of 04/25/2024.
-Cetirizine 10 mg (milligrams) with an expiration date of 04/25/2024.
-Cetirizine 10 mg (milligrams) with an expiration date of 04/14/2024.
-Senna Laxative 8.6 mg (milligrams) with an expiration date of 04/25/2024.

Resident 2 had a medication card which contained a prescription for Tramadol 50 mg with an expiration date of 02/15/2024.

Resident 3 had a medication card which contained a prescription for Lorazepam 0.5 mg with an expiration date of 05/05/2024.

Resident 4 had a medication card which contained a prescription for Lorazepam 0.5 mg with an expiration date of 04/29/2024.

Findings include:

On 05/21/2024 at approximately 11:45 A.M., Surveyor observed 1 of 1 medication carts in the facility. Surveyor observed the following:

Resident 1 had the following medication cards which contained a prescription for:
-Acetaminophen 500 mg (milligrams) as needed

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with an expiration date of 05/04/2024. Surveyor reviewed Resident 1's May 2024 MAR. Resident 1 received 3 doses after 05/04/2024.
-Acetaminophen 500 mg as needed with an expiration date of 04/25/2024. Surveyor reviewed Resident 1's April 2024 MAR. Resident 1 did not receive Acetaminophen after 04/25/2024.
-Famotidine 20 mg once a day with an expiration date of 04/14/2024. Resident 1 did not receive any doses after 04/14/2024.
-Famotidine 20 mg as needed with an expiration date of 04/25/2024. Resident 1 did not receive any doses after 04/25/2024.
-Cetirizine 10 mg as needed with an expiration date of 04/25/2024. Resident 1 did not receive any doses after 04/25/2024.
-Cetirizine 10 mg one tablet per day with an expiration date of 04/14/2024. Resident 1 did not receive any doses after 04/14/2024.
-Senna Laxative 8.6 mg one tablet per day as needed with an expiration date of 04/25/2024. Surveyor reviewed Resident 1's April 2024 MAR. Resident 1 did not receive any doses after 04/25/2024.

Resident 2 had a medication card which contained a prescription for Tramadol 50 mg with an expiration date of 02/15/2024. Surveyor reviewed Resident 2's February through May 2024 MAR. Resident 2 received 6 doses after 02/15/2024.

Resident 3 had a medication card which contained a prescription for Lorazepam 0.5 mg 1 tablet twice a day as needed with an expiration date of 05/05/2024. Surveyor reviewed Resident 3's May 2024 MAR. Resident 3 did not receive any doses after 05/05/2024.

Resident 4 had a medication card which

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N 406	Continued From page 8 contained a prescription for Lorazepam 0.5 mg 1 tablet every 2 hours as needed with an expiration date of 04/29/2024. Surveyor reviewed Resident 4's April through May 2024 MAR. Resident 4 did not receive any doses after 04/29/2024. On 05/21/2024 at 11:45 A.M., Surveyor interviewed Assistant Director B. Assistant Director B verified the prescriptions were expired. Assistant Director B stated all medication passers are responsible for checking the medication cart each day for expired medications. Assistant Director B removed the medication cards from the medication cart and brought them to Director A's office.	N 406		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed that received a scheduled psychotropic medication had the use of the psychotropic medication reassessed at least quarterly for the	N 407		

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desired responses and possible side effects by a pharmacist, practitioner or registered nurse. Resident 8's Citalopram was not reassessed quarterly.

Findings include:

On 05/21/2024 at approximately 10:35 AM, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the facility on 06/23/2022 with diagnoses including cognitive heart failure, anxiety, hypertension, cerebral infarction and mild protein/calorie malnutrition. Resident 8's medication admission record (MAR) identified s/he was prescribed Citalopram 10 milligram (mg) tablet by mouth once daily. A physician's order for Citalopram indicated Resident 8 was prescribed this medication on 12/26/2023. Resident 8's record did not include any scheduled psychotropic reviews.

On 05/21/2024 at 12:45 PM, Surveyor spoke with Director A regarding Resident 8's psychotropic reviews who stated s/he would reach out to their regional nurse and provide an update to Surveyor.

On 05/23/2024 at 12:45 PM, Surveyor received a follow up email from Director A with the completed psychotropic reviews; however, the medications listed on the reviews did not include Citalopram.

On 05/30/2024 at 4:22 PM, Surveyor followed with Director A via email inquiring if any psychotropic reviews were completed for Resident 8's Citalopram.

On 05/31/2024 at approximately 10:00 AM, Surveyor followed up with Director A via phone.

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N 407	Continued From page 10 Director A confirmed there were no psychotropic reviews completed for Resident 8's Citalopram. S/he stated s/he would follow up with their regional nurse and have this completed.	N 407		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure weekly written menus were made available to residents and deviations from the menu were documented. Findings include: On 12/04/2023, the department received a complaint alleging the menu is not being followed. On 05/21/2024 at 9:25 AM, Surveyor observed a dry erase board hanging on the wall near the kitchen. The board stated, "May 22nd Tuesday; Breakfast: Sausage, egg and cheese biscuit; Lunch: Taco Salad; Dinner: Pizza and baked beans; Sweets: Cinn Rolls & Watermelon." Surveyor asked Director A for a weekly or monthly menu as Surveyor did not observe one posted. Director A indicated s/he thought one was posted, but s/he would check in the kitchen. Director A came out from the kitchen and provided Surveyor	N 450		

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N 450	Continued From page 11 with a menu and reported it was an old menu from April and did not have May's menu. Surveyor reviewed the menu and the dates listed were 04/01/2024 to 04/29/2024. On 05/21/2024 at 9:35 AM, Surveyor interviewed Director A who acknowledged Surveyor's findings. S/he explained 3rd shift prepares the meals and 1st and 2nd shift cook the meal. Director A stated, "I need to talk with staff about following the menu. They are often deviating as they claim we don't have what is needed on the menu." S/he reported if they do not have the food for what is on the menu, staff will look to see what we do have and make that. Director A stated if staff need to provide an alternative to the menu there is a form they need to fill out, but they have not been doing that. Surveyor asked what was supposed to be on the menu for breakfast today and Director A pointed to "Tuesday 4/16" on the April menu which stated, "Dry cereal Rice Krispies, a fruit cup fresh and canned, and toasted wheat slice." Director A acknowledged dry cereal was not served this morning for breakfast and was not sure why staff came up with the sausage, egg and cheese biscuit instead. Director A confirmed staff have no way of knowing if 3rd shift changes the menu if they do not fill out the alternatives form. On 05/21/2024 at 9:50 AM, during an interview, Assistant Director B verified staff and residents do not know what they are having to eat tomorrow. S/he stated, "It's day by day. We have to trust 3rd shift to prepare the menu for the next day."	N 450		
N 454	83.42(1) Resident record maintained.	N 454		

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N 454	Continued From page 12 The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or	N 454		

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N 454	Continued From page 13 symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on observation, record review and interview the provider did not maintain a record that included a current list of the type and dosage of medications or supplements for 1 of 1 (Resident 8) residents reviewed. Resident 8's MAR (Medication Administration Record) indicated Resident 8 received Donepezil 5 mg(milligrams) tablet once a day at bedtime on 05/01/2024, 05/02/2024, 05/03/2024, 05/05/2024, and 05/06/2024. Resident 8's record did not contain an order for Donepezil. Findings Include:	N 454		

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N 454	Continued From page 14 On 12/04/2023, the department received a complaint regarding medication administration. On 05/21/2024, Surveyor conducted an onsite visit to the facility. A sample of residents was selected including the record of Resident 8. Surveyor reviewed Resident 8's May 2024 MAR. Resident 8 received Donepezil 5 mg(milligrams) tablet once a day at bedtime on 05/01/2024, 05/02/2024, 05/03/2024, 05/05/2024, and 05/06/2024. Resident 8's record did not contain an order for Donepezil. On 05/21/2024 at approximately 11:30 AM, Surveyor observed the medication cart with Assistant Director B. Surveyor and Assistant Director B were unable to locate a medication card for Resident 8's Donepezil. On 05/22/2024 at 9:00 AM, Surveyor interviewed Pharmacist D. Pharmacist D verified the pharmacy contracts with the facility for medication dispensing. Pharmacist D reviewed Resident 8's pharmacy record and was unable to locate an order for Resident 8 for Donepezil. Pharmacist D stated the pharmacy has no record of Resident 8 ever being on it. On 05/23/2024 at 9:30 AM, Surveyor interviewed Director A. Director A stated s/he was unable to locate a prescription for Donepezil for Resident 8. Director A stated s/he called the pharmacy and they verified they did not have an order. Director A stated pharmacy would not send a presciption they didn't have an order for so s/he is currently investigating to find out who wrote the prescription on Resident 8's MAR.	N 454		

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N 481	Continued From page 15	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable and homelike. Findings Include: On 12/04/2023, the department received a complaint alleging concerns with cleanliness in resident bedrooms and bathrooms. On 05/21/2024 at approximately 12:00 PM, Surveyor toured the facility accompanied by Director A and observed the following: *carpet in the main living room had several black spots and debris throughout the entire room *large vents on the walls near the floor (one near Director A's office and in the hallway near the kitchen) appeared to be filled with dust *exit near the kitchen had a loose plate and gap underneath the door to allow for bugs to enter Resident 4: *bathroom toilet had feces splattered around the inside of the toilet bowl and was clogged *base of toilet appeared to have dried urine *strong odor of feces	N 481		

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N 481	Continued From page 16 *carpeting in bedroom had large black stains near the entry of the bathroom which appeared to be fecal matter as well as lint and crumbs throughout the entire room Resident 5: *dried feces on high rise toilet seat *particles on the floor Resident 2: *feces on high rise toilet seat and toilet bowl *base of toilet and surrounding area appeared to have dried urine and feces *carpeting in bedroom had stains, lint and crumbs throughout the entire room Resident 6: *red circular stain near the bedside nightstand *carpeting in bedroom had stains, lint and powder throughout the entire room Resident 7: *recliner chair with rips and stains *large black stains on the carpet surrounding the base of the recliner chair *carpeting in bedroom had lint and crumbs throughout the entire room *shelving unit and dresser appeared to have a layer of dust On 05/21/2024 at approximately 12:15 PM, Surveyor interviewed Director A who acknowledged Surveyor's concerns. Surveyor asked when the facility was vacuumed last and s/he reported, "Well, it's broke." Director A could not verify when the facility was vacuumed last, but stated they would get another vacuum here today. Surveyor asked about staff cleaning schedules and s/he reported 1st shift staff clean resident bed and bath rooms 1-8, 2nd shift staff	N 481		

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N 481	Continued From page 17 clean resident bed and bath rooms 9-15 and 3rd shift staff clean the two shower rooms and the staff bathroom. Director A reported s/he will address the cleaning concerns with staff. The provider did not ensure they provided a living environment that was safe, clean, comfortable and homelike.	N 481		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility. Resident 1 had a procedure scheduled to remove a ureteral stent on 02/09/2024. The provider did not arrange transportation as needed for	Y3244		

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Y3244	Continued From page 18	Y3244		

Resident 1. Resident 1 missed the appointment. On 03/01/2024, Resident 1 was sent to the ER (emergency room) after a fall. At the ER, it was discovered that Resident 1 still had the stent. The ER removed the stent and Resident 1 was prescribed antibiotics for a UTI. Resident 1 missed an urology appointment to have catheter changed, resulting in Resident 1 being sent to the ER for UTI management and catheter changes.

Findings Include:

On 01/11/2024 and 03/07/2024, the department received complaints regarding catheter cares and transportation.

A facility policy titled, " Foley Catheter Care Urinary Catheter" dated 12/12/12 states, "...Fixing Catheter Problems:...Notify the physician if any of the following occurs: ...the resident complains of pain in the abdomen or lower back...urine appears thick and cloudy, mucus, red specks or blood in it, urine has a strong (bad) smell, drainage comes from the catheter insertion site that looks like pus or has a foul odor, the catheter comes out or is leaking, temperature above 101 degrees Fahrenheit or shaking chills."

On 05/21/2024, Surveyors conducted an onsite visit to the facility. A sample of residents was selected, including the resident record of Resident 1.

Resident 1 was admitted to the facility on 03/15/2023 with diagnoses to include neuropathy, chronic kidney disease, heart disease, atrial fibriliation, congestive heart failure, UTI. Resident 1 is under guardianship. Resident 1's most recent ISP (individual service plan) dated 01/23/2024 indicated Resident 1 requires a motorized

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wheelchair to move around the facility, requires 2 staff for assistance for transferring with pivot disc. Resident 1 is also noted to have a catheter, however, the ISP does not indicate who provides catheter cares. The ISP also does not identify what catheter cares are to be performed by staff, if any.

Surveyor reviewed Resident 1's resident record at the facility. The following was noted:
-On 02/01/2024, Resident 1 was scheduled for a left ureteroscopy with stone lasering, stone fragment removal and ureteral stent placement.
-A clinic discharge summary dated 02/01/2024 indicated Resident 1 was to return to the clinic on 02/09/2024 for removal of the ureteral stent.
-Resident 1's resident record did not contain any information related to a visit to the clinic on 02/09/2024 for removal of stent.
-A nurse's note dated 02/13/2024 stated, "Res[resident] was complaining stomache[sic] new bag put on but urin[sic] seems a little cloudy keeping an eye on it."
-A nurse's note dated 02/13/2024 stated, "Res[resident] was wet cathader[sic] must be leaking. Director notified ouput 800cc[cubic centimeters]."
-A nurse's note dated 02/14/2024 stated, "Res[resident] stayed in bed and bag was drained and was 300cc but bag was a bit cloudy..."
-A nurse's note dated 02/15/2024 stated, "Res has cloudy urin[sic] from kidney stones..."
-A nurse's note dated 02/15/2024 stated, "Res slept most of the night. Did wake up once to tell staff that [s/he] was wet and thinks the cathader[sic] is leaking again. Staff emptied bag (400cc) and noticed blood and mucus in urine. please monitor."
-A nurse's note dated 02/27/2024 stated, "Res ran over cathater[sic] bag changed bag some

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Y3244	Continued From page 20	Y3244		

blood in urine."
-A nurse's note dated 02/27/2024 stated, "Res slept most the nite bag had alot of blood in urine when bag was emptied output was 550."
-A nurse's note dated 02/28/2024 stated, "Writer noticed that res had blood in [his/her] bag. Guardian regional nurse and director was notified and vitals were taken..."
-A nurse's note dated 02/28/2024 stated, "Res has some blood in urin[sic] Res had a bed bath..."
-A facility incident report dated 03/01/2024 stated, went in [Resident 1's room number] to assist with getting [his/her] for the day. We pull[sic] pivot out to transfer from bed to chair. [S/he] refused to use pivot transfer and I told [him/her] [s/he] had to use it to prevent spraining [his/her] ankle. [S/he] said no and [s/he] tried to move [him/herself] and [s/he] sled[sic] to the floor and complained of pain. So we sent [him/her] out."
-A nurse's note dated 03/01/2024 stated, "Res came back around 540-50pm from hospital with new pills for urinary tract infection, output was 690 when res came back, res ate sandwich and asked for PRN Ace[sic] for pain."
-A hospital after visit summary dated 03/01/2024, indicated Resident 1 was treated in the ER for UTI symptoms and prescribed an antibiotic.

On 05/21/2024 at approximately 10:00 AM, Surveyor interviewed Director A. Director A stated they use Fox Valley Cab for transportation services. Director A stated if a resident is an managed care organization (MCO)member, the facility is responsible for arranging for transportation. Director A verified Resident 1 was a MCO member. Director A stated they need to let the transportation company know about a week ahead of time and the company doesn't always have someone available to take a resident in a wheelcahir. Director A indicated s/he was

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Y3244	Continued From page 21	Y3244		

working on looking into another transportation company to help with transports of residents in wheelchairs. Director A was unable to recall if s/he set up transportation for Resident 1 for the 02/09/2024 appointment to have stent removed. Director A stated sometimes residents do not give us the after visit summary to know they have an upcoming appointment. Director A confirmed Resident 1's After Visit Summary was in Resident 1's resident record.

On 05/21/2024 at approximately 11:00 AM, Surveyor interviewed Resident 1. Resident 1 verified s/he does have a catheter in place. Resident 1 stated Director A arranges transportation for any needs Resident 1 has. Resident 1 stated s/he recently had an appointment at urology clinic and there was a mixup with dates. Resident 1 stated s/he went to the clinic but the clinic said they weren't going to change the catheter because it was just changed, so sent Resident 1 back. Resident 1 stated, "I went to appointment but came right back."

On 05/22/2024, Surveyor requested hospital records from Resident 1's 03/01/2024 visit. Surveyor was informed by hospital medical records that due to a cybersecurity breach, hospital records were currently unavailable prior to 05/08/2024.

On 05/22/2024 at 9:40 AM, Surveyor interviewed Guardian C. Guardian C verified s/he was the court appointed guardian for Resident 1. Guardian C stated Resident 1 had a ureteral stent placed on 02/01/2024 with discharge instructions to have it removed on 02/09/2024. Guardian C indicated the facility arranges for transportation so didn't think of following up to see if Resident 1 made it to appointment. On 03/01/2024, Guardian

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Y3244	Continued From page 22 C received a call that Resident 1 and they were going to be sent to ER. Guardian C then called the ER to find out how Resident 1 was doing. ER called Guardian C back and said Resident 1 still had stent and a UTI. Guardian C stated s/he attempted to find out from facility why Resident 1 didn't make it to the appointment on 02/09/2024 but did not hear back from facility. Guardian C stated "transportation gets missed a lot." Guardian C stated Resident 1 goes out every month to have catheter changed. Guardian C indicated Resident 1 missed a urology appointment to have catheter changed on 04/18/2024. On 04/19/2024, Resident 1 was sent to ER for a UTI. ER changed catheter and prescribed antibiotics. Guardian C stated if Resident 1 would have made it to the appointment on 04/18/2024, the physician would have recognized the UTI and Resident 1 could have avoided an ER trip. On 04/22/2024, Guardian C emailed Director A about missing the appointment. Director A then scheduled a urology appointment the following week to have catheter changed. Transportation was setup and came to pick Resident 1 up at the facility, brought Resident 1 to clinic and physician said they would not change the catheter because it was just changed a week ago and it could increase chances of infection. Resident 1 was sent back to facility. Guardian C stated this was an unnecessary trip. Guardian C stated s/he always makes sure the After Visit Summary from any physician or hospital visit is provided to the facility so the facility knows if there is a new prescription or appointment. Guardian C stated, "there is just alot of miscommunication at the facility." On 05/28/2024, Surveyor requested Resident 1's urology visit notes from Director A via email.	Y3244		

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Y3244	Continued From page 23 On 05/30/2024, Surveyor requested Resident 1's urology visit notes from Director A via email again. Director A had only sent notes from November 2023 to February 1, 2024, nothing futher was in Resident 1's record at the facility. On 05/30/2024 at 10:40 AM, Surveyor interviewed Director A. Director A stated Guardian C had emailed Director A with appointments for Resident 1 to have catheter changed. Director A verified in emails from Guardian C to Director A that Resident 1 was to have catheter changed on 03/18/2024, 04/18/2024 and most recently 05/09/2024. Director A stated that Resident 1 missed the 04/18/2024 appointment due to a transportation issue but the appointment was rescheduled to 04/30/2024. Director A had indicated Resident 1 had catheter changed at that appointment. Director A was unable to provide documentation from urology office about those appointments but indicated s/he would contact the urology office to see if s/he could request them. Director A stated they do not always receive the After Visit Summary from the urology office, Surveyor reminded Director A it is the facility's responsibility to followup with the provider so everyone understands what is happening with Resident 1's care. In summary, Resident 1 had a foley catheter with a uretheral stent placed on 02/01/2024. Resident 1 had an appointment for the stent to be removed on 02/09/2024. Resident 1 missed the 02/09/2024 appointment due to a transportation issue, no follow up appointment was scheduled. Resident 1 had a fall on 03/01/2024. Resident 1 was sent to ER on 03/01/2024 and doctors discovered Resident 1 still had uretheral stent in place and Resident 1 had a UTI. Resident 1 received oral antibiotics and stent was removed.	Y3244		

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Y3244	Continued From page 24 Resident 1 goes to urology clinic every month to have catheter changed. Resident 1 missed the 04/18/2024 appointment to have catheter changed due to transportation issue. On 04/19/2024, Resident 1 was showing signs of a UTI and was sent to the ER. At the ER, Resident 1 had catheter changed and was prescribed an antibiotic. Director A was made aware of the catheter change at the ER, but rescheduled the 04/18/2024 to 04/30/2024 to have Resident 1's catheter changed. Transportation was set up for 04/30/2024 and Resident 1 was taken to the urology clinic. At the clinic, staff indicated they would not change the catheter because it had just been changed and sent Resident 1 back to the facility. Director A was not aware of Resident 1 not having the catheter changed due to not following up with the urology clinic and keeping track of Resident 1's current care needs related to the catheter.	Y3244		