

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2024
NAME OF PROVIDER OR SUPPLIER  Waunakee Valley Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  801 Klein Dr Waunakee, WI 53597	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>29360</p> <p>Based on record review and interview, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, not later than 24 hours if the events that cause the suspicion do not result in serious bodily harm for 4 of 10 sampled residents reviewed (R1, R10, R11 and R7.)</p> <p>According to S483.12(c)(1) of the State Operations Manual; all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>R1 reported to NHA A (Nursing Home Administrator) that CNA E (Certified Nursing Assistant) was rude and yelled at R1. This allegation was not reported to the State Agency.</p> <p>R10 was found to have a black eye. This was not reported to the State Agency.</p> <p>R11 reported to NHA A (Nursing Home Administrator) that staff refused to assist R11 with wiping his bottom when using the toilet. The staff indicated she did not need to wipe R11 was not R11's wife and does not have to do that. This allegation was not reported to the State Agency.</p> <p>R7 reported to staff that she was missing a white ski jacket and a pair of Jordashe jeans. R7 alleged the jacket and jeans were stolen. This was not reported to the State Agency.</p> <p>Evidenced by:</p> <p>The facility's Abuse and Neglect Procedural Guidelines policy, dated 2019, updated 7/2/24, includes, in part, the following:</p> <p>Procedure:</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Definitions: ABUSE is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>diii) Reporting/Response</p> <p>iii.Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>Example 1</p> <p>The facility's Grievance Log has an entry dated 6/5/24 that states, in part, the following: R1 is upset with interaction with staff member.</p> <p>On 7/24/24 at 10:45 AM Surveyor interviewed R1 regarding the interaction with a staff member on 6/5/24. R1 stated CNA E (Certified Nursing Assistant) was rude and yelled at R1.</p> <p>On 7/2/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked NHA A (Nursing Home Administrator) if this allegation was reported to the State Agency. NHA A stated this allegation should have been reported to the State Agency.</p> <p>Example 2</p> <p>The facility's Grievance Log has an entry dated 1/17/24 that states, in part, the following: R10's wife upset regarding not being informed about resident having a black eye (December 2023) .</p> <p>Surveyor reviewed R10's medical record. R10 did not have any documentation in his progress notes for December 2023.</p> <p>On 7/25/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked NHA A if this allegation of an injury of unknown origin was reported to the State Agency. NHA A stated this allegation should have been reported to the State Agency.</p> <p>Example 3</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 - Some</p>	<p>The facility's Grievance Log has an entry dated 4/11/24 that states, in part, the following: Interaction from staff when asking for assistance - resident (R11) was participating in speech therapy session when asked how his night was the prior night- he indicated not good. When asked further he noted that he was taken to the bathroom and had a bm (bowel movement) in his crack - he asked the staff person to assist him - they declined indicating that she did not need to wipe him, he again asked her to wipe him, and she stated that she was not his wife and does not have to do that.</p> <p>On 7/25/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked NHA A if this allegation of neglect was reported to the State Agency. NHA A stated this allegation should have been reported to the State Agency.</p> <p>Example 4</p> <p>R7's progress note, dated 4/7/24, 7:05PM, includes the following: Resident is claiming that a white ski jacket that is silky and pair of Jordashe jeans of unknown color were stolen from her. She doesn't know if it is staff or residents, she is just claiming every time I leave my room something is taken from me. Writer looked in laundry and, in her room, and was not able to find items. Writer left a message for SS H (Social Services). She is very upset.</p> <p>On 7/25/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked NHA A if this allegation of misappropriation was reported to the State Agency. NHA A stated this allegation should have been reported to the State Agency.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>29360</p> <p>Based on record review and interview, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were thoroughly investigated for 4 of 10 residents reviewed (R1, R10, R11 and R7).</p> <p>R1 reported to NHA A (Nursing Home Administrator) that CNA E (Certified Nursing Assistant) was rude and yelled at R1. This allegation was not thoroughly investigated.</p> <p>R10 was found to have a black eye. This allegation was not thoroughly investigated.</p> <p>R11 reported to NHA A (Nursing Home Administrator) that staff refused to assist R11 with wiping his bottom when using the toilet. The staff indicated she did not need to wipe R11 was not R11's wife and does not have to do that. This allegation was not thoroughly investigated.</p> <p>R7 reported to staff that she was missing a white ski jacket and a pair of Jordashe jeans. R7 alleged the jacket and jeans were stolen. This allegation was not thoroughly investigated.</p> <p>Evidenced by:</p> <p>The facility's Abuse and Neglect Procedural Guidelines policy, dated 2019, updated 7/2/24, includes, in part, the following:</p> <p>Procedure:</p> <p>3. Definitions: ABUSE is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>a) Verbal abuse - Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.</p> <p>i. Staff to resident - any episode.</p> <p>c) Deprivation of goods and services by staff - staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from resident(s), which result in care deficits to a resident(s).</p> <p>j) Injuries of Unknown Source - means an injury that occurs when both of the following conditions are met:</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 - Some</p>	<p>i. The source of the injury is not observed by any person, or the source of the injury could not be explained by the resident and</p> <p>ii. The injury is suspicious in nature because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time of the incidence of injuries over time).</p> <p>m) Misappropriation of Property - means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>b) Training</p> <p>i. Provide training for new training for new employees through orientation and with ongoing training programs.</p> <p>ii. Documentation of training of Training of Trilogy employees will be maintained with in-service records in the campus.</p> <p>d) Identification</p> <p>i. Review Service Recovery Reports routinely to monitor for indicators leading to suspected abuse, exploitation, or neglect.</p> <p>ii. Any person with knowledge of or suspicion of suspected violations shall report immediately without fear of reprisal.</p> <p>1. Abuse, neglect, exploitation, and misappropriation of resident property is a crime and may result in the loss of professional license or nursing assistant certification.</p> <p>iii. The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows:</p> <p>iv. Immediately notify the Executive Director, if the Executive Director is absent, they may appoint a designee.</p> <p>i. The Executive Director or designee must notify the resident(s)' physician and family/resident representative.</p> <p>ii. The Executive Director is responsible for:</p> <p>1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated.</p> <p>di) Protection</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 - Some</p>	<p>i. Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to the following:</p> <p>ii. Moving the resident to another room.</p> <p>iii. Providing 1:1 monitoring, as appropriate.</p> <p>iv. Suspend suspected employee(s) pending outcome of investigation.</p> <p>v. Implement discharge process immediately, if resident is a danger to self or others.</p> <p>dii)Investigation</p> <p>i.The Executive Director is accountable for investigating and reporting.</p> <p>ii.Exercising caution in handling evidence that could be used in a criminal investigation. (e.g.not tampering or destroying evidence)</p> <p>iii.Investigating different types of alleged violations.</p> <p>iv. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.</p> <p>v. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause.</p> <p>vi. Providing complete &amp; thorough documentation of the investigation.</p> <p>Example 1</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 - Some</p>	<p>The facility's Grievance Log has an entry that states, in part, the following: Resident: (R1). Concern Date: 6/5/24. Concern Time: 10:00 (AM). Concerned Person: Resident. Nature of Concern: R1 is upset with interaction with staff member. - . Exec Director (ED) (NHA A) received a voicemail from (R1) on 6/4 to discuss her concerns regarding (CNA E) around 1:30 PM. ED told (R1) that she would follow up on her concern and will return to talk with (R1) no later than next day (6/5) to ensure that the concern was resolved. ED asked (R1) if she would like to file a grievance and resident was in agreement. 3. ED spoke with (CNA E) and other CNA that was present during (R1's) cares to speak about residents preference and concerns as it relates to interactions with the staff. This was completed right after conversation with (R1) on 6/4. Both were present and able to speak to the interaction. 4. CNAs told ED that (R1) was speaking to them in a very demeaning way, which led them to ask (R1) why was she upset that day. (R1) proceeded to use foul language towards the employees as they provided (R1's) cares. Shortly after, (R1) started complimenting the CNAs new hair style and no longer had an issue with their interactions. The CNAs stated that they have a hard time knowing what mood she is in. Some days she doesn't want them to talk to her and other days she wants to hear about their kids, etc. Resident will get mad at them if they ask how is she doing that day. 5. On 6/4 and 6/5 (R1) left voicemails for social services stating that they have yet to address her grievance and her plan is to get (CNA E) fired by calling state. 6. On 6/5 ED followed up with (R1) as promised to review the items discussed the day prior to be sure they were improved and she said that they were. Resident continued to be upset social services had not come in, however ED was handling. Resident told ED that she called state and that she received a return phone call from someone from the state. She informed ED that she told the state that no one has addressed her concern. ED tried talking with (R1) regarding the conversation they had the day prior addressing the concern and (R1) didn't think it was enough. ED apologized and asked resident what she could do to further address her grievance. Resident did not have any further suggestions other than firing (CNA E). 7. ED had social services speak with (R1) shortly after her. Dissatisfaction Level: Upset. Entered by: (NHA A). Date Entered: 6/30/24.</p> <p>On 7/24/24 at 10:45 AM Surveyor interviewed R1 regarding the interaction with a staff member on 6/5/24. Surveyor asked R1 what she told NHA A occurred on 6/5/24 between R1 and CNA E. R1 stated CNA E was rude and yelled at R1.</p> <p>On 7/24/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked if R1's allegations CNA E yelled at R1 and was rude to R1 could be considered abuse. NHA A stated it could be. Surveyor asked NHA A if this allegation was thoroughly investigated. NHA A stated this allegation was not thoroughly investigated but was looked into as a grievance.</p> <p>On 7/24/24 at 5:35 PM Surveyor requested the complete documentation of the investigation of R1's allegations of CNA E yelling at R1 and being rude to R1 from NHA A. On 7/25/24 at 10:32 AM Surveyor received a Grievance Log update. Surveyor was not provided complete documentation of a complete and thorough investigation.</p> <p>The facility failed to identify the allegation as an allegation of abuse, interview other staff and residents, failed to protect by suspending suspected employee pending outcome of investigation and failed to document a thorough investigation.</p> <p>Example 2</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 - Some</p>	<p>The facility's Grievance Log has an entry that states, in part, the following: Resident: (R10). Concern Date: 1/17/24. Concern Time: (3:00 PM). Family Member: wife. Concerned Person: Family Member. Nature of Concern: not being informed of changes to residents medical condition - residents wife upset regarding not being informed about resident having a black eye (December 2023) and now about a laceration to his arm - came in to visit him to find a bandage on his arm - concerned about communication from facility staff and how these things occurred. Care conference held w/ (with) family member; ED (Executive Director) (NHA A), DHS and SS (Social Services) attending meeting. Staff discussed concerns with POA (Power of Attorney) and were able to clear up concerns with POA and were able to clear up concerns related to the incident. Family member was pleased with the conversation. Dissatisfaction Level: Upset. Date Entered 1/24/24. Review Date: 1/25/24. Comments: Facility reviewed root cause of black eye; caused by lift due to spastic movements during transfer; bumping of face on lift was witnessed by employee providing cares; family member updated on cause of bruising to eye during care plan meeting with IDT (Interdisciplinary Team).</p> <p>Surveyor reviewed R10's medical record. R10 did not have any documentation in his progress notes for December 2023 and no documentation of an assessment of an injury to R1's eye was found in R10's medical record.</p> <p>On 7/2/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked NHA A if R10's black eye/injury of unknown origin could be considered abuse. NHA A stated maybe. Surveyor asked NHA A if R10's black eye/injury of unknown origin was thoroughly investigated. NHA A stated this allegation was not thoroughly investigated.</p> <p>On 7/24/24 at 5:35 PM Surveyor requested the complete documentation of investigation of R1's black eye/injury of unknown origin from NHA A. On 7/25/24 at 10:32 AM Surveyor received a Grievance Log update. Surveyor was not provided complete documentation of a complete and thorough investigation.</p> <p>The facility failed to identify the injury of unknown origin as an allegation of abuse, interview staff, update physician, update R1's representative, and failed to document a complete and thorough investigation.</p> <p>Example 3</p> <p>The facility's Grievance Log has an entry that states, in part, the following: Resident: (R11). Concern Date: 4/11/24. Concern Time: (4:15 PM). Concerned Person: Resident. Nature of Concern: Interaction from staff when asking for assistance - resident was participating in speech therapy session when asked how his night was the prior night- he indicated not good. When asked further he noted that he was taken to the bathroom and had bm (bowel movement) in his crack - he asked the staff person to assist him - they declined indicating that she did not need to wipe him he again asked her to wipe him and she stated that she was not his wife and does not have to do that the speech therapist apologized for the behavior of the staff person and reminded him to continue to use the call light for needed assistance. Dissatisfaction Level: Upset. Date Entered 4/12/24. Review Date: 4/16/24. Call Review: Communicated to resident. Comments: ED (Executive Director) (NHA A) and DHS reviewed resident concern and addressed with alleged employee. The employee that was interviewed denied these statement, however, was still educated on customer service expectations. Employee apologized to resident for alleged complaint to resident. ED followed up with resident and he had no additional concerns.</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 - Some</p>	<p>On 7/2/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked NHA A if R11's allegation could be considered an allegation of abuse. NHA A stated maybe. Surveyor asked NHA A if R11's allegation was thoroughly investigated. NHA A stated this allegation was not thoroughly investigated.</p> <p>On 7/24/24 at 5:35 PM Surveyor requested the complete documentation of the investigation of R11's allegations from NHA A. On 7/25/24 at 10:32 AM Surveyor received a Grievance Log update. Surveyor was not provided complete documentation of a complete and thorough investigation.</p> <p>The facility failed to interview other staff and other residents, failed to suspend suspected employee pending outcome of the investigation and failed to document a complete and thorough investigation.</p> <p>Example 4</p> <p>R7's progress note, dated 4/7/24, 7:05PM, includes the following: Resident is claiming that a white ski jacket that is silky and pair of jordashe jeans of unknown color were stolen from her. She doesn't know if it is staff or residents, she is just claiming every time I leave my room something is taken from me. Writer looked in laundry and in her room and was not able to find items. Writer left a message for SS H (Social Services). She is very upset.</p> <p>On 7/2/24 at 5:15 PM Surveyor interviewed NHA A. Surveyor asked NHA A if R7's allegation of misappropriation was thoroughly investigated. NHA A stated she was unaware of the concern. NHA A stated this allegation was not thoroughly investigated.</p> <p>On 7/24/24 at 5:35 PM Surveyor requested the complete documentation of the investigation of R7's allegations of misappropriation from NHA A. Surveyor was not provided complete documentation of a complete and thorough investigation.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788</b></p> <p>Based on interview and record review, the facility did not ensure each resident received the necessary care and services in accordance with professional standards of practice to meet each resident's physical needs for 1 (R2) of 4 sampled residents.</p> <p>The facility failed to complete a focused assessment for R2 when he presented with a change in condition on [DATE]. R2 had reported not feeling well and had a gray emesis the morning of [DATE]. The nurse took a set of vital signs and did not assess R2 thoroughly. R2 was found in his room that afternoon expired in his bed with black liquid emesis in the bed and on the floor.</p> <p>Evidenced by:</p> <p>The facility policy entitled Notification of Change in Condition, dated [DATE], states, in part: .</p> <p>PURPOSE: To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative when: .</p> <p>2. A significant change in the resident's physical, mental or psychosocial status .</p> <p>Sample reasons to notify the physician immediately but not limited to:</p> <p>1. A deterioration in health, mental or psychosocial status .</p> <p>PROCEDURES:</p> <p>1. Resident assessments for change in condition . should be completed in a timely manner .</p> <p>The facility policy entitled Physician-Provider Notification Guidelines, dated [DATE], states, in part: .</p> <p>PURPOSE: To ensure the resident's physician or practitioner . is aware of . change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care.</p> <p>PROCEDURES:</p> <p>1. Resident assessments for change in condition . should be completed in a timely manner .</p> <p>Note: Facility indicated they did not have a Policy on Nurse Assessment.</p> <p>Example:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Waunakee Valley Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  801 Klein Dr Waunakee, WI 53597	
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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>R2 admitted to the facility on [DATE] and has diagnoses that include Metabolic Encephalopathy (a brain dysfunction that occurs due to a chemical imbalance in the blood that affects the brain), Rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), and congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).</p> <p>R2's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], shows that R2 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R2 is cognitively intact.</p> <p>R2's Care Plan dated [DATE], states, in part: .</p> <p>Problem: Category: Pain</p> <p>R2 is at risk for chest and stomach pain and burning related to diagnosis of GERD (gastroesophageal reflux disease- A digestive disease in which stomach acid or bile irritates the food pipe lining) .</p> <p>Approach: .</p> <p>Report any changes in resident's stomach pain or discomfort. Approach Start Date: [DATE] .</p> <p>R2's progress notes dated [DATE] at 8:14 AM, states Entered resident's room to give meds. This writer noticed a dark liquid in urinal. Resident stated he had thrown up in the urinal. Certified Nursing Assistant (CNA) stated he had drank prune juice. New urinal given. Contents in urinal was a thin dark gray colored liquid without odor. Vital signs checked and WNL (within normal limits). Resident stated he was ok to take his meds and took his meds without difficulty. The writer got him a glass of sprite. Wife arrived and was updated on resident's condition.</p> <p>R2's progress notes dated [DATE] at 1:00 PM states While walking down the hall to check on resident, RN (Registered Nurse) and wife walking towards writer, stated that the resident was deceased . This writer entered the room and noted resident to have had a large amount of dark grey colored, odorless liquid in bed and on the floor. Staff present cleaned resident up. Clean gown placed on resident.</p> <p>R2's progress notes dated [DATE] at 1:15 PM states, in part: Writer notified by housekeeping that something was wrong with resident at 12:45. She stated he looked like he had vomited and wasn't responding. Writer entered resident's room to find him nonresponsive, blue, with a large amount of black thin emesis covering the upper half of the bed and the floor. Resident had no pulse and no respirations. Resident's wife had just arrived to the facility and walked in the room. Writer comforted her and asked if she would like to sit in social services while we cleaned the resident up. She stated she did .</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 [DATE] at 2:05 PM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked LPN C to tell Surveyor about R2's change in condition today. LPN C indicated at 8:00 AM LPN C went to administer R2's medications and when she entered R2's room she observed dark gray liquid in R2's urinal. R2 informed LPN C he had thrown up in his urinal and he didn't feel well. LPN C indicated she checked R2's vital signs. BP (Blood Pressure)- ,d+[DATE] Pulse- 76 Temperature- 98.1 Respirations- 18 O2- 98%. LPN C indicated she gave R2 a Sprite and R2 felt ok to take his medications, so LPN C administered medications at that time. LPN C indicated R2's wife came in and LPN C updated her on R2 having an emesis and vital signs. Surveyor asked LPN C if R2's physician was updated, and LPN C indicated no. Surveyor asked LPN C if not feeling well and having a gray emesis would be a change in condition and LPN C indicated it was an emesis. Surveyor asked if having an emesis is considered a change in condition and LPN C indicated if that is what you want to call it. LPN C indicated the night CNA reported R2 had had prune juice sometime and R2 did not eat breakfast. Surveyor asked LPN C if she followed up with R2 after that and LPN C indicated not until approximately 1 PM when a nurse and wife informed her R2 had passed. LPN C indicated a housekeeper had found R2, but she could not recall her name. Surveyor asked LPN C if she should have gone back at some point to follow up on R2 and LPN C indicated yes, but she was swamped by training someone and having 34 residents to care for and do treatments. Surveyor asked LPN C if the physician should have been notified this morning with change and gray emesis and LPN C indicated not at the time but knowing he passed away, yes.</p> <p>On [DATE], at 2:40 PM, Surveyor interviewed ES D (Environmental Services) and asked about what she observed with R2 this morning. ES D indicated she seen a package outside R2's room when she was passing by and picked up package and entered R2's room and observed a lot of black liquid on the floor next to the bedside table and black liquid running out of R2's mouth. ES D indicated there was black liquid pooled in the bend of R2's arm. ES D left R2's room to find help and found SDN E (Staff Development Nurse) and informed SDN E that something was wrong with R2. SDN E had gone in R2's room and ES D left.</p> <p>On [DATE] at 2:50 PM, Surveyor interviewed SDN E and asked her what she knows regarding R2's incident today. SDN E indicated at about 12:45 PM, ES D informed her something is not right with R2 and he looks like he vomited. ES D informed SDN E R2 is not blinking and not responding. SDN E had gone in his room and could tell he had passed away by the blue color and no response. There was a large amount of thin, watery, black emesis pooled under his bed, pooled in his arm, and spilled over the bed and onto the floor. It was all black with like a gritty sediment substance. R2 was not responding and there was no heartbeat or respirations audible with stethoscope. Surveyor asked SDN E if having a gray emesis and not feeling well as R2 did that morning, be a change in condition. SDN E indicated yes, and physician should have been notified. Surveyor asked SDN E if she would expect R2 to be assessed throughout the day after complaints of not feeling well and a gray emesis and SDN E indicated yes. Surveyor asked what Standard of Practice the facility follows and SDN E could not indicate as she was unsure.</p> <p>On [DATE] at 3:12 PM, DON B (Director of Nursing- Interim) indicated complaints of not feeling well and gray emesis would be considered a change in condition, and she would have expected physician notification. DON B indicated she would expect the nurse to follow up with R2 throughout the day.</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 [DATE] at 4:05 PM, Surveyor asked DON B and SDN E if checking a set of vital signs is considered a full assessment and they both indicated no. Surveyor asked if both would expect at least a focused system assessment with bowel sounds and abdominal assessment at the time R2 complained of not feeling well with gray emesis and both indicated they would have done one- GI (gastrointestinal) for sure.</p> <p>On [DATE] at 3:20 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if she would have expected the nurse to listen to bowel sounds, lung sounds and do an abdominal assessment of R2 and NHA A indicated she is not a nurse she would not know. NHA A indicated she would not have expected the physician to be notified with one emesis and sprite given and effective for R2. Surveyor asked if she would expect the nurse to follow up with R2 throughout day and NHA A indicated yes, and staff was aware R2 was not feeling well and were to report to the nurse if R2 needed the nurse. Surveyor asked NHA A what standard of practice the facility uses and NHA A said its different for different situations. NHA A could not provide a standard of practice. Surveyor asked for change of condition and NHA A indicated it depends on the situation.</p> <p>On [DATE] at 5:25 PM, Surveyor interviewed NP H (Nurse Practitioner). NP H indicated she would have expected the nurse to assess heart sounds, bowel sounds, and assess abdomen. NP H indicated she would have expected bowel movements to be checked for R2 at the time of complaining of not feeling well and gray emesis. NP H indicated she would have expected the nurse to follow up and assess R2 during the day following that episode.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713</b></p> <p>Based on observation, interview, and record review, the facility did not ensure each resident receives cares, consistent with professional standards of practice to prevent pressure injuries (PIs) for 2 of 2 residents (R) sampled out of a total sample of 13 (R4 and R6).</p> <p>R4 was admitted on [DATE], without a pressure injury or catheter. Resident was hospitalized on [DATE], returning on [DATE] with a foley catheter in place. The facility failed to ensure interventions to prevent medical device-related pressure injuries were implemented correctly to prevent PI development, failed to complete weekly measurements and assessments, and failed to complete treatments as ordered. R4 subsequently developed a full thickness wound that extended from the tip of the penis where the catheter is placed, through the meatus, and down to the shaft.</p> <p>These failures created a finding of immediate Jeopardy (IJ) which began on [DATE]. The NHA (Nursing Home Administrator) was notified of the IJ on [DATE] at 1:20 PM. The jeopardy was removed on [DATE]; however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm that is not immediate jeopardy/isolated) as evidenced by the following example:</p> <p>R6 was admitted to the facility on [DATE] without a pressure injury. The facility did not put interventions in place on admission to prevent the development of pressure injuries, did not notify the physician when the wound worsened, and did not ensure proper hand hygiene during wound care.</p> <p>This is evidenced by:</p> <p>Example 1:</p> <p>An article from the National Library of Medicine (NIH) at <a href="https://pubmed.ncbi.nlm.nih.gov/21205992">pubmed.ncbi.nlm.nih.gov/21205992</a> from, [DATE] states in part . Medical devices often are overlooked as a potential cause of pressure ulcers. Indwelling urinary catheters have been described as a cause of urethral erosion. In men, the resultant partial-thickness or full-thickness wound can involve a small area of the glans penis or [NAME] the glans or penile shaft, requiring reconstructive surgery or urinary diversion.</p> <p>An article from the NIH at <a href="https://pubmed.ncbi.nlm.nih.gov/36493361">pubmed.ncbi.nlm.nih.gov/36493361</a> from, [DATE] states in part . Urethral erosion secondary to a medical device-related pressure injury (MDRPI) is preventable, understudied , not well understood, and often overlooked.</p> <p>The facility policy titled Guidelines for Wound Rounds, last reviewed [DATE], states in part . Policy: Guidelines for Wound Rounds. Purpose: To ensure treatment approaches and interventions are being followed through by resident care givers. Procedure: 5. Wound event and Wound Management forms should be monitored 5 days a week in CCM to ensure weekly measurements and proper documentation is in place.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Urinary Catheter Care, last reviewed [DATE], states in part . Overview: To prevent infection of the resident's urinary tract. SOP details: 5. Check the resident frequently to be sure he/she is not lying on the catheter and to keep the catheter and tubing free of kinks. 6. Notify the charge nurse in the event of hemorrhage (bleeding), or if the catheter is pulled out. 14. Ensure the catheter remains secured. A leg strap may be used to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) 15. Be observant of skin irritation.</p> <p>R4 was admitted to the facility on [DATE]. R4's diagnoses include Hemiplegia and hemiparesis following cerebral infarction affecting the left non dominant side, aphasia following cerebral infarction, hypertension (HTN), congestive heart failure (CHF), and obstructive and reflux uropathy.</p> <p>R4's significant change Minimum Data Set (MDS) assessment, with an assessment reference date of [DATE] indicates R4 has a Brief Interview of Mental Status (BIMS) of 7, indicating severe cognitive impairment. R4 is dependent on staff for toileting hygiene, shower/bathe, upper and lower body dressing, bed mobility, toilet transfers, and tub/shower transfers. R4 requires partial/moderate assistance with personal hygiene. Urinary continence is not rated due to urinary catheter in place and R4 is always incontinent of bowel.</p> <p>R4 was hospitalized on [DATE] and returned on [DATE] with foley catheter in place.</p> <p>R4's Braden Score on admission, [DATE], indicates a 12, High Risk.</p> <p>R4's care plan includes .</p> <p>Problem: R4 uses catheter for diagnosis of obstructive uropathy, implemented [DATE]. Interventions: leg strap in place to prevent resident's catheter from being pulled out, implemented [DATE]. Observe for any signs of complication such as UTI (Urinary Tract Infection), urethral trauma, structures, bladder calculi or silent hydronephrosis notify my MD, implemented [DATE]. Observe tubing and avoid any obstructions, implemented [DATE]. Provide assist with catheter care and change foley per physician orders, implemented [DATE].</p> <p>Problem: R4 demonstrates non-compliance with physician orders and/or plan of care as evidenced by: Removing catheter strap from leg causing the catheter to pull and give increased pain implemented [DATE]. Interventions: Educate resident and activated POA (Power of Attorney) regarding physician orders and risk and benefits of compliance, implemented [DATE]. Encourage resident and activated POA to actively participate in care plan and decision making, implemented [DATE]. Encourage resident and activated POA to participate in decision making by offering choices and discussion of advance directives, implemented [DATE].</p> <p>Physician Orders dated [DATE] state: Foley catheter care every shift, TID (three times a day).</p> <p>Nurses Note from [DATE] at 12:01 PM states, called to resident's room to assess tip of penis for purulent drainage, redness, and pain. Upon assessment, appears that foley catheter was not in stat lock correctly and there is a tight pull from the penis to catheter which has caused the urethra to open more. Cleansed well, iodine applied, and new stat lock placed and educated CNAs (Certified Nursing Assistant) to correct positioning. Call placed to Hospice to address before the weekend.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Of note, despite the nursing staff documenting pressure from the foley to the penis resulting in redness, pain, drainage, and urethra to open more, the facility did not implement weekly assessments or complete weekly measurements of this area.</p> <p>The [DATE] and [DATE] Treatment Assessment Records (TAR) state in part: Weekly Skin Assessment once a day on Saturday start date: [DATE]. This skin assessment is signed out weekly however there is no notation in the medical record regarding the erosion/PI to R4's penis. A weekly assessment should include measurements, the location of the PI, description of the wound bed, surrounding tissue, if there is drainage or pain. There is no documentation in R4's medical record to indicate this type of weekly wound assessment occurred.</p> <p>Nurses Note from [DATE] at 1:35 PM states, received call back from RN from Hospice. She will be coming to address catheter issues and skin issues.</p> <p>Hospice order from [DATE]. Vaseline white petroleum topical ointment. Apply to meatus BID (twice a day) for irritation. Lidocaine 3% topical cream. Apply to meatus 2x (2 times)/day prn (as needed) for pain/irritation.</p> <p>The [DATE] Medication Administration Record (MAR) states in part;</p> <p>Vaseline [NAME] Petroleum, apply to meatus topical BID PRN. Start date: [DATE]. End date [DATE].</p> <p>Of note, the facility transcribed the Vaseline order onto the MAR as BID (twice a day) PRN; however, it should have stated BID. Due to the transcription error, the Vaseline order was not completed as ordered until [DATE].</p> <p>Hospice Note from [DATE] states in part, Patient still has the red, itchy patches to left arm and both legs near the ankles. Did not receive triamcinolone cream yet. No order in computer even though sent on Friday. Received new fax number from supervisor and had office fax again. This also includes treatment for sore penis. Will reassess later this week to see if treatments are working. No other concerns at this time.</p> <p>Physician Order: Check Foley catheter leg strap/stat lock is in place, change when needed, TID. Start date: [DATE].</p> <p>Nurses Note from [DATE] at 7:03 PM states: Writer was asked to come into resident's room today as there was some concern about blood coming out if his penis around the catheter. There was some visible blood noted, with a scant amount of blood noted in his catheter bag. Writer called hospice to see if the hospice nurse could come out and assess the resident to see if anything should be addressed. RN from hospice called back and she arrived before supper and declined that he did not need to have it replaced but did place a stat lock on his leg that might help with the placement of the catheter and prevent it from getting pulled.</p> <p>Hospice Note from [DATE] states in part: Staff reported irritation/bleeding at meatus and dark colored urine. Foley is patent draining clear, yellow urine. No bleeding present, meatus enlarged due to chronic foley. Application of lidocaine gel and Vaseline encouraged as ordered. Patient denies pain, 200 ml clear yellow urine emptied.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], order for Vaseline [NAME] Petroleum apply to meatus BID PRN discontinued in MAR and correntcurrent order put in MAR for Vaseline [NAME] Petroleum, apply to meatus BID.</p> <p>Hospice Note from [DATE] states in part, Foley draining clear yellow urine. No other concerns at this time.</p> <p>Physician Orders placed on MAR: Check Foley catheter leg strap/stat lock is in place, change when needed, TID (Three Times Daily). Start date: [DATE].</p> <p>Hospice Note from [DATE] states in part, Foley changed by facility staff today and has s/s (signs and symptoms) of UTI. Notified MD (medical doctor) and requested antibiotic. Will call into pharmacy when orders received.</p> <p>Hospice Note from [DATE] states in part, Foley patent and draining clear amber urine. No other concerns at this time.</p> <p>Hospice Note from [DATE] states in part, Foley draining clear yellow urine.</p> <p>On [DATE] at 11:20 AM, Surveyor observed CNA D (Certified Nursing Assistant) and CNA E complete foley catheter care for R4. CNAs removed resident's brief to start cares when they voiced that they would not be doing any catheter care but were getting the nurse. Surveyor observed that the resident's stat lock connected to the catheter tubing was taut causing the catheter to cause pressure on the meatus. Surveyor noted a full thickness wound that extended from the tip of the penis where catheter is placed, through the meatus, and down to the shaft. Surveyor noted mild amount of bleeding and R4 denied pain to area. CNA E left the room and notified the nurse who came into the room to assess R4.</p> <p>Nurses Note from [DATE] at 11:24 AM states, Called to resident's room for complaint of penis bleeding and painful. Upon assessment catheter has eroded away and it now split down into the penis. Bleeding is controlled at this time. Call placed to hospice for return call.</p> <p>On [DATE] at 11:50 AM, Surveyor was in R4's room as nurse entered room to assess resident catheter. Admissions RN C (registered nurse) reported that the facility would be calling hospice for orders to treat or send R4 out to the ER (emergency room ). Nurse reported to Surveyor that the DON (Director of Nursing) is calling hospice but if they do not return a call timely, a call will be placed to the NP (Nurse Practitioner) for direction and orders. At this time, nurse indicates she is going to clean the area and apply skin prep. Admission RN C cleaned area and applied skin prep to the wound.</p> <p>Note: Physician Orders are for Vaseline and lidocaine to meatus.</p> <p>On [DATE] at 11:55 AM, DON B (Director of Nursing) approached Surveyor stating she was able to get in touch with hospice who will be contacting the resident's care nurse and R4 may need to be sent out for evaluation.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Nurses Note from [DATE] at 11:55 AM states, Writer went into resident's room to assess foley catheter and penis. Writer was told the resident's catheter was secured with a stat lock, but the tubing was tight from the penis to the stat lock and staff had just removed the stat lock. Writer placed new stat lock to ensure the catheter had adequate slack from the penis to the stat lock. No active bleeding from the tip of the penis at this time. Slit noted on the posterior meatus approximately an inch long. Resident is calm and chatting with writer during assessment. When asked if he was having pain, he stated not now.</p> <p>Nurses Note from [DATE] at 12:13 PM states, call placed to NP to give update on resident with meatus eroded. NP stated that could possibly manage in house with lidocaine urojet (a sterile aqueous product that contains a local anesthetic agent and is administered topically) and proper placement of stat lock. Stated it was up to family and ok to send to ER.</p> <p>On [DATE] at 12:25 PM, DON B approached Surveyor indicating that hospice and family were requesting R4 be sent to hospital for evaluation.</p> <p>On [DATE] at 1:20 PM, Surveyor interviewed CNA D about resident's catheter and erosion of meatus. CNA D stated that this is nothing new. We have been telling them for months, but they did nothing.</p> <p>On [DATE] at 1:25 PM, Surveyor interviewed admissions RN C. Surveyor asked RN C if this was something new. RN C stated, A few days ago there was something going on and hospice came out.</p> <p>On [DATE] at 1:30 PM, Surveyor interview DON B. Surveyor asked DON B when this started and if she had been aware. DON B stated, on [DATE], resident started to have a tear in the penis. The Hospice nurse and NP did order lidocaine gel and skin prep. The tear prior to today was approximately 1 cm (centimeter).</p> <p>On [DATE] at 1:40 PM, Surveyor interviewed CNA E. Surveyor asked CNA E if she had noted any erosion to this area prior to today. CNA E states, yes but not this bad. We have told hospice and they looked at it, but it has progressively gotten worse. We have been asking to have him sent out and have been telling them for a while.</p> <p>On [DATE] at 1:45 PM, Surveyor interviewed CNA J. Surveyor asked CNA J if she ever noted any skin issues around resident's catheter. CNA J stated, I observed a tear at the tip approximately ,d+[DATE] cm maybe 2 weeks ago. I told the nurse, but it was on PM shift. R4 did have a stat lock at that time, but it was tight and pulling and I told the nurse that too.</p> <p>On [DATE] at 3:07 PM, Surveyor interviewed DON B. Surveyor asked DON B when the facility noticed R4 had an erosion of the penis. DON B stated, it started a while ago but can't give a specific date. Surveyor asked DON B if this would be considered a medical device related pressure injury. DON B stated she had not considered it a medical device related pressure injury. Surveyor asked DON B if the facility did any weekly assessments or measurements of the area. DON B stated I don't think any measurements or assessments have been done but I will look.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Waunakee Valley Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  801 Klein Dr Waunakee, WI 53597	
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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 4:15 PM, Surveyor interviewed NP I regarding resident's meatus. NP I stated she was not aware of any issues with the resident's catheter until today. Surveyor asked NP I if she would have expected to have been notified of any issues prior to today. NP I stated she would want to be made aware of any skin integrity or pressure injury concerns. I was made aware that the hospice team had been updated and feel ok with that as they treated. I am on the unit weekly and could have assessed. This likely could have been prevented if caught early. R4 does have decreased sensation, but staff should have noted concerns with skin during catheter cares, reported those concerns to the nurse, and then reported to me and hospice. R4 has orders for catheter care three times a day and this should have been caught earlier. Having a device puts you at risk but should have assured catheter was not pulling with cares and assessment.</p> <p>On [DATE] at 4:20 PM, Surveyor interviewed Anonymous Staff F. Surveyor asked Anonymous Staff F if she was aware of any skin issues around R4's penis. Anonymous Staff F stated, the CNAs have reported concerns to me about R4's penis. The CNAs told me about it then and reported it to Admission RN C. R4 did not have a stat lock when he first returned with the catheter. R4 does mess around with himself a lot.</p> <p>On [DATE] at 4:30 PM, Surveyor interviewed CNA G. Surveyor asked CNA G about any skin concerns around R4's penis and if R4 always had a stat lock. CNA G stated, R4 did not always have a stat lock in place. It was passed on to me a while ago that the day shift had noted a tear in the meatus and reported it to the nurse then. I am unsure how long ago that was, but it has been a while.</p> <p>The facility's failure to implement interventions to ensure a medical device did not cause a pressure injury, failure to complete weekly assessments and measurements, and failure to complete treatments as ordered created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the immediacy on [DATE] when they completed the following:</p> <ul style="list-style-type: none"> <li>-On [DATE], the facility reviewed the care plan of resident to identify and complete follow up, if indicated for concerns related to the catheter device. The resident was sent to hospital for evaluation.</li> <li>-The facility identified all residents currently admitted to identify any possible similar events related to abnormal findings for residents with catheters at risk for injury including but not limited to pressure ulcers.</li> <li>-Facility conducted a sweep of all residents with an indwelling foley catheter to ensure interventions are in place to prevent PI development.</li> <li>-Skin assessments have been completed on all residents with an indwelling catheter.</li> <li>-The facility initiated proactive education with licensed nursing staff on catheter care and pressure ulcer prevention on this date as well.</li> <li>-Nursing staff will be educated prior to the start of their next shift to ensure correct positioning to prevent tubing from being taut or causing pressure on the urethra.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Nursing staff will be educated on monitoring of skin integrity on residents with catheters during cares, paying special attention to skin impairment and will be completed with the change in condition policy. Any findings will be reported immediately.</p> <p>-The facility initiated a skills check list for licensed nursing staff for catheter care.</p> <p>-The facility audited all residents with catheters with or without wounds related to catheter use to ensure orders were appropriate and treatment plans were in place for care as well as prevention of pressure ulcers.</p> <p>-Proactive education on the use of stat locks for catheters.</p> <p>-Documentation is to include weekly measurements and assessments if a pressure ulcer is identified. These are to be signed out in the TAR as ordered.</p> <p>-The facility initiated education with licensed nurses to ensure physician orders are transcribed correctly to the MAR/TAR.</p> <p>-Licensed Nursing Staff were also educated on documenting and reporting changes of condition at the time of the observation to the physician as well as the resident's responsible party and hospice.</p> <p>-On [DATE], the facility initiated reeducation with all Licensed Nursing Staff on identifying and reporting Changes of Condition when newly identified changes in health status are identified.</p> <p>-On [DATE], the facility initiated reeducation with all Licensed Nursing Staff on completion of a comprehensive assessment on all skin events with a noted change in size, shape, and clinical presentation at the time of discovery.</p> <p>-On [DATE], the Licensed Nursing staff was reeducated on completing a notification to the MD, RP, and or Guardian at the time of identification.</p> <p>-On [DATE], the Licensed Nursing Staff were reeducated on catheter care including but not limited to pressure ulcer prevention and treatment.</p> <p>-On [DATE], the Licensed Nursing staff were reeducated on transcribing orders to the MAR/TAR as ordered.</p> <p>-The facility will review orders daily in the Morning Clinical Meeting to ensure that preventative orders are in place for catheters to decrease the risk for pressure.</p> <p>-The facility will review Matrix EHR (electronic health record) daily during Morning Clinical Meeting to identify Changes of Condition and ensure notifications/consultations were completed. Follow up will be completed if indicated based on the outcome of the audit.</p> <p>-The facility will complete random audits 3x weekly with Licensed Nurses to gauge understanding related to completion of Changes of Condition. Remedial education will be provided at the time of completion of audits if indicated.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The facility will complete random audits 3x weekly on catheters to ensure care is provided per clinical standards. To include proper placement of leg strap/stat lock to prevent pressure. Remedial education will be provided at the time of completion of audits if indicated.</p> <p>-The facility will complete random audits 3x weekly on pressure ulcers to ensure care is provided per clinical standards. Remedial education will be provided at the time of completion of audits if indicated.</p> <p>-The facility will complete random audits 3x weekly on treatment records and weekly skin assessments to ensure care is provided per clinical standards. Remedial education will be provided at the time of completion of audits if indicated.</p> <p>-The facility will audit residents with medical device pressure injuries 3x weekly to ensure weekly assessments are documented in the medical record including measurements.</p> <p>-The results of the audits will be reported to the quality assurance and performance improvement (QAPI) committee and adjustments will be made to frequency of audits based on findings.</p> <p>Example 2:</p> <p>The facility policy titled Guidelines for General Wound and Skin Care, last reviewed [DATE], states in part . Guidelines for General Wound and Skin Care. Purpose: To provide measures that will promote and maintain good skin integrity. Procedure: The following general wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity. 5. Evaluate the need for a pressure reduction surface for bed/chair and the need for the elbow protectors and/or heel floats/boots.</p> <p>The facility policy titled Handwashing/Hand Hygiene, last reviewed [DATE], states: Policy: Guidelines for Handwashing/Hand Hygiene. Purpose: Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 3. Health Care Workers (HCW) shall use hand hygiene at times such as: d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Enhanced Barrier Precautions (EBP) Standard Operating Procedure, last reviewed [DATE], states in part . Overview: Guidance for enhanced barrier precautions (EBP to decrease risk of becoming colonized and developing infections with multidrug-resistant organism (MDRO) status. EBP does not replace existing guidance regarding the use of Contact precautions for other pathogens (ie: Cdiff, scabies, norovirus etc). SOP (Standard of Practice) details: 1. Enhanced Barrier Precautions (EBP) will be in place during high-contact care activities for residents with the following conditions: a. Residents at an increased risk of MDRO acquisition which include: ii. All resident with indwelling medical devices. 1. Includes but not limited to: catheters, central lines, feeding tubes, tracheostomy tubes. 2. Personal Protective Equipment (PPE) should be used even if blood and body fluid exposure is not anticipated. a. At minimum, staff shall wear gloves and gowns during high-contact care activities. May include face protection if splashes or sprays are anticipated during care. 3. High-contact care activities include but are not limited to: morning and evening ADL care, toileting, and showers. Includes transfers when bundled together with other high-contact activity which does not typically include transfers in common areas such as dining or activity rooms but would be included in therapy gym/treatment.</p> <p>R6 was admitted to the facility on [DATE]. R6's diagnoses include fracture of the left acetabulum (the socket of the hipbone, into which the head of the femur fits), fracture of left pubis, rhabdomyolysis, CKD stage 3 (chronic kidney disease), wedge compression fracture T11-T12, peripheral vascular disease, and Type 2 diabetes mellitus.</p> <p>R6's admission Minimum Data Set (MDS) assessment, with an assessment reference date of [DATE] indicates R6 has a Brief Interview of Mental Status (BIMS) of 13, indicating R6 is cognitively intact. R6 is independent with indoor mobility and stairs. R6 is dependent on staff for toileting hygiene, lower body dressing and bed mobility. R6 requires substantial/maximum assistance with transfers personal hygiene. R6 requires partial/moderate assistance with upper body dressing. R6 is occasionally incontinent of urine and always continent of bowel.</p> <p>R6's care plan includes .</p> <p>Problem: R6 has a pressure ulcer coccyx, initiated [DATE]. Approach: Assess and record the condition of the skin surrounding the pressure ulcer, initiated [DATE]. Weekly skin assessment, measurement, and observation of the pressure ulcer and record, initiated [DATE]. Pressure reducing cushion to chair, initiated [DATE]. Pressure reducing mattress, initiated [DATE]. Treatment per MD order. Notify MD if treatment is not effective, initiated [DATE].</p> <p>On [DATE] Surveyor requested copy of Braden Scales completed for R6. DON B (Director of Nursing) brought Surveyor a copy of the Braden showing R6 was at risk for pressure injury development but without a date that it was completed this was not provided to Surveyor.</p> <p>Wound Management Note from [DATE] at 2:55 PM states, Length: 0.5. Width 0.5. Exudate: None. Stage: Stage II. Tissue Type: Epithelial Tissue. Percent of wound covered by epithelialization tissue: 100. Wound edges/margins: Well defined wound edges. Skin surrounding wound: Assess within 4cm of wound edge: Pink/Normal. Comments: Resident has a stage 2 pressure area on coccyx, measures 0.5 x 0.5cm. No drainage, depth or odor. Resident c/o (complains of) some tenderness to area. Therapy notified to provide appropriate cushion for recliner. Area is 100% granulation tissue. Surrounding tissue is pink and blanchable. Border dressing applied. NP (Nurse Practitioner) updated on wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Wound Management Note from [DATE] at 2:55 PM edited by another RN and states, Length: 0.5. Width 0.5. Exudate: None. Stage: Stage II. Tissue Type: Epithelial Tissue. Percent of wound covered by epithelialization tissue: 100. Wound edges/margins: Well defined wound edges. Skin surrounding wound: Assess within 4cm of wound edge: Pink/Normal. Comments: Resident noted to have stage 2 pressure injury on coccyx. Area measures 0.5 x 0.5cm in size. No drainage, depth, or odor. Has some tenderness at wound site. No s/s infection. Resident sits in recliner during waking hours. Therapy requested to provide resident with pressure reducing cushion in recliner. Resident able to reposition self in recliner by lifting self-up with chair arms. Residents transfers with Sara Steady.</p> <p>Of Note: Wound Management Notes from [DATE] was completed by one nurse and edited by another which shows two entries for the same time and date.</p> <p>Nurses Note from [DATE] at 3:03 PM states, Resident has stage 2 pressure area on coccyx. No drainage, depth, or odor. No s/s infection. 100% granulation tissue present. Surrounding tissue is pink and blanchable. See wound management. NP updated and NOR (new order received) for border dressing. Daughter [name] updated on wound and interventions.</p> <p>Clinical Support Note from [DATE] at 10:39 AM states, Resident has a stage 2 pressure wound on coccyx. Tx (treatment) applied as ordered. Resident transfers will with Sara Steady lift. Usually sits in recliner during her waking hours but does ambulate to dining room for meals and therapy. Therapy provided her with cushion for recliner. Resident is able to reposition herself to relieve pressure to wound. Appetite is good. Usually eats ,d+[DATE]% of all meals. Blood sugars checked as ordered and usually run between ,d+[DATE] but there are a few outliers of blood sugars being &gt; (greater than) 250 and &gt;300. Insulin administered as ordered. Pertinent Dx (diagnoses) include: Left Acetabulum and left Pubis fx (fracture), rhabdomyolysis, CKD stage 3, Osteoporosis, Compression Fx T-3, T-11, T-12, PVD (peripheral vascular disease), Pulmonary Fibrosis, DM (diabetes mellitus) and liver disease. Pertinent meds (medications) include: NPH insulin, Levothyroxine, Vitamin D. Barriers to wound healing include DM, left Acetabulum and left Pubis fx. Attending therapy as scheduled.</p> <p>Physician's Order from [DATE] states, Order set WC (Wound Care) - cleanse Coccyx wound with wound cleanser or normal saline, apply skin prep, and cover with sacral foam dressing on mon (Monday)/wed (Wednesday)/fri (Friday) and prn.</p> <p>R6's Treatment Administration Record (TAR) states in part . Order Set WC - cleanse coccyx wound with wound cleanser and normal saline, apply skin prep, and cover with sacral foam dressing on mon/wed/fri and prn, start date [DATE].</p> <p>Of Note: Treatment not signed out on TAR as completed until [DATE]. Treatment not signed out as completed on [DATE] and [DATE].</p> <p>Wound Management Note from [DATE] at 3:47 PM states, Length: 0.5. Width 0.25. Exudate: Light. Exudate Color: Serous (clear, amber, thin and watery). Tissue Type: Granulation Tissue. Percent of wound covered by granulation tissue: 100. Wound edges/margins: Edge not attached to base; Macerated/soft. Skin surrounding wound: Assess within 4cm of wound edge: Dry and thin; Erythema (redness)/blanchable. Wound healing status: Stable. Comments: Open area continuing to get smaller but there is a reddened area 3 x 2cm that is red but blanchable. Tender to the touch for resident. Cushion noted in recliner and education done with resident regarding repositioning, laying down in her bed in the afternoons to reduce pressure to coccyx.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Wound Management Note from [DATE] at 7:11 PM states, Length: 0.5. Width 0.5. Exudate: Light. Exudate color and consistency: Serous (clear, amber, thin, and watery). issue Type: Granulation Tissue. Wound edges/margins: Macerated/soft. Skin surrounding wound: Assess within 4cm of wound edge: Erythema (redness)/blanchable.</p> <p>On [DATE] at 12:50 PM, Surveyor observed Admissions Nurse C complete dressing to pressure injury on R6's coccyx. Admissions Nurse C washed hands and applied gloves before starting. R6 was in the bathroom and needed assistance with incontinence care. Admissions Nurse C wiped R6 front the back, then removed the old dressing from R6's wound and discarded it. Admissions Nurse C removed her gloves and put on new gloves to cleanse the area of R6's pressure injury. Admissions Nurse C removed gloves, applied new gloves, and used skin prep to coccyx pressure injury. Admissions Nurse C removed gloves, applied new gloves prior to applying new dressing, initialing, and dating the dressing.</p> <p>Of Note: Admissions Nurse C did not complete any hand hygiene between glove changes.</p> <p>On [DATE] at 1:00 PM, Surveyor interviewed Admissions Nurse C. Surveyor asked Admissions Nurse C when hand hygiene is to be performed. Admissions Nurse C stated, when going from dirty to clean, prior to applying gloves and anytime gloves are soiled. Surveyor asked Admissions Nurse C if she should have performed hand hygiene when going from dirty to clean. Admissions Nurse C stated, yes. Surveyor asked Admissions Nurse C if hand [TRUNCATED]</p>