

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Lincoln Park Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 C A Becker Dr Racine, WI 53406	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845</p> <p>Based on observation, interview and record review, the Facility did not ensure 1 (R1) of 5 Residents were provided with reasonable accommodations of Resident needs and preferences.</p> <p>*The Facility was aware of R1 having concerns regarding the shower room being too cold for R1 to take a shower, causing R1 to refuse showers. R1 was noted to have 1 documented bed bath in the last 30 days. R1 was not offered or given interventions to allow R1 to stay warm while taking a shower.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on [DATE] with diagnoses which include: excoriation (skin picking disorder), stomatitis, heart failure, dependence on supplemental oxygen and anemia.</p> <p>R1's Annual Minimum Data Set (MDS), dated [DATE], documents R1 has adequate hearing, speech and is able to understand and be understood. R1 has a Brief Interview for Mental Status (BIMS) score of 13, indicating R1 is cognitively intact. No behaviors exhibited. R1 expressed being able to choose between a tub bath, shower, bed bath or sponge bath, is very important to R1. R1 has no impairment in upper or lower extremities, requires substantial/maximal assistance with shower/bathing. R1 is always incontinent of bladder and has an ostomy device. R1 receives oxygen therapy.</p> <p>R1's quarterly MDS, dated [DATE], documents R1 has verbal behaviors toward others 1 to 3 days, no rejection of care, is supervision or touch assistance with shower/bathing, frequently incontinent of bladder and has an ostomy device. R1 receives oxygen therapy.</p> <p>On 03/03/2025, at 09:35 AM, Surveyor interviewed R1. R1 indicated R1 last had a shower 3 months ago. R1 indicated R1 has been refusing showers due to the shower room being too cold. R1 indicated that R1 has informed staff of this concern and is not offered any solutions or follow up. R1 indicated that R1 will give herself a sponge bath in R1's bathroom but would prefer to take a shower.</p> <p>On 03/03/2025, at 03:13 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-K . CNA-K indicated R1 refuses showers a lot because R1 is cold. CNA-K indicated R1 has not indicated that the shower room is cold, and indicated R1 just says that R1 is cold and refuses to shower.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R1's Electronic Health Record (EHR). Surveyor reviewed R1's care plan and noted the following, (R1) has actual for an activities of daily living (ADL) self-care performance/mobility deficit r/t (related to) weakness, Parkinsonism, chronic pain syndrome, RLS (restless leg syndrome), chronic L1 compression fracture, COPD (chronic obstructive pulmonary disorder), chronic respiratory failure. behaviors such as resistance to cares, with interventions that include, Bathing: Physical assist of one. Date Initiated: 05/09/2023 . Locomotion: Uses power Wheelchair-up ad lib in facility, will need assist when getting in and out of the door to courtyard. She also has manual w/c (wheelchair) she is able to propel self with Date Initiated: 09/27/2023 All staff . BATHING/SHOWERING: Resident prefers a shower Date Initiated: 02/21/2023</p> <p>(R1) has a behavior problem issue: Resident chooses not to allow wound care/care/use/wear colostomy supplies, O2 (oxygen), refuses care/showers, refuses appointments/consults, refuses to have weights obtained, uncooperative w/appointments if attends, verbally aggressive w/staff/others, makes racial statements about staff/others,</p> <p>dislikes staff/others, combative w/staff/others @ (at) times, hoards uncovered food, soiled towels/washcloths, throws stool soiled towels/wash cloths against walls, resistive cleaning of room, makes false accusations about staff and other residents. Date Initiated: 08/29/2022. Surveyor noted Interventions include, . Explain risk and benefits of refusing cares to help resident understand the risk she is taking when refusing cares.</p> <p>Date Initiated: 05/23/2024 . Reapproach if resident refuses cares. Date Initiated: 05/23/2024</p> <p>(R1) is resistive to care Date Initiated: 06/05/2023 with interventions which include, If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed upon time. Date Initiated: 11/06/2023</p> <p>Surveyor reviewed R1's KARDEX. Surveyor noted R1 shower days are Tuesday and Fridays on PM shift and as needed.</p> <p>Surveyor reviewed the Facility provided document for R1, titled What type of bath did resident receive? with a look back period of 30 days. Surveyor noted R1 should have received showers on 02/04/2025, 02/07/2025, 02/11/2025, 02/14/2025, 02/18/2025, 02/21/2025, 02/25/2025 and 02/28/2025.</p> <p>Surveyor noted on 02/04/2025, 02/07/2025, 02/18/2025 and 02/21/2025 R1 had documented refusals.</p> <p>Surveyor noted on 02/25/2025, R1 received a bed bath.</p> <p>Surveyor noted no information provided as to why R1 refused, if R1 was reapproached, or if risk/benefits were explained to R1 regarding R1's refusal.</p> <p>On 03/04/2025, at 07:20 AM, Surveyor interviewed Maintenance Director-L Maintenance Director-L used Maintenance Director-L's thermometer to measure the temperature of the shower room. Surveyor noted the temperature to read 73.7 degrees Fahrenheit (F). Maintenance Director-L indicated the shower room uses base board radiant heaters and downstairs in the basement is where the master controls are. Surveyor noted Maintenance Director-L took a temperature of the radiant base board, which was 87 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/04/2025, at 08:23 AM, Surveyor interviewed Maintenance Director-L. Maintenance Director-L indicated Nursing Home Administrator (NHA)-A verbally informed Maintenance Director-L of resident concerns of the shower room being too cold. Maintenance Director-L indicated NHA-A informed Maintenance Director-L of the concerns around January 2025. Maintenance Director-L indicated the shower room heat loss is due to the communal area heating being off and the designated smoking area door open and closing. Maintenance Director-L indicated the Facility was looking into an additional heater for the shower room, and had a contractor come out but are exploring other options as well.</p> <p>On 03/04/2025, at 08:14 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-O. Surveyor asked LPN-O about R1's refusals. LPN-O indicated R1 refuses all cares and showers, weights, everything. LPN-O indicated R1 has expressed concerns regarding the shower room being cold and is why R1 refuses showers. LPN-O indicated LPN-O informed Maintenance verbally regarding R1's concerns of the shower room being cold. LPN-O indicated no interventions can be implemented to assist R1 staying warm to R1's comfort while in the shower room, because R1 just refuses to shower.</p> <p>On 03/04/2025, at 09:56 AM, Surveyor interviewed NHA-A. NHA-A indicated that a couple residents have refused showers due to complaints of the shower room being too cold. NHA-A indicated the Facility has looked into heating lamps for the shower room and has sent information to corporate for options. NHA-A indicated that the temperature in the shower room is being monitored and currently meets regulation. NHA-A indicated the plan moving forward is based on the cost needed to implement a resolution. NHA-A indicated residents could use additional bath blankets and robes going to the shower room.</p> <p>On 03/04/2025, at 02:10 PM, Surveyor informed the Facility of the concerns regarding R1 not receiving a shower in the last 30 days, due to reasonable accommodations not implemented to allow R1 to be warm while taking a shower.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on interview and record review the facility did not report 1 (R4) of 2 incidents to the State survey agency and/or Nursing Home Administrator during the required timeframe.</p> <p>R4 voiced concerns of staff being rough with him. This allegation of mistreatment was not reported to the Nursing Home Administrator or State agency.</p> <p>Findings include:</p> <p>The facility's policy titled, Abuse, Neglect and Exploitation and reviewed/revised 1/5/24 documents under policy It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Under section VII Reporting/Response documents A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>R4 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>R4's diagnoses includes diabetes mellitus, hemiplegia affect right non dominate side, peripheral vascular disease, depression disorder, atrial fibrillation, and left below knee amputation. R4 does not have an activated power of attorney for healthcare.</p> <p>R4's quarterly MDS (minimum data set) with an assessment reference date of 10/20/24 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. R4 is assessed as not having any behavior including refusal of care, eats independently, requires partial/moderate assistance for roll left & right and is dependent for toileting hygiene & chair/bed to chair transfer. R4 is assessed as being frequently incontinent of urine and always incontinent of bowel.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/3/25, at 3:24 p.m., Surveyor interviewed Licensed Practical Nurse (LPN)-U regarding R4. LPN-U informed Surveyor she transferred him to the hospital on her shift as he hadn't been taking his medication, hadn't been eating or drinking. LPN-U indicated she asked R4 if it was okay to go to the hospital due to refusals. R4 said yes. LPN-U informed Surveyor she didn't think there were any other issues like his vital signs being off. Surveyor asked LPN-U if R4 complained of knee pain. LPN-U replied yes he had. LPN-U informed Surveyor she made everyone aware and believes the NP (nurse practitioner) gave an order for Voltaren gel. Surveyor inquired if R4 got out of bed. LPN-U informed Surveyor R4 refused to get out of bed, has seen him up but the majority of time he refused. Surveyor asked LPN-U if R4 complained of staff being rough with him. LPN-U replied I think he did due to his pain. LPN-U informed Surveyor sometimes he would refuse anyone to change him and she would have to go in with the CNA (Certified Nursing Assistant). LPN-U informed Surveyor when staff had to check and change R4 he would complain staff was rough due to his pain in his knee. LPN-U informed Surveyor she didn't witness any form of roughness when she would be in with the CNAs.</p> <p>On 3/3/25, at 3:35 p.m., Surveyor interviewed LPN-V regarding R4. LPN-V informed Surveyor R4 didn't do too much, was always in bed and she would go in and speak with him. Surveyor asked LPN-V if R4 complained of staff being rough with him. LPN-V replied yes. Surveyor asked LPN-V after R4 said staff was rough what did you do. LPN-V informed Surveyor she let the girls know if they need assistance to come and get her. LPN-V informed Surveyor she knows she has assisted with cares on the unit when she works. Surveyor asked LPN-V if she reported R4 complained of staff being rough with him. LPN-V replied no. Surveyor asked why she didn't. LPN-V informed Surveyor she put it on the 24 hour report being rough or pairs for cares.</p> <p>On 3/3/25, at 3:37 p.m., Surveyor asked LPN-U if she reported R4 complained of staff being rough to Director of Nursing (DON)-B or anyone else. LPN-U replied no. LPN-U informed Surveyor R4 didn't want one of the CNAs to take care of him anymore so she replaced that CNA. Surveyor asked LPN-U if she remembers why R4 didn't want the CNA. LPN-U replied no I don't. Surveyor asked LPN-U if she remembers who the CNA was. LPN-U replied no.</p> <p>On 3/4/25, at 10:04 a.m., Surveyor asked Director of Nursing (DON)-B if a resident voices a concern staff is rough to a nurse what should they do. DON-B informed Surveyor they should remove the CNA from care, contact herself or Administrator and then they would do their investigation. Surveyor asked DON-B if anyone reported to her R4 complained of staff being rough with him. DON-B replied no. Surveyor asked if there were any concerns brought to her attention regarding R4. DON-B informed Surveyor he was refusing cares & medication at times and towards the end of his staff he wasn't eating or drinking much. Surveyor informed DON-B of the concern of R4 reporting to LPN-V & LPN-U staff was rough with him. Surveyor asked DON-B no one brought this to your attention? DON-B replied no.</p> <p>On 3/4/25, at 10:59 a.m., Surveyor asked Nursing Home Administrator (NHA)-A if a resident complained of staff being rough what would be done. NHA-A informed Surveyor they would look what occurred, body check, interview. Surveyor asked NHA-A if anyone reported to her R4 complained staff was rough with him. NHA-A replied no.</p> <p>R4's allegation of mistreatment for staff being rough was not report to NHA-A or state agency. No additional information was provided to Surveyor.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483</p> <p>Based on interview and record review the facility did not ensure 2 of 2 allegation of abuse, neglect, exploitation or mistreatment involving R4, R9, & R10 were investigated or thoroughly investigated timely.</p> <p>* R4 allegation of staff being rough with him was not investigated.</p> <p>* R9 & R10 resident to resident altercation was not thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's policy titled, Abuse, Neglect and Exploitation and reviewed/revise 1/5/24 documents under policy It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Under section V. Investigation of Alleged Abuse, Neglect and Exploitation documents A. An immediate investigation is warranted when allegation of suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s); 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.</p> <p>1.) R4 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>R4's diagnoses includes diabetes mellitus, hemiplegia affect right non dominate side, peripheral vascular disease, depression disorder, atrial fibrillation, and left below knee amputation. R4 does not have an activated power of attorney for healthcare.</p> <p>R4's quarterly MDS (minimum data set) with an assessment reference date of 10/20/24 has a BIMS (brief interview mental status) score of 13 which indicates cognitively intact. R4 is assessed as not having any behavior including refusal of care, eats independently, requires partial/moderate assistance for roll left & right and is dependent for toileting hygiene & chair/bed to chair transfer. R4 is assessed as being frequently incontinent of urine and always incontinent of bowel.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/3/25, at 3:24 p.m., Surveyor interviewed Licensed Practical Nurse (LPN)-U regarding R4. LPN-U informed Surveyor she transferred him to the hospital on her shift as he hadn't been taking his medication, hadn't been eating or drinking. LPN-U indicated she asked R4 if it was okay to go to the hospital due to refusals. R4 said yes. LPN-U informed Surveyor she didn't think there were any other issues like his vital signs being off. Surveyor asked LPN-U if R4 complained of knee pain. LPN-U replied yes he had. LPN-U informed Surveyor she made everyone aware and believes the NP (nurse practitioner) gave an order for Voltaren gel. Surveyor inquired if R4 got out of bed. LPN-U informed Surveyor R4 refused to get out of bed, has seen him up but the majority of time he refused. Surveyor asked LPN-U if R4 complained of staff being rough with him. LPN-U replied I think he did due to his pain. LPN-U informed Surveyor sometimes he would refuse anyone to change him and she would have to go in with the CNA (Certified Nursing Assistant). LPN-U informed Surveyor when staff had to check and change R4 he would complain staff was rough due to his pain in his knee. LPN-U informed Surveyor she didn't witness any form of roughness when she would be in with the CNAs.</p> <p>On 3/3/25, at 3:35 p.m., Surveyor interviewed LPN-V regarding R4. LPN-V informed Surveyor R4 didn't do too much, was always in bed and she would go in and speak with him. Surveyor asked LPN-V if R4 complained of staff being rough with him. LPN-V replied yes. Surveyor asked LPN-V after R4 said staff was rough what did you do. LPN-V informed Surveyor she let the girls know if they need assistance to come and get her. LPN-V informed Surveyor she knows she has assisted with cares on the unit when she works. Surveyor asked LPN-V if she reported R4 complained of staff being rough with him. LPN-V replied no. Surveyor asked why she didn't. LPN-V informed Surveyor she put it on the 24 hour report being rough or pairs for cares.</p> <p>On 3/3/25, at 3:37 p.m., Surveyor asked LPN-U if she reported R4 complained of staff being rough to Director of Nursing (DON)-B or anyone else. LPN-U replied no. LPN-U informed Surveyor R4 didn't want one of the CNAs to take care of him anymore so she replaced that CNA. Surveyor asked LPN-U if she remembers why R4 didn't want the CNA. LPN-U replied no I don't. Surveyor asked LPN-U if she remembers who the CNA was. LPN-U replied no.</p> <p>On 3/4/25, at 10:04 a.m., Surveyor asked Director of Nursing (DON)-B if a resident voices a concern staff is rough to a nurse what should they do. DON-B informed Surveyor they should remove the CNA from care, contact herself or Administrator and then they would do their investigation. Surveyor asked DON-B if anyone reported to her R4 complained of staff being rough with him. DON-B replied no. Surveyor asked if there were any concerns brought to her attention regarding R4. DON-B informed Surveyor he was refusing cares & medication at times and towards the end of his staff he wasn't eating or drinking much. Surveyor informed DON-B of the concern of R4 reporting to LPN-V & LPN-U staff was rough with him. Surveyor asked DON-B no one brought this to your attention? DON-B replied no.</p> <p>On 3/4/25, at 10:59 a.m., Surveyor asked Nursing Home Administrator (NHA)-A if a resident complained of staff being rough what would be done. NHA-A informed Surveyor they would look what occurred, body check, interview. Surveyor asked NHA-A if anyone reported to her R4 complained staff was rough with him. NHA-A replied no.</p> <p>NHA-A & DON-B were unaware of R4's complaint of staff being rough and therefore no investigation was conducted prior to R4 being discharged on [DATE]. No additional information was provided to Surveyor.</p> <p>38829</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) R9 was admitted to the facility on [DATE], with diagnoses of Memory Deficit, Following Nontraumatic Intracerebral Hemorrhage, Dysarthria, Essential Hypertension, Vascular Dementia, Major Depressive Disorder, and Unspecified Psychosis. R9 has an activated Health Care Power of Attorney (HCPOA).</p> <p>R9's 5 day Minimum Data Set (MDS) completed 2/19/25 documents R9's Brief Interview for Mental Status (BIMS) score to be a 4 indicating R9 is severely impaired for daily decision making. R9 has no mood or behaviors documented. R9 has no range of motion concerns. R9 is occasionally incontinent of bladder and always incontinent of bowel. R9 is independent with transfers and mobility and is ambulatory.</p> <p>R10 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Unspecified Atrial Fibrillation, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Chronic Kidney Disease, Peripheral Vascular Disease, Vascular Dementia, Major Depressive Disorder, and Anxiety Disorder. R10 has an activated Health Care Power of Attorney (HCPOA).</p> <p>R10's MDS completed 2/1/25 documents R10's BIMS score to be 3, indicating R10 is severely impaired for daily decision making. R10 has no mood or behaviors documented. R10 has no range motion concerns. R10 requires partial/moderate assistance for transfers and mobility. R10 is always incontinent of bowel and bladder. R10 uses a wheelchair for locomotion.</p> <p>Surveyor reviewed the Misconduct Incident Report submitted on 1/17/25. The report documents that on 1/12/25, R9 struck R10 in the face at approximately 2:30 PM. Staff intervened and separated R9 and R10 to maintain safety. Assessments were completed and the police were notified. R10 was noted to have a chin abrasion and slight swelling to the left side of R10's face. Surveyor notes the Misconduct Incident Report submitted does not contain any names of witnesses to the incident.</p> <p>There is 1 statement from Housekeeper (HSK)-F that documents HSK-F was coming down the hall by the activity room and HSK-F saw R9 strike R10 in the face. HSK-F took R10 to R10's room and a CNA took R9 away. There are no other staff statements.</p> <p>Surveyor received the working schedule for 1/12/25 to review. It is unclear who was assigned to R9 and R10 as the shift assignment details are blank for all 3 shifts. Surveyor notes there is documentation in the report of where R9 and R10 reside and what staff was assigned to either or both of R9 and R10 on that day, prior to and at the time of the altercation.</p> <p>Registered Nurse (RN)-G documented in R9's progress notes that RN-G was informed by staff on Unit 2 that R9 slapped another Resident on the other unit.</p> <p>Interventions were for R9 to be placed on 1:1 supervision on the PM shift and conduct a 2 day sleep study. Sleep study indicated R9 is awake and wanders throughout the facility mid-morning through PM shift. The care plan was reviewed and updated. Director of Nursing (DON)-B documented that DON-B sent an email to activities to update R9's activity preference and increase offering preferred activities during high wandering times.</p> <p>Surveyor reviewed R9's comprehensive care plan.</p> <p>1.) (R9) has little or no activity involvement due Resident wishes not to participate-Initiated 3/5/24</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The last intervention was initiated on 6/5/24.</p> <p>-No interventions were updated since the 1/12/25 Resident to Resident altercation</p> <p>2.) (R9) is resistive to care, refuses medications, treatments due to memory deficit-Initiated 8/15/24</p> <p>-The last intervention was initiated on 12/2/24.</p> <p>-No interventions were updated since the 1/12/25 Resident to Resident altercation</p> <p>3.) (R9) has a behavior problem due to refusing staff to clean room, or letting staff assist with getting dressed-Initiated 12/11/24</p> <p>-Praise any indication of Resident's progress/improvement in behavior-Initiated 2/24/25</p> <p>4.) (R9) has a mood problem due to vascular dementia. ie. being sexually inappropriate with female Residents(exposing self). Monitor psychosocial wellbeing due to peer-peer altercation-Initiated 2/28/24</p> <p>-Monitor psychosocial wellbeing. Report any altercations and notify provider to determine if any other interventions are recommended-Initiated 1/13/25</p> <p>Surveyor notes the 2 updated interventions for R9 are challenging given R9's cognitive status is severely impaired for daily decision making.</p> <p>Surveyor reviewed R9's psychiatric notes.</p> <p>On 1/6/25, Psychiatric Nurse Practitioner (PsychNP)-M documented that R9 has become more difficult again. Refusing medication and wanders the halls ambulating independently. Staff reports no physical or verbal behaviors and difficult to redirect at times. PsychNP-M recommends to continue current medications.</p> <p>On 2/3/25, PsychNP-M documented staff report behaviors have better. R9 had a peer to peer interaction and is not taking medications consistently. Recommendation was to monitor for symptoms of psychosis and visual or auditory hallucinations.</p> <p>On 3/4/25, at 10:52 AM, Surveyor reviewed R9 and R10's Misconduct Incident Report with Nursing Home Administrator (NHA)-A. NHA-A confirmed NHA-A is the abuse coordinator. NHA-A does not remember what nurse reported the altercation between R9 and R10. NHA-A initially indicated that HSK-F was an agency employee and does not know who it was. Surveyor shared the concern that there are no witnesses listed in the Misconduct Incident Report, however, HSK-F witnessed the altercation between R9 and R10. Surveyor shared that there are no other staff statements describing R9's behavior before, during, and after the altercation in order to get a grasp of what may have triggered R9 to strike R10. There are no staff statements of what R10 was doing at the time or describing R10's behaviors before, during, and after the altercation. Shared that the investigation of R9 and R10 was not a thorough investigation with a root/cause analysis of the altercation.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Lincoln Park Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 C A Becker Dr Racine, WI 53406	

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/4/25, at 12:01 PM, NHA-A shared with Surveyor that neither R9 or R10 recalled the incident. NHA-A informed Surveyor that technically we didn't have to report based on the Resident to Resident diagram guidelines. We reported out of good faith.</p> <p>Surveyor notes that R9 hitting R10 on the side of the face meets the definition of willful and R10 suffered physical injury as indicated in the incident report that R10 sustained a chin abrasion and swelling to the left side of R10's face.</p> <p>At this time, the facility has not provided additional information.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>20483</p> <p>Based on interview and record review the facility did not ensure 1 (R7) of 8 residents received treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan and the residents choice.</p> <p>* On 3/3/25 R7 was not wearing tubigrips according to R7's physician orders and plan of care.</p> <p>Findings include:</p> <p>R7's diagnoses includes hemiplegia and hemiparesis following cerebral infarction, aphasia, vascular dementia, anxiety disorder, and paranoid schizophrenia.</p> <p>R7's actual ADL (activities daily living) self-care performance/mobility deficit care plan initiated documents an intervention * Dressing: Physical Assist of 1 -Tubigrips on in AM (morning) off HS (hour sleep) -Wears glasses. Initiated 9/9/22.</p> <p>R7's physician order dated 5/16/23 documents Tubigrips on in the AM and off at HS. In the morning for edema on and in the evening for edema off.</p> <p>R7's quarterly MDS (minimum data set) with an assessment reference date of 1/27/25 has a BIMS (brief interview mental status) score of 3 which indicates severe impairment. R7 is assessed as being dependent for lower body dress and putting on/taking off footwear.</p> <p>R7's Certified Nursing Assistant (CNA) Kardex as of 3/3/35 under the section Dressing/Splint Care documents * Dressing: Physical Assist of 1 -Tubigrips on in AM (morning) off at HS (hour sleep) - wears glasses. * Apply tubigrips. * Remove tubigrips.</p> <p>On 3/3/25, at 9:30 a.m., Surveyor observed R7 with his eyes closed & wearing glasses, leaning towards the right in a wheelchair at a table in the dining room with the TV. Surveyor observed R7 is wearing beige grippers socks and slippers. Surveyor observed R7 is not wearing tubigrips.</p> <p>On 3/3/25, at 9:59 a.m., Certified Nursing Assistant (CNA)-S approached R7 who was sitting in a wheelchair in the dining room stating to R7 she going to take your weight. CNA-S wheeled R7 away from the hallway and down the hallway. Surveyor observed R7 is not wearing tubigrips.</p> <p>On 3/3/25, at 10:29 a.m., Surveyor observed R7 continues to be sitting in a wheelchair in the dining room with his head towards the right and eyes closed. Surveyor observed R7 continues to be wearing beige gripper socks with slippers. R7 is not wearing tubigrips.</p> <p>On 3/3/25, at 11:33 a.m., Surveyor observed CNA-S wheel R7 out of the dining room, down the hallway, and into R7's room. From 11:36 a.m. to 11:46 a.m. Surveyor observed CNA-S and [NAME] Clerk Secretary/CNA-R transfer R7 from the wheelchair onto the toilet using a sit to stand lift, provide continence care for R7, and transfer R7 back into the wheelchair. Surveyor observed during this observation R7 was not wearing tubigrips.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/3/25, at 12:19 p.m., Surveyor observed Licensed Practical Nurse (LPN)-P provide R7 with his lunch. Surveyor observed R7 is still not wearing tubigrips and has beige gripper socks with slippers on his feet.</p> <p>On 3/3/25, at 1:48 p.m., Surveyor observed R7 sitting in a wheelchair at a table in the dining room. R7 continues to be wearing beige gripper socks with slippers and does not have tubigrips on.</p> <p>On 3/3/25, at 3:39 p.m., Surveyor observed R7 rolling back & forth in the wheelchair in the dining room with the TV. Surveyor observed R7 still does not have tubigrips on.</p> <p>On 3/4/25, at 7:27 a.m., Surveyor observed R7 dressed for the day being wheeled down the hallway. Surveyor observed R7 is wearing tubigrips.</p> <p>On 3/4/25, at 7:28 a.m., Surveyor asked CNA-T when is R7 suppose to have tubigrips on. CNA-T informed Surveyor R7 gets them on during the day and is suppose to come off at night.</p> <p>On 3/4/25, at 9:58 a.m., Surveyor asked Director of Nursing (DON)-B is the expectation staff follow a residents care plan and Kardex. DON-B replied yes. Surveyor informed DON-B Surveyor noted R7's care plan and Kardex documents tubigrips on AM and off HS. Surveyor did not observe R7 having the tubigrips on yesterday (3/3/25). DON-B informed Surveyor there is also an order for the nurses.</p> <p>On 3/4/25, at 10:15 a.m., Surveyor reviewed R7's March 2025 TAR (treatment administration record). Surveyor noted tubi grips are checked & initialed as being on in the AM and checked & initialed as off on 3/3/25. On 3/3/25 R7 did not have tubigrips on.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829</p> <p>Based on observation, interview, and record review the facility did not ensure 1 (R2) of 1 Residents reviewed with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>*R2 was observed not wearing R2's right hand splints to prevent further decrease in range of motion.</p> <p>Findings Include:</p> <p>Surveyor reviewed the facility policy and procedure Range of Motion Exercises revised 10/2010 which documents:</p> <p>.Documentation</p> <p>The following information should be recorded in the Resident's medical record:</p> <p>4. Whether the exercise was active or passive.</p> <p>7. Any problems or complaints made by the Resident related to the procedure.</p> <p>8. If the Resident refused the treatment, the reason(s) why and the intervention taken.</p> <p>9. The signature and title of the person recording the data.</p> <p>Reporting</p> <p>1. Notify the supervisor refuses the exercises.</p> <p>2. Report other information in accordance with facility policy and professional standards of practice.</p> <p>R2 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease, Essential Hypertension, Alcohol Dependence, Depression, and Anxiety Disorder. R2 is currently his own person.</p> <p>R2's Quarterly Minimum Data Set (MDS) completed 1/6/25 documents R2's Brief Interview for Mental Status (BIMS) score to be 13, indicating R2 is cognitively intact for daily decision making. R2's Patient Health Questionnaire(PHQ-9) score is 1 indicating minimal depression. No behaviors are documented for R2. R2 is always incontinent of bladder and occasionally incontinent of bowel. R2 has range of motion (ROM) impairment on 1 side of both upper and lower extremity. R2 requires set-up for eating, and is dependent for showers, lower dressing, hygiene, and transfers. R2 is substantial/maximum for upper dressing and mobility. R2's MDS does not document R2 has splint or brace assistance.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/3/25, at 9:25 AM, Surveyor observed R2 in a wheelchair with a significantly right hand contracture. All of R2's fingers are contracted in except for the second finger, the index. R2 is not wearing a splint on the right hand.</p> <p>R2's Kardex as of 3/3/25 does not document R2 has a right hand splint.</p> <p>Surveyor reviewed R2's current comprehensive care plan.</p> <p>-R2 has actual for an activities of daily living (ADL) self-care performance/mobility deficit due to CVA right side weakness/hemiplegia. 12/28/21</p> <p>This focused problem does not document an intervention for R2 to wear a splint on the right hand.</p> <p>R2's Occupational Therapy (OT) Discharge Summary dated 1/28/25 and signed by Occupational Therapist (OT)-E documents:</p> <p>Skilled Interventions Provided:</p> <p>Manual stretch to right upper extremity(RUE) to facilitate joint extension and prevent contractures, assessment of RUE hand splint fit, tolerance and establishment of restorative RUE ROM program, splint program, caregiver education in splint application, wear schedule and precautions.</p> <p>Patient Progress:</p> <p>(R2's) functional performance has improved as a result of instruction in compensations, modifications and adaptations.</p> <p>Communication:</p> <p>Reviewed (R2's) plan of treatment and treatment services with interdisciplinary team members.</p> <p>Discharge Recommendations and Status:</p> <p>Right hand splint wear recommended during waking hours as tolerated to enhance finger extension. Caregivers shall provide Upper Extremity ROM during cares, routine hand washing and skin and nail assessment during routine cares.</p> <p>ROM program established and trained on right hand splint wear.</p> <p>Splint and Brace program established on right hand splint wear.</p> <p>Prognosis: Prognosis to maintain current level of functioning=good with consistent staff follow-through.</p> <p>Caregivers verbalize understanding of right upper extremity ROM and splinting application, care and wear schedule.</p> <p>Surveyor notes that OT notes documented R2 tolerated wearing the right hand splint.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Therapy Referral to Restorative Nursing Program or Functional Maintenance Program Form dated 1/28/25 and signed by Occupational Therapist (OT)-E documents:</p> <p>Recommended Program-ROM and Splint/Brace</p> <p>Precautions-Monitor nail length and skin integrity</p> <p>Range of Motion</p> <p>Extremity-Right Upper-Passive ROM-2 sets of 10 repetitions 2 times a day.</p> <p>Splint/Brace</p> <p>Right Upper-right hand-ROM during routine cares, assess skin/nail length</p> <p>-right hand splint as tolerated during waking hours</p> <p>Surveyor reviewed R2's resolved comprehensive care plan.</p> <p>(R2) is at risk for developing impairment in functional joint mobility due to generalized weakness, discomfort when moving, poor motivation, inactivity related to history of CVA. (R2) has a contracture note to right upper extremity and requires passive range of motion (PROM). 8/24/23 Initiated 2/10/25 Resolved</p> <p>Interventions:</p> <p>-Assess skin/nail length when applying/removing splint. Cut fingernails as needed. Initiated 1/30/25 Resolved 2/10/25</p> <p>-PROM-maintain good body alignment. Provide PROM to right shoulder/elbow/wrist/hand as tolerated. Perform in slow and smooth motion. Initiated 8/9/24 Resolved 2/10/25</p> <p>-Right hand splint as tolerated during waking hours Initiated 1/30/25 Resolved 2/10/25</p> <p>Surveyor notes there is no documentation as to why OT-E recommends the right hand splint to maintain current level of functioning for the contracture on 1/28/25 and R2's care plan documents wearing the right hand splint is resolved on 2/10/25.</p> <p>On 2/25/25, MSN/APRN/FNP (MAF)-I completed a comprehensive assessment on R2 and documented:</p> <p>.(R2) has a splint for (R2's) right hand to wear daily. Encouraged to wear daily to prevent contractures. Assisted with placing splint onto (R2's) right hand. No changes made to plan of care.</p> <p>Diagnostic Statement: Contracture, right hand</p> <p>Plan: Contracture right hand due to past stroke with hemiplegia on right side. Plan of care: Continue splint use daily. Follow-up with Physiatry department as recommended. OT as needed. Keep nails short. Continue ROM exercises daily.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/3/25, at 10:25 AM, Surveyor did not observed R2 wearing a splint on the right hand.</p> <p>On 3/3/25, at 12:05 AM, Surveyor asked R2 if R2 has a right splint. R2 stated, I think it doesn't fit and I have to get a new one. Surveyor notes R2 does not have splint on the right hand, but observed a splint on R2's counter in R2's room.</p> <p>On 3/3/25, at 1:02 PM, OT-E confirmed that R2 has a splint for the right hand and should be wearing the splint. Staff should know to put the splint on. OT-E stated R2 occasionally will not wear the splint.</p> <p>On 3/4/25, at 7:43 AM, Surveyor observed R2 not wearing the right hand splint. Surveyor observed the hand splint on R2's counter next to the closet in R2's room.</p> <p>On 3/4/25, at 8:16 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. ADON-C stated that the care plan to wear the right hand splint was resolved because R2 refused to wear the splint on a regular basis. Surveyor shared the concern there is no documentation that R2 was refusing to wear the right hand splint and no documentation of interventions to re-approach R2 to wear the splint. ADON-C stated ADON-C will look for documentation.</p> <p>On 3/4/25, at 8:35 AM, Surveyor interviewed Social Worker (SW)-J in regards to R2. SW-J stated that SW-J is unaware of any recent behaviors and has been compliant with cares.</p> <p>On 3/4/25, at 9:35 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-D in regards to R2. CNA-D confirmed CNA-D provides cares to R2 on a regular basis. CNA-D confirmed that R2 has a splint for R2's right hand. CNA-D stated that when R2 has refused to wear the right hand splint, CNA-D has informed the nurse, but not everytime.</p> <p>On 3/4/25, at 9:47 AM, Surveyor interviewed R2. Surveyor asked R2 if R2 would wear the right hand splint. R2 stated that R2 would wear the right hand splint, but they have to help me put it on. I can't do it. I don't want it to get worse. Surveyor asked R2 if they offered today to put on the right hand splint and R2 stated, No. Surveyor observed all fingers are significantly contracted in on the right hand except for the index finger. R2's nails appear to be making significant contact with R2's inner palm.</p> <p>On 3/4/25, at 10:41 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated if a Resident refuses cares, the CNA updates the nurse. The nurse updates the physician of refusals and it is placed on the 24 hour board or in the Resident progress notes. It should be documented.</p> <p>On 3/4/25, at 10:52 AM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R2 has not been wearing R2's right hand splint during the survey process and there is no documentation that R2 has been refusing to wear the right hand splint.</p> <p>On 3/4/25, at 2:09 PM, Surveyor again shared the concern with NHA-A and DON-B the concern that R2 has a right hand contracture and has not received appropriate treatment and services to prevent further decrease in range of motion by observations of R2 not wearing the right hand splint.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845</p> <p>Based on observation, interviews and record review the facility did not ensure 1 (R1) of 1 residents reviewed for colostomy, urostomy or ileostomy services, received care consistent with professional standards of practice.</p> <p>*R1 was not provided ostomy supplies and R1 ordered ostomy supplies from (community pharmacy name) & R1 was provided the incorrect ostomy supplies, per R1's order.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS), dated [DATE], documents R1 has verbal behaviors toward others 1 to 3 days, no rejection of care, is supervision or touch assistance with shower/bathing, frequently incontinent of bladder and has an ostomy device. R1 receives oxygen therapy.</p> <p>On 03/03/2025, at 09:35 AM, Surveyor interviewed R1. R1 indicated The Facility ran out of R1's ostomy supplies. R1 indicated that Staffing Coordinator/CNA-N indicated to R1 that the supplies were stolen. R1 indicated that R1 had to make an order for delivery from (community pharmacy name) for R1's ostomy supplies, and is waiting for the order to arrive. R1 indicated R1 is currently using paper towels and washcloths in place of ostomy supplies. R1 indicated R1 last had a shower 3 months ago. R1 indicated R1 has been refusing showers due to the shower room being too cold. R1 indicated that R1 has informed staff of this concern and is not offered any solutions or follow up.</p> <p>Surveyor reviewed R1's Electronic Health Record (EHR). Surveyor reviewed R1's care plan and noted the following, . has actual for an activities of daily living (ADL) self-care performance/mobility deficit r/t (related to) weakness, Parkinsonism, chronic pain syndrome, RLS (restless leg syndrome), chronic L1 compression fracture, COPD (chronic obstructive pulmonary disease), chronic respiratory failure. behaviors such as resistance to cares, with interventions that include, -Bathing: Physical assist of one. Date Initiated: 05/09/2023 . Locomotion: Uses power Wheelchair-up ad lib in facility, will need assist when getting in and out of the door to courtyard. She also has manual w/c (wheelchair) she is able to propel self with Date Initiated: 09/27/2023 All staff . BATHING/SHOWERING: Resident prefers a shower Date Initiated: 02/21/2023</p> <p>. has a behavior problem issue: Resident chooses not to allow wound care/care/use/wear colostomy supplies, O2 (oxygen), refuses care/showers, refuses appointments/consults, refuses to have weights obtained, uncooperative w/appointments if attends, verbally aggressive w/staff/others, makes racial statements about staff/others, dislikes staff/others, combative w/staff/others @ (at) times, hoards uncovered food, soiled towels/washcloths, throws stool soiled towels/wash cloths against walls, resistive cleaning of room, makes false accusations about staff and other residents. Date Initiated: 08/29/2022. Surveyor noted Interventions include, . Explain risk and benefits of refusing cares to help resident understand the risk she is taking when refusing cares. Date Initiated: 05/23/2024 . Reapproach if resident refuses cares. Date Initiated: 05/23/2024</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>. is resistive to care Date Initiated: 06/05/2023 with interventions which include, If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed upon time. Date Initiated: 11/06/2023</p> <p>. has an ostomy to RLQ (right lower quadrant) r/t hx (related to history of) bowel obstruction Date Initiated: 04/22/2022, interventions include, Resident chooses not to follow correct protocol for ostomy care. Removes her ostomy bag catching her stool with towels and paper towels causing her skin irritation, incontinence. Date Initiated: 07/11/2023 . prefers to self-care of her colostomy. Offer assist of 1/help if she appears to be struggling. Date Initiated: 05/24/2023.</p> <p>On 03/03/2025, at 10:45 AM, Surveyor checked back in with R1. At this time R1 expressed being uncomfortable due to the paper towels and wash cloth R1 was using in place of R1's colostomy supplies. Surveyor observed R1 had bowel contents that leaked through onto R1's gown. R1 indicated that R1 does not refuse to wear R1's colostomy bags but does refuse staff assistance with the care of R1's colostomy.</p> <p>On 03/03/2025, at 11:50 AM, Surveyor interviewed Staffing Coordinator/CNA-N. Staffing Coordinator/CNA-N indicated The Facility does not have a stock supply of colostomy supplies, and indicated only 2 residents in the Facility require ostomy supplies. Staffing Coordinator/CNA-N indicated Staffing Coordinator/CNA-N only orders supplies for 1 of the 2 residents. Staffing Coordinator/CNA-N indicated R1's ostomy supplies come through (name of supplier) and are on auto order around the beginning of the month every month. Staffing Coordinator/CNA-N indicated R1 likes to use 4-5 bags per day and is always requesting a new one, which has caused R1 to run out early. Staffing Coordinator/CNA-N indicated once R1's supplies come in Staffing Coordinator/CNA-N will bring them to the nurses station and R1's ostomy supplies are kept behind the nurses station. Staffing Coordinator/CNA-N indicated Staffing Coordinator/CNA-N was unsure who would be responsible to call and request a quantity increase for R1's ostomy supplies. Staffing Coordinator/CNA-N indicated Staffing Coordinator/CNA-N is unsure of how many ostomy supplies R1 has at this time.</p> <p>On 03/03/2025, at 12:01 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P. Surveyor asked LPN-P to show Surveyor where R1's ostomy supplies are kept. LPN-P indicated R1's ostomy supplies are kept in Staffing Coordinator/CNA-N's office and indicated R1 currently does not have any ostomy supplies in the nurses station or medication room. LPN-P indicated R1 should receive 1 ostomy bag per shift. LPN-P indicated that Agency staff have given R1 a whole box in the past and R1 would go through them too fast.</p> <p>On 03/03/2025, at 12:03 PM, Surveyor interviewed LPN-O. LPN-O indicated R1's colostomy supplies are kept in the schedulers office. LPN-O indicated R1 goes through colostomy supplies frequently and is suppose to be given 2 per day.</p> <p>On 03/03/2025, at 12:41 PM, Surveyor interviewed Staffing Coordinator/CNA-N. Staffing Coordinator/CNA-N indicated Staffing Coordinator/CNA-N does not have any ostomy supplies for R1 in Staffing Coordinator/CNA-N office at this time. Staffing Coordinator/CNA-N indicated that Staffing Coordinator/CNA-N called (name of supplier) this morning and is now waiting on insurance. Staffing Coordinator/CNA-N indicated R1 last received R1's colostomy supplies, about 1 month ago.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Lincoln Park Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 C A Becker Dr Racine, WI 53406	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/03/2025, at 12:49 PM, Surveyor interviewed LPN-O. Surveyor asked LPN-O if R1 had been given an ostomy supplies yet. LPN-O indicated that the R1 had not asked for any supplies and LPN-O did not give R1 any supplies.</p> <p>On 03/03/2025, at 12:52 PM, Surveyor was in R1's room and noted R1 to have light brown, liquid matter, on R1's gown in the area of R1's colostomy. R1 indicated R1 should be receiving R1's (community pharmacy name) order for R1's colostomy supplies by this evening. LPN-P then came into R1's room with a single system colostomy bag. LPN-P indicated R1's colostomy supplies were located on another unit, and R1 has 2 bags left. R1 confirmed the single system colostomy device provided by LPN-P, is the same that R1 has been using.</p> <p>Surveyor reviewed R1's orders and noted the following, Please provide 2 pouch ostomy supplies every shift for ileostomy encourage to keep the wafer in place and change the ostomy bag only if soiled. CHANGE Wafer every 7 days -Order Date- 02/11/2025 1743.</p> <p>Surveyor reviewed the Facility provided document, titled *eMar - Medication Administration Note, dated 03/01/2025, and documents not available. Surveyor noted progress note was written by LPN-O.</p> <p>Surveyor reviewed the Facility provided document, titled Delivery Ticket/ DME (durable medical equipment) Certification Receipt Form, documents R1 received 1- Ostomy skin powder, 30-One-piece drainable pouch, cut to fit stoma and 25- skin barrier wipes on 02/04/2025.</p> <p>On 03/04/2025, at 08:14 AM, Surveyor interviewed LPN-O. LPN-O indicated R1 was given the last of R1's ostomy supplies last night. Surveyor asked LPN-O about LPN-O 's progress note on 03/01/2025, that indicated R1's ostomy supplies were not available. LPN-O indicated R1 did not have ostomy supplies available at that time. LPN-O informed Surveyor that R1 doesn't even use a wafer system as per R1's order. Surveyor asked LPN-O what LPN-O would do if LPN-O had questions regarding an order. LPN-O indicated LPN-O would ask Director Of Nursing (DON)-B or the provider who put in the order. LPN-O indicated LPN-O did not ask DON-B or the provider regarding R1's order. Surveyor asked LPN-O about R1's refusals. LPN-O indicated R1 refuses all cares and showers, weights, everything.</p> <p>On 03/04/2025, at 08:33 AM, Surveyor interviewed DON-B and Assistant Director Of Nursing (ADON)-C. DON-B indicated R1's colostomy order indicates to change R1's wafer every 7 days and supply 2 pouch system every shift. DON-B indicated R1's insurance will only cover 1 pouch per day. DON-B indicated that if R1 needs an increase in quantity, nursing staff is responsible for contacting community care. DON-B indicated staff should use Facility stock ostomy supplies for a resident if the resident runs out of ostomy supplies. Surveyor indicated to DON-B that Surveyor was informed by Staffing Coordinator/CNA-N that the Facility does not have a stock supply of ostomy supplies. DON-B indicated the Facility should have stock ostomy supplies and would look into it. DON-B then indicated that R1 does not use a wafer and uses the single system ostomy device. DON-B indicated DON-B would need to clarify the order and get back to Surveyor.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lincoln Park Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 C A Becker Dr Racine, WI 53406	

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/03/2025, at 08:50 AM, DON-B came to Surveyor and informed Surveyor that Nurse Practitioner (NP)-Q would like to speak with Surveyor via phone. NP-Q informed Surveyor that NP-Q put in the order for R1 to be provided a wafer and bag, a 2 device system, for colostomy supply. NP-Q indicated NP-Q ordered R1 to have the 2-part system, with a wafer to encourage R1 to allow R1 to keep the wafer on to promote skin integrity, while allowing R1 to just change the bag of the device. NP-Q indicated R1 has reoccurring cellulitis around R1's stoma. NP-Q indicated R1 needs to be provided education regarding the importance of using the 2-system device to encourage R1's independence and promote skin integrity. NP-Q indicated using the 2-system device would hinder R1 from having to repeatedly rip off the 1 system device each time to change the bag.</p> <p>On 03/04/2025, at 09:56 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A indicated that R1's insurance covers 1 ostomy bag per day. NHA-A indicated nursing staff is responsible for ensuring ostomy supplies are ordered.</p> <p>On 03/04/2025, at 02:10 PM, Surveyor informed the Facility of concerns regarding R1 not having ostomy supplies, having the ordered ostomy supplies and R1 having to order ostomy supplies. DON-B indicated R1's order has been updated and community care has been contacted to update R1's order to the correct ostomy supplies.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20025</p> <p>Based on observation, interview and record review the facility did not ensure 1 of 4 residents observed during medication pass had appropriate dispensing of medication that did not break infection control practices.</p> <p>On 3/4/25 at 8:03 a.m. Surveyor observed Registered Nurse (RN)-H dispense R11's medications. RN-H touched each of the pills dispensed for R11 with bare hands.</p> <p>Findings include:</p> <p>The facility's Administering Medications policy with revised date of December 2024. The policy documents .</p> <p>22. Staff shall follow established facility infection control procedures (e.g handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.</p> <p>On 3/4/25 at 8:03 a.m. Surveyor observed RN-H dispense R11's medications. Surveyor observed RN-H bare handed open over the counter medications and bare handed touch the medications and placed it in the medication cup. Surveyor observed RN-H pop out medications from the blister pack and into her bare hands then placed it in the medication cup.</p> <p>On 3/4/25 at 1:00 p.m. Surveyor interviewed NHA (nursing home administrator)-A. Surveyor explained the concern RN-H touched medications with her bare hands that were for R11. Surveyor asked if this was proper handling of medications. NHA-A stated this is not the appropriate way to dispense medications.</p>