STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525108	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observations, interviews and record review, the facility did not ensure that residents who entered the facility with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 1 (R47) residents reviewed for range of motion. R47 was not wearing her palm protectors during survey. Findings include: R47 admitted to the facility on [DATE] with diagnoses that include Bipolar Disorder, Idiopathic Peripheral Autonomic Neuropathy, Type 2 Diabetes Mellitus, Morbid Obesity, Hypertension, Cerebral Infarction and Disruptive Mood Dysregulation Disorder. The facility policy titled Resident Mobility and Range of Motion revised July 2017 documents (in part) . .2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM (range of motion). 5. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. 6. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. 7. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. R47's Annual Minimum Data Set (MDS) dated [DATE] and Quarterly MDS dated [DATE] document: Functional Limitation in Range of Motion - impairment both sides upper extremity and lower extremity. R47's care plan documents: (continued on next page)

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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R47) requires a restorative program for splints to prevent further loss of movement and ensure proper limb alignment - revised 10/22/21. (R47) requires a functional maintenance program for splints to prevent further loss of movement and ensure proper limb alignment - revised 10/13/23. Interventions: NURSING MAINTENANCE SPLINT/BRACE: Bilateral palm protectors to be applied daily and removed for meals and hygiene. Pt (patient) will request nsg (nursing) to doff (remove) throughout day. Wear as tolerated - revised 5/8/24. R47's Kardex as of 6/4/24 documented: Nursing Maintenance Splint/Brace: Bilateral palm protectors to be applied daily and removed for meals and hygiene. Pt will request nsg to doff throughout day. Wear as tolerated. On 6/3/24 at 9:57 AM during interview with R47, Surveyor noted several fingers on both hands are contracted. R47 reported she had a stroke a few years ago and her fingers became contracted after the stroke, but she can feed herself. Surveyor asked R47 if she wears any splints or anything on her hands. R47 stated: Yes, I'm supposed to have them on my hands, I don't know where they are. On 6/4/24 at 10:09 AM Surveyor noted the door to R47's room was closed. Surveyor knocked, announced self, and looked inside. R47 was asleep, lying on her right side, wearing a gown. Surveyor noted her (consumed) breakfast tray was on the bedside table. Surveyor noted R47 was not wearing splints or palm protectors on either hand. On 6/4/24 at 1:32 PM Surveyor observed R47 sitting in her wheelchair in the elevator with a staff member. R47 was dressed and well groomed. Surveyor complimented her on appearance, R47 thanked Surveyor. R47 reported she was going to sit outside and get fresh air for a while. Surveyor noted R47 was not wearing splints or palm protectors on either hand. On 6/4/24 at 2:12 PM Surveyor spoke with Therapy Director-D who reported R47 was most recently seen by OT (Occupational Therapy) in February 2024 and there were no recommended changes regarding her palm protectors. Therapy Director-D stated: She should be wearing them. I believe she takes them off to eat because she can feed herself. On 6/5/24 at 3:32 PM Surveyor observed R47 sitting in her wheelchair next to the first-floor nurse's station. R47 was dressed and well groomed. Surveyor noted R47 was not wearing splints or palm protectors on either hand. R47's June 2024 Treatment Administration Record (TAR) documents: CNA (Certified Nursing Assistant) to Don (put on)/Doff Bilateral Palm protectors daily. On in the am, off in the pm as tolerated. Inspect skin and perform hand hygiene upon removal. Two times a day - start date 5/13/24. Times: 7:00 AM and 4:00 PM. Surveyor noted a check mark next to 7:00 AM on 6/3/24, 6/4/24 and 6/5/24. Surveyor had no observations of R47 wearing palm protectors on the dates indicated and there was no documentation of refusal. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Point Click Care (PCC) Tasks document: CNA to Don/Doff Bilateral palm protectors daily. On in the am off in the pm as tolerated. Inspect skin and perform hand hygiene upon removal. Surveyor noted there was no documentation indicating palm protectors were applied on 6/3/24 or 6/4/24 and no documentation R47 refused. On 6/6/24 at 7:52 AM Surveyor noted PCC tasks now have check mark next to N/A (not applicable on 6/3/24, a check mark next to yes on 6/4/24 times 1:51 PM and 8:51 PM, and a check mark next to yes on 6/5/24 times 1:59 PM and 7:20 PM. Surveyor had no observations of R47 wearing palm protectors on the dates indicated and there was no documentation of refusal. On 6/6/24 at 7:56 AM Surveyor noted a progress note entered on 6/4/24 at 2:32 PM by Assistant Director of Nursing (ADON)-C which documented: CNA to Don/Doff Bilateral Palm protectors daily. On in the am off in the pm as tolerated. Inspect skin and perform hand hygiene upon removal. Two times a day. Resident refuses to wear bilateral palm protectors. On 6/6/24 at 8:58 AM Surveyor advised ADON-C of concern regarding observations of R47 not wearing splints or palm protectors while on survey. Surveyor advised staff signed on the TAR that R47's palm protectors were applied and there was no documentation of refusal. PCC tasks documented palm protectors were applied and there was no documentation of refusal. ADON-C stated: Yeah, she does not wear them. Surveyor advised ADON-D her progress note on 6/4/24 indicated refusal, however there was no other documentation of R47's refusal and staff signed on the TAR and PCC the palm protectors as applied. ADON-C stated: I just know she doesn't like to wear them because she likes to eat snack throughout the day. I don't know why they're signing it out if she isn't wearing them, we'll have to do some education. No additional information was provided.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38146 Based on observation, interview and record review the facility did not ensure it's medication error rate is not 5 percent or greater. The facility had a medication error rate of 6.45% affecting 1 of 4 (R76) residents observed during medication pass. R76 was administered medications crushed, which is contraindicated. Findings include: The facility policy titled Specific Medication Administration Procedures dated March 2021 documents (in part) . .Purpose: To administer oral medications in a safe, accurate and effective manner. Special Considerations: A. Refer to crushing guidelines (See Appendix 1: Medication Crushing Guidelines) prior to crushing any medication for assurance that it can be pulverized. B. Appendix 1: Medication crushing guidelines dated March 2021 documents (in part) . .Medications that should not be crushed or chewed: The solid dosage forms of many medications should not be crushed or chewed for a variety of reasons. When a resident's condition prohibits the administration of solid dosage forms (tablets, capsules, etc.), the nurse administering the medication should check to see that there is no contraindication to crushing the medications in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance in obtaining the medication in liquid form or a form that allows crushing, if possible, and obtain a physician's order to change dosage forms and directions. The rationale for not crushing or chewing some medications include: D. Timed Release Tablets are designed to release medication over a sustained period, usually 8 to 24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed. Some specific types of timed-release tablets include the following: 1). Slow-Release Core: The outer coating may dissolve immediately to provide an initial dose of medication followed by the slow dissolving of the tablet core to provide a prolonged dose of medication. 2). Mixed-Release Granules: A tablet made of individual granules with varying rates of dissolution, compressed together. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3). Multilayer Tablets: Are usually composed of two or three layers with one layer designed to dissolve rapidly to provide immediate action and the remaining layers dissolving at much slower rates to provide sustained release. 4). Porous Inert Carriers: Are plastic or wax matrix tablets with thousands of passages tilled with medication. The medication leaches out of the passages very slowly. It should be noted that with some products the plastic or wax tablet may be found in a resident's stool. This is a normal finding with this type of formulation. 5). Osmotic Pup Tablet: Osmotic pump drug delivery systems (OPS) utilize osmotic pressure as the driving force for the delivery of drugs. The formulation of this system mainly consists of an osmotic core, which is coated with a semi-permeable membrane, and delivery orifice on the membrane, which is created by a laser drill. After orally taking, as soon as the tablet comes into contact with water in stomach, water will be absorbed through the membrane because of the resultant osmotic pressure, and then the drug will be released through the orifice at a controlled rate. 6). Refer to Medications Not to Be Crushed label packaging, manufacturer guidelines or a pharmacist for any questions about the ability to crush or chew medications. 7). A legal prescribers order is needed to crush medications. On 6/4/24 at 7:25 AM Surveyor observed Licensed Practical Nurse (LPN)-E prepare medications for R76. The following medications were prepared: Oxycodone HCL (Hydrochloride) IR (Immediate Release) 5 mg (milligrams) - 1 tablet, Cinacalcet HCL 30 mg -1 tablet. Surveyor noted the label on the bag read swallow whole do not chew or crush. Quetiapine 50 mg - 1 tablet, Acetaminophen 325 mg - 2 tablets, Amantadine 100 mg - 1 tablet, Amlodipine Besylate 10 mg - 1 tablet, Aspirin 325 mg - 1 tablet, Carvedilol 25 mg - 1 tablet, Donepezil HCL 10 mg - 1 tablet, Gabapentin 300 mg - 2 capsules, Levetiracetam 500 mg - 1 tablet, Losartan Potassium 50 mg - 1 tablet, Pantoprazole Sodium DR (Delayed Release) 40 mg 1 tablet, Senna Plus 8.6/50 mg - 2 tablets, Terazosin HCL 2 mg - 1 capsule, Vitamin B-1 - 1 tablet and Thiamine 100 mg - 1 tablet. LPN-E crushed all the tablets together with exception of Gabapentin and Terazosin capsules, which were opened and placed in a medication cup. LPN-E added the remaining crushed tablets to the medication cup and mixed with applesauce. R76 swallowed the medication in a few bites followed by nutritional supplement. R76's Physicians order dated 6/1/24 documented: May crush medications and administer together unless contraindicated. On 6/4/24 at 8:25 AM Surveyor advised LPN-E of observation of Cinacalcet having been crushed although label reads do not crush, and Pantoprazole DR crushed, although delayed release medications should not be crushed. LPN-E acknowledged the errors; no additional information was provided. On 6/6/24 at 8:58 AM Surveyor advised Assistant Director of Nursing (ADON)-C of the above observations and medication error rate. ADON-C stated: That's not bad. Thank you, we'll do some education. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38146 Based on observation, interview and record review the facility did not ensure that drugs and biological's used in the facility were labeled in accordance with currently accepted professional standards of practice, to include the expiration date when applicable for 2 of 2 (R50 and R84) residents' insulin observed. Open and used insulin belonging to R50 and R84 were not dated when opened. Findings include: The facility policy titled Preparation and General Guidelines dated March 2021 documents (in part) . .Policy: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. Procedures: B. Expiration dates: Opening a vial or not following storage requirements triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to be recorded on multidose vials on the vial label or an accessory label affixed for that purpose. At a minimum, the date opened must be recorded. F. USP <797> guidelines recommend discarding multidose vials (other than some insulin's) at 28 days after opened. The date opened and the triggered expiration date should be recorded on a label for such purpose affixed to the vial. On 6/3/24 at 3:23 PM Surveyor observed the 1 North medication cart with Licensed Practical Nurse (LPN)-F. In the drawer of the medication cart, Surveyor observed 2 brown plastic bags. 1 bag contained a vial of Lantus insulin, belonging to R84, which was opened and used, but not dated when opened. The other bag contained 2 vials of Humalog insulin belonging to R84, which were opened and used, but not dated when opened. Surveyor advised LPN-F of the above insulin's that were not dated and asked how long the insulin's were good for once opened. LPN-F replied, 28 or 30 days. R84's Medication Administration Record (MAR) included orders for Insulin Glargine (Lantus) Subcutaneous Solution - inject 20 unit subcutaneously at bedtime for DM (Diabetes Mellitus) II (Type 2) and Insulin Lispro (Humalog) - inject as per sliding scale before meals and HS (hour of sleep). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 8:38 AM Surveyor observed the 2 north medication cart with Assistant Director of Nursing (ADON)-C. In the drawer of the medication cart, Surveyor observed a clear plastic bag containing a Humulin 70/30 Kwik pen belonging to R50, which was opened and used, but not dated when opened. The label on the pen read: Expires 10 days after opening. R50's MAR included an order for Humulin 70/30 KwikPen - inject 76 unit subcutaneously in the morning, 88 unit subcutaneously in the evening for DM2 (type 2 diabetes mellitus). On 6/6/24 at 8:58 AM Surveyor advised ADON-C of the above observations. No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42248 Based on observations, interviews and record review, the facility did not establish and maintain an infection prevention and control program based upon current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to several of the 79 residents. The facility's Water Management Plan (WMP) was not based on current standards of practice and did not: ~Include water management team members who were knowledgeable about the facility's water system. ~Identify all locations where Legionella could grow and spread. ~Identify where control measures should be applied based on where Legionella could grow and spread and identify how to monitor the control measures and risks. ~Identify acceptable ranges of control limits (temperature ranges) and corrective actions to take when control limits are not met. ~Identify what actions should be taken to protect all residents when a resident is diagnosed with Legionnaires' disease or when environmental samples identify the presence of Legionella in the water. The facility's water management plan (WMP) did not document facility specific control measures to implement with the determination of health care acquired legionellosis existing in the facility. Review of the ad hoc QAPI timeline created by the facility shows some control measures implemented, such as stop using showers for bathing and use bed baths. On 5/23/24 point of use filters were added to shower rooms and a sink in the ice room. The facility continued to use water sources in the facility for handwashing and the ice machines. The facility instructed staff to use water from water coolers as alternate sources of water. The referenced water coolers were not brought in specifically for control measures. The water coolers were identified as a possible bacterial concern and samples were taken during Division of Public Health's (DPH) physical environmental assessment on 5/29/24 and 5/30/24. These water coolers were not identified in the facility water management plan to ensure control measures were implemented. Findings include: The 7/6/18 revised Centers for Medicare & Medicaid Services (CMS) Quality, Safety and Oversight Letter 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire" Disease (LD) states Facilities must have water management plans and documentation that, at a minimum, ensure each facility: ~Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~Develops and implements a water management program that considers the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) industry standard and the CDC toolkit. ~Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. ~Maintains compliance with other applicable Federal, State, and local requirements. The 6/24/21 CDC Toolkit titled Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings identifies the key elements of a water management program for healthcare facilities to include: 1. Establish a water management program team 2. Describe the building water systems using text and flow diagrams 3. Identify areas where Legionella could grow and spread 4. Decide where control measures should be applied and how to monitor them 5. Establish ways to intervene when control limits are not met 6. Make sure the program is running as designed and is effective 7. Document and communicate all the activities Water Management Plan (WMP) not consistent with current standards of practice: The facility Water Management Plan (WMP) dated 1/2/24 with an expiration of 1/2/25 documents: Purpose: The purpose of this water management plan (WMP) is to establish the minimum legionellosis risk management requirements by illustrating the procedures for minimizing the risk of Legionnaires' disease within the building water systems of one facility. General requirements: Program team: identify persons responsible for program development and implementation. Describe Water Systems/Flow Diagrams: Describe the potable and nonpotable water systems within the building and on the building site and develop water-system schematics. Analysis of Building Water Systems: Evaluate where hazardous conditions may occur in the water systems and determine where control measures can be applied. Control Measures: Determine Locations Where control measures must be applied and maintained in order to stay in established control limits. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitoring/Corrective Actions: Establish procedures for monitoring whether control measures are operating within established limits and if not, take corrective action. Confirmation: Establish procedures to confirm that: The program is being implemented as designed (verification), and the program effectively controls the hazardous conditions throughout the building water systems (validation). Documentation: Establish documentation and communication procedures for all activities of the program. Program team: identify persons responsible for program development and implementation. Review of the plan dated 1/2/24 identifies a former Nursing Home Administrator (FNHA)-S as the building manager/administrator. FNHA-S was the facility administrator from 2/17/20-7/1/22. The program team in the plan also identifies Former Maintenance Director (FMD)-T as the Director of Maintenance in the plan. During the survey, the facility provided Surveyor with a revised Water Management Plan with a revised date of 5/29/24. On 6/5/24 at approximately 4:00 pm Surveyor spoke to Assistant Nursing Home Administrator (ANHA)-Q about the revised WMP dated 5/29/24. ANHA-Q shared with Surveyor the only changes between the two plans was updating the program team for the WMP for the facility. The revised WMP dated 5/29/24 identified Nursing Home Administrator (NHA)-A and Director of Maintenance (DM)-H as the program team. ANHA-Q shared there should not have been any changes other than changing the names of NHA and Maintenance Director. The expiration date on both WMP documents 1/1/25. The WMP identifies an optional section regarding the program team documenting: 4.3.2 Health Care facilities that meet all of the following qualifications shall comply with either the requirements in Sections 4.2, 6, and 7 or the requirements in Normative Annex A, Health Care Facilities: a. The health care facility is accredited by a regional, national, or international accrediting agency or by the authority having jurisdiction (AHJ) over the health care facility Infection Prevention and Control (IC) activities. b. The health Care facility (IC) program has an infection preventionist that is certified in infection prevention control (CIC) by the certification board of infection control and epidemiology (CBIC) or other regional, national, or inter-national certifying body, or the health care facility has an epidemiologist with a minimum of a master's degree or equivalent. A.2.1 Senior organizational leadership shall select the individual responsible for leading the designated team from the group responsible for compliance with the physical environment accreditation standards. The membership of the designated team shall include but is not limited to: a. A person with senior organization leadership authority to make command decisions about water restrictions or other response measures. b. A member of the facilities [sic] management staff with knowledge of the building water systems; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. A member of the healthcare facility Infection Prevention and Control (IC) program 1. within the U.S. who is an infection preventionist certified in infection prevention and control (CIC Certification) by the Certification Board of Infection Control and Epidemiology (CBIC), or who is an epidemiologist with a minimum of a master's degree . Surveyor noted the Water Management Program team does not identify any other members beyond the Administrator and the Maintenance Director. On 6/3/24 at 12:00 p.m., Surveyor asked DM-H how DM-H ensured the water management program is implemented. DM-H stated they follow the schedule of tasks that are in the Tels system (computer program that maintenance uses to organize projects and maintenance of the building.) DM-H stated DM-H was not aware of the facility document titled Water Management Program and that DM-H did not receive a lot of training since starting approximately nine months ago. General Building Risk Factors: The 1/2/24 WMP includes a Risk Assessment asking yes and no questions for General Building Risk Factors and Device Risk Factors. Review of the WMP dated 1/2/24 and the revised WMP dated 5/29/24 document the same yes and no responses to the general building and devise specific risk questions. Surveyor noted this includes the question of whether point of use filters are in use as these would be a possible WMP risk factor to include in the plan. Despite indications the facility installed a few point of use 0.2 micron filters on 5/23/24, this not noted in the revised WMP dated 5/29/24. Describe Water Systems/Flow Diagrams: Describe the potable and nonpotable water systems within the building and on the building site and develop water-system schematics. On 06/30/24 between 9:35 and 10:15 am, when DM-H was asked to describe the domestic hot water system, and water temperature at plumbing fixtures in common showers, sinks and sinks in toilet rooms in resident sleeping areas, DM-H stated that the facility had three [NAME] hot water heaters replaced within the last 5 years in the Boiler Room in basement, and that the point-of-use hot water temperature was maintained in the range of 112 degrees F and 115 degrees F. When asked about temperature of water at the source equipment i.e. hot water heaters, DM-H stated that the water temperature in water tanks is 120 degrees F and water flows through the mixing valve comes out of the valve at a temperature around 115 degrees F. He further stated that two of six common shower rooms in the facility have not been used for residents for more than 9 months, and that he started to work in the facility 9 months ago. DM-H stated that shower heads in remaining 4 shower rooms were replaced with new shower heads, new hose and new Nephr's filter to filter particulates of 0.2 micron or greater. During the walk-through of the facility starting at the basement mechanical room with DM-H, the water temperature gauge at the mixing valve outlet pipe read 120 degrees F. There was no temperature gauge in the mixing valve inlet pipe. Two hot water heater LED front panels had a digital reading of 115 degrees F; the 3rd water heater did not have front panel to display temperature. DM-H did not know whether the 115 degrees F was the hot water set point in water heaters. At 12:10 P.M., the hot water temperature at the mixing valve outlet was read to be 115 degrees F. (continued on next page)

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	525108	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted the facility WMP identified the description of hot water distribution to be maintained at 140 degrees in the water heaters. The facility document titled Legionella Surveillance Policy revised 3/3/23 included within the facility WMP binder documents: 5. Primary prevention strategies: d. Temperature controls: ii. Hot water shall be stored above 140 F (degrees Fahrenheit) and circulated at a minimum return temperature of 124 F. Surveyor noted despite the facility WMP and additional policies documenting control measures regarding temperatures the facility was not maintaining the water heaters at a temperature identified in the WMP. The WMP includes analysis of building water systems: Hot and Cold-Water Systems (in part) documenting: . The prevention of outbreaks caused by hot and cold-water systems depends on a comprehensive application of a water management plan with thorough attention to good design, management, and control of the system . The Water Management Plan does not dentify all locations where Legionella could grow and spread or identify where control measures should be applied or how to monitor the control measures and risks. The CDC toolkit identifies locations in a buildings water system where Legionella can grow and spread to include but not limited to: ~Hot and cold-water storage tanks ~Water heaters ~Water Filters ~Electronic and manual faucets ~Aerators ~Shower heads and hoses ~Pipes, valves, and fittings ~Infrequently used equipment including eye wash stations. ~Ice machines ~Hot tubs Control Measures: Determine Locations Where control measures must be applied and maintained in order to stay in established control limits. The WMP documents: Water System Flow Diagram for: (Name of facility) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Description of Building Water Entry: Water enters via 2 line on the east side of the building from the municipal water supply. Water passes through a backflow preventer and then is fed down the hallway to the boiler room that contains the water heaters and boiler. Description of Cold-Water Distribution: Cold water is routed directly to the building fixtures and supplies all floors and resident rooms. This includes faucets, ice machines and showers. Description of Hot Water Heating: Cold water is routed to the boiler room where it is split to supply three 100-gallon water heaters and the boilers. The hot water heaters provide water for all fixtures on all floors. Description of Hot Water Distribution: Hot water is distributed to all plumbing fixtures from the boiler room. There are two recirculation pumps. Water is maintained at 140 degrees in the water heater. Description of Waste/Sewer: All grey and black water systems exit the building via the sanitary sewer line located in the basement. The WMP includes a diagram documenting: 1. Receiving: Municipal Water 2 Main (Enters from Eastside of Building) with a backflow identified. 2. Cold Water Distribution: The water flows to Ice Makers (1st & 2nd Floor); Beauty Shop; Kitchen; Laundry; Sinks & Toilets (all units) Showers (Resident Halls) Eye Wash (various locations) (not specified). 3. Heating: 3-100-gallon Hot Water Heaters (Mechanical Room). The diagram shows these to have recirculating return flow. 4. Hot Water Distribution: The diagram shows the 3 hot water heaters going to the Kitchen; Beauty Shop; Laundry; Showers (Resident Halls) Sinks (all units) 5. Waste: Main Sewer (Leaves from under building). The diagram shows all cold and hot water distribution going to the Main City Sewer. The facility Water Management Binder includes two floor plans of the facility 1st and 2nd floors. The diagrams identify a color-coded system for cold water, hot water and return. The diagrams do not identify any specific areas of risk with the flow diagrams. On 6/5/24 at approximately 10:30 am Surveyor spoke to Division of Public Health - Infection Preventionist (DPH-IP) regarding the facility and their WMP. DPH-IP shared they were present in the facility when the State Legionella Public Health team came in on 5/29/24 to tour and collect water samples. DPH-IP shared she had been expressing concern to the facility going back to 2022 regarding the creation of dead legs in the facility with the removal of sinks in the shower rooms and having shower rooms not being used on a routine basis. DPH-IP shared on 5/29/24 during a public health facility physical environment assessment, those concerns continued to be present in the facility. Analysis of Building Water Systems: Evaluate where hazardous conditions may occur in the water systems and determine where control measures can be applied: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/2/24 WMP includes a Risk Assessment asking yes and no questions regarding the General Building and Device Risk Factors. The WMP documents analysis of building water systems: Hot and Cold-Water Systems (in part): .The prevention of outbreaks caused by hot and cold-water systems depends on a comprehensive application of a water management plan with thorough attention to good design, management, and control of the system . The facility provided a revised copy of the WMP with a revised date of 5/29/24 that asks the same building and device yes and no questions. Review of the revised WMP dated 5/29/24 indicates the same information as the 1/2/24 including documentation the facility does not use point of use filters (which can become a risk factor) despite the facility installing some point of use filters on 5/23/25. The Wisconsin State Plumbing Code Chapter SPS 382.50(3)(b)6 requires a nursing homes hot water system to be installed and maintained to provide bacterial control by one of the following methods: ~Water stored and circulation initiated at a minimum of 140 F and with a return of a minimum of 124 F. This standard is best practice even considering the facility was built prior to May 2003 and grandfathered to meet requirement. The facility WMP does not identify the fact that the facility was built before 2003 therefore, the facility is not required to meet Wisconsin Administrative Code, Chapter SPS 382.50(3)(b)6. requirement for nursing homes to have a hot water distribution system installed and maintained to provide bacterial control by one of the following methods: a) Water stored and circulation initiated at a minimum of 140 degrees F (Fahrenheit) and with a return of a minimum of 124 degrees F b) Water chlorinated at 2mg/L residual c) Another disinfection system approved by the department The WMP does not address how the age of the building, existing systems are analyzed to address risks and maintain water temperatures or controlled water sources at conditions established by standards of practice to prevent waterborne bacteria. Control Measures: Determine Locations Where control measures must be applied and maintained in order to stay in established control limits. * The 1/2/24 WMP documents for Control Measures: Cold Water Systems. Risk Factor: Eyewash station. Plumbed units are to be activated weekly to flush the line and verify operation; at least a 3-minute flush is recommended. Fluid replacement frequency in self-contained units depends on whether a preservative is used. Plain water: weekly replacement; if a preservative is used, 1-4 month replacement depending upon instructions. If factory-sealed cartridges are used, up to two years may be acceptable. Follow Manufacturer's Operations and Maintenance Instructions. Surveyor noted the WMP does not specify what type of Eyewash stations exist specifically in the building. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Location is identified as Building (it is noted it does not identify how many stations there are and specific locations). Frequency: weekly Monitoring: Execute control measure based upon the stated frequency and type of eyewash station present as indicated in control measure. Control limits (lower) NA (not applicable) Control Limits (upper): NA Corrective actions: For self-contained units destroy via incineration. For plumbed units, sterilize (if station is tied to a hot water line) via heat and flush using water at temperatures at or above 150 F (70 C) for 5-30 minutes. Date last verified: Refer to digitally signed and verified. Verified By/Reported To Program Team: FNHA-S and FMD-T are identified. Review of the Tels system identified by DM-H as the record of maintenance for the water system, Water Systems: Eyewash Station and Water systems: Inspect Eyewash stations for May 2024-March 2024 documents: Due Date: 5/25/24 Task completion: 5/20/24 Due Date: 5/18/24 Task completion: 5/20/24 Due Date: 5/11/24 Task completion: 5/7/24 Due Date: 5/4/24 Task completion: 4/30/24 Due Date: 4/27/24 Task completion: 4/25/24 Due Date: 4/20/24 Task completion: 4/15/24 Due Date: 4/13/24 Task completion: 4/8/24 Due Date: 4/6/24 Task completion: 4/2/24 Due Date: 3/30/24 Task completion: 3/27/24 Due Date: 3/23/24 Task completion: 3/20/24 Due Date: 3/16/24 Task completion: 3/12/24 Due Date: 3/9/24 Task completion: 3/5/24 Due Date: 3/2/24 Task completion: 3/4/24 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Control Measure: Clean and sterilize medical devices according to the manufacturer's instructions in their prescribed manner and procedure; or as required or necessary as determined by the program team. Location identifies Building Frequency: According to Manufacturer's Instructions ([NAME]). Control Limits (Lower): NA Control Limits (Upper): Exceeding manufacturer's stated interval or as determined by the Program Team. Corrective Actions: Replace or destroy (incinerate) the medical device; and assure there is no collateral contamination. Date Last Verified: Refer to digitally signed documentation. Documentation: Digitally signed and verified. Verified By/Reported To Program Team: FNHA-S and FMD-T are identified. Due Date for Next Verification: At stated frequency in the digitally signed documentation. Surveyor noted this control measure does not identify what the facility is specifically checking as a medical device that could be a water management concern. The WMP does not specify manufacturer's information for possible medical devices to set individual frequencies if necessary. Review of the Tels system identified by DM-H as the record of maintenance for the water system, Water Systems: Medical Device (not specified) for May 2024-March 2024 documents: Due Date: 5/31/24 Task completion: 5/20/24 Due Date: 4/30/24 Task completion: 4/2/24 Due Date: 3/31/24 Task completion: 3/14/24 Due Date: 2/29/24 Task completion: 2/4/24 Surveyor noted it is unclear what medical devices this monitor is referring to or what the specified frequency may be for individual medical devices. The due date in the facility Tels system sets a monthly interval for completion of the monitoring. Review of dates completed indicate monitoring not consistently implemented with some monitoring periods greater than monthly and some shorter in their interval. * The 1/2/24 WMP documents for Control Measures: Hot Water Systems. Risk Factor: Water Heater Control Measure: Check flow and return temperature at hot water heater. Location: Boiler Room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Frequency: Monthly or as required or recommended by AHJ (Authority having jurisdiction) or your water treatment professional. Monitoring: Supply temperature should be checked at the outlet of the Hot Water Heater and should not be lower than 140 F. The return temperature should also be checked monthly and should not be lower than 122 F. Control Limits (Lower): 122 F (50 C) Control Limits (Upper): 140 F (60 C). Corrective Actions: If unable to maintain desired temperatures: The Program Team shall consider alternate methods to conform with compliance to reduce the risk of Legionella. NOTE: State and Local regulations limit the temperature set-points of water heaters due to scald protection This places most facilities out of control limits set by the scientific community. Accordingly, the only way to confirm Legionella is under control is to test specifically for Legionella. (Name of company preparing WMP) suggests performing at a minimum 2 (biannual) tests per year, with 4 (quarterly) being more ideal. By doing so, the Program Team responsible has documented evidence that the hazard of Legionella is under control. Please see the ERRATA section for Program Team Test Location and Intervals. Date Last Verified: Refer to digitally signed documentation. Documentation: Digitally signed and verified. Verified By/Reported To Program Team: FNHA-S and FMD-T are identified. Due Date for Next Verification: At stated frequency in the digitally signed documentation. Procedures for Legionella Testing if specified by Program Team: For potable water systems: Cold-water: Samples should be taken from the cold-water storage tank (if present) and the furthest outlet from the tank (or source). Samples may also be required from outlets in areas of particular concern. Hot water: Samples should be taken from the water heater outlet or the nearest tap plus the return supply or nearest tap to that return supply. The furthest outlet from the water heater should also be sampled. Samples should be analyzed at a laboratory accredited to the ISO/IEC 17025:2017 standard. The laboratory should be capable of a detection limit of less than or equal to .10 cfu/ml for Legionella per liter of sample. Legionellae are commonly found in almost all natural water sources, so sampling of water systems and services will often yield positive results. Failure to detect Legionella should not lead to the relaxation of control measures and monitoring. Neither should monitoring for the presence of Legionella in a cooling system be used as a substitute in any way for vigilance with control strategies and those measures identified in the risk assessment. If a Legionella-positive sample is found outside of control limits, more frequent samples may be required as part of the review of the system operation, in order to establish the source of the contamination and determine when the system is back within control limits as specified in the WMP. Water Management Plan Procedures for testing: (continued on next page)

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