

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2024
NAME OF PROVIDER OR SUPPLIER  Edgerton Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  313 Stoughton Rd Edgerton, WI 53534	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849</b></p> <p>Based on observation, interview, and record review, the facility did not implement its policy and procedure to prevent abuse, neglect, and mistreatment of residents which had a potential to affect all 13 residents on the unit.</p> <p>The facility did not implement its policy and procedures to safeguard residents by removing CNA D (Certified Nursing Assistant) from patient care when R2 accused CNA D of sexual abuse on 4/20/24.</p> <p>This is evidenced by:</p> <p>The Facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, revised April 2021, documents in part: Policy Statement -- Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation - The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: .10. Protect residents from any further harm during investigations .</p> <p>R2 was admitted to the facility on [DATE] with diagnoses, in part, Anxiety Disorder, Unspecified Injury of Head, Other amnesia-Memory Loss, and Muscle wasting and atrophy.</p> <p>On 4/20/24, the facility was made aware of an allegation of sexual abuse by R2 that CNA D had touched her breast(s).</p> <p>On 5/15/24 at 12:53 PM, Surveyors interviewed CNA D who indicated about a month ago he had been told an accusation had been made that he tried to touch R2's breast. CNA D indicated he was instructed by RN E (Registered Nurse) to leave third floor and come to second floor and stay on second floor. CNA D indicated that he was not told that he could not care for other residents. CNA D indicated after he became aware of the accusation, he did continue to care for residents, at times independently, on the second floor that night from approximately 7:30 PM or 7:45 PM until he finished his shift at 10:30 PM.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/15/24 at 2:11 PM, Surveyor interviewed ADON C (Assistant Director of Nursing) who indicated the allegation made by R2 was reported to her. ADON C indicated when an allegation of abuse is made the staff member should have been removed from working with residents until the investigation was done.</p> <p>On 5/15/24 at 4:20 PM, Surveyors interviewed DON B (Director of Nursing) and NHA A (Nursing Home Administrator) via telephone. DON B indicated an allegation was reported to her that R2 had told a staff member that CNA D wanted to touch her breast. DON B indicated she contacted RN E and told her to remove CNA D from the 3rd floor. DON B indicated she did not inform RN E that CNA D could not work with other residents and told RN E that she needed to stay with CNA D until they figured out what to do. DON B indicated she was not aware that CNA D was allowed to work independently with residents after the allegation and that he was supposed to stay with RN E.</p> <p>On 5/15/24 at 5:35PM Surveyor interviewed NHA A via telephone who indicated the facility abuse policy was not followed.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39849</p> <p>Based on interview and record review, the facility did not ensure all alleged violations involving mistreatment, neglect, or abuse were reported to the state agency and other officials, and that the residents were protected during the facilities investigation for 1 of 3 abuse investigations reviewed (R2) of a total sample of 3.</p> <p>On 4/20/24 the facility became aware of an allegation by R2 that a Certified Nursing Assistant (CNA) had touched her breasts. This allegation of abuse was not reported to the state agency and other officials and the facility failed to protect other residents during the investigation.</p> <p>This is evidenced by:</p> <p>The Facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, revised April 2021, documents in part: Policy Statement -- Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation - The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property .9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations .</p> <p>R2 was admitted to the facility on [DATE] with diagnoses of, in part, Anxiety Disorder, Unspecified Injury of Head, Other amnesia-Memory Loss, and Muscle wasting and atrophy.</p> <p>On 5/15/24 at approximately 3:30 PM, Surveyors interviewed CNA J (Certified Nursing Assistant). CNA J indicated she was aware of an accusation of abuse that was made by R2 but could not provide an exact date. CNA J indicated she thought it was during rounds that R2 told her That brown boy touched my titties. CNA J indicated she believed R2 was referring to CNA D. CNA J indicated that another CNA was by R2's room door and the two of them told MA K (Medication Aide) and she told them to call DON B (Director of Nursing) or NHA A (Nursing Home Administrator) but could not recall which one for certain. CNA J indicated they got RN E (Registered Nurse) from second floor, and she came to third floor and she took CNA D from the floor.</p> <p>On 5/15/24 at 12:53 PM, Surveyors interviewed CNA D and asked if he had been informed by the facility of any accusations of abuse against him in the last few months. CNA D indicated about a month ago he had been told by RN E that he should come to the second floor as there was an accusation that he tried to touch R2's breast. CNA D indicated he went to the second-floor nurses' station and RN E asked CNA D to write a report of what happened and told him he could stay on the second floor. CNA D indicated that he was not told that he could not care for other residents. CNA D indicated after he became aware of the accusation, he did continue to care for residents, at times independently, on the second floor that night from approximately 7:30 PM or 7:45 PM until he finished his shift at 10:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/15/24 at 2:53 PM, Surveyor interviewed RN E and asked what she recalled of what happened the night that R2 alleged that CNA D had touched her breast. RN E indicated someone told her that CNA D had to move to her floor on second, so he wasn't working with R2. RN E indicated she was not told that CNA D could not work with other residents on second floor. RN E also indicated that CNA D did care for residents alone on the second floor that night. Surveyors asked RN E if CNA D should have been working alone with residents after the accusation of abuse was made. RN E indicated she felt administration should have said to investigate and send CNA D home, but that she did not have the power to send him home.</p> <p>On 5/15/24 at 2:11 PM, Surveyor interviewed ADON C (Assistant Director of Nursing) and asked if it had been reported to her that R2 alleged that CNA D had touched her breast. ADON C indicated the allegation was reported to her, she thought on 4/20/24. ADON C indicated she received a call from DON B that R2 had said something to a staff member about being touched and that there was a to do on the floor about it and basically it was hard to know what to believe. ADON C indicated that when an accusation of abuse is made it should be reported to the abuse coordinator, which is NHA A. ADON C further indicated that the staff member should have been removed from working with residents until the investigation was done. ADON C indicated this should have been reported to the state agency and potentially the police.</p> <p>On 5/15/24 at 4:20 PM, Surveyors interviewed DON B and NHA A via telephone. DON B indicated an allegation was reported to her that R2 had told a staff member that CNA D wanted to touch her breast, does not recall the exact date, it was on a weekend around 8pm. DON B indicated she contacted NHA A who told her she thought CNA D needed to leave the building and an investigation was started. DON B indicated she contacted RN E and told her that everyone needed to write statements and to remove CNA D from the 3rd floor. DON B indicated she did not inform RN E that CNA D could not work with other residents and told RN E that she needed to stay with CNA D until they figured out what to do. DON B indicated that if a resident alleges that a staff member said they wanted to touch their breasts it is an allegation of abuse and should be reported to the state agency and the police. DON B indicated she was not aware that CNA D was allowed to work independently with residents after the allegation and that he was supposed to stay with RN E.</p> <p>The facility became aware of an allegation of abuse made by R2 and failed to report to state agency and other officials within the regulatory timeframes and failed to protect residents during the investigation.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39849</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an accusation of sexual abuse for 1 of 3 residents (R2) reviewed for abuse.</p> <p>On 4/20/24, the facility became aware of a sexual abuse allegation involving R2 and a thorough investigation was not completed.</p> <p>This is evidenced by:</p> <p>The Facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, revised April 2021, documents in part: Policy Statement -- Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation - The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property .8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements.</p> <p>R2 was admitted to the facility on [DATE] with diagnoses of, in part, Anxiety Disorder, Unspecified Injury of Head, Other amnesia-Memory Loss, and Muscle wasting and atrophy.</p> <p>On 4/20/24, the facility was made aware of an allegation of sexual abuse by R2 that CNA D (Certified Nursing Assistant) had touched her breast(s).</p> <p>On 5/15/24 at 1:11 PM, Surveyors interviewed SS I (Social Services) who indicated that she was aware of the allegation made by R2. SS I indicated the day after the allegation was made, on Sunday, she came into the facility and helped gather information. Staff provided written statements and she went around and asked interviewable residents abuse and safety questions. SS I also indicated she knew an investigation was completed and that she had a call out to NHA A (Nursing Home Administrator) to find out where this was in her office.</p> <p>On 5/15/24 at 5:12 PM, SS I provided a soft file for this abuse allegation to Surveyors. Surveyors reviewed the file which included staff statements confirming the allegation that R2 indicated a CNA touched her breast. Ten resident interviews were included on a typed grid. SS I indicated that when she came in on Sunday and interviewed residents, she did not wake anyone who was sleeping or unavailable nor did she do anything for non-interviewable residents. SS I indicated she was not aware of skin checks being completed for signs of abuse for non-interviewable residents.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/15/24 at 4:20 PM, Surveyors interviewed DON B (Director of Nursing) and NHA A (Nursing Home Administrator) via telephone. DON B indicated an allegation was reported to her that R2 had told a staff member that CNA D wanted to touch her breast. DON B indicated she contacted NHA A who told her she thought CNA D needed to leave the building and an investigation was started. NHA A indicated witness statements had been completed and that residents were interviewed and that she had just informed SS I where to find them in her office. DON B indicated that they did not perform a skin sweep to examine non-interviewable residents for potential indicators of abuse.</p> <p>There is no specific investigation process that the facility must follow, but the facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary (if any) for the protection of the residents. The investigation did not include residents that were unable to verbally express abuse concerns.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</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** 41788</b></p> <p>Based on observation, interview, and record review, the facility did not implement professional standards of practice to promote healing or prevent pressure injury (PI) development for 1 of 3 residents reviewed for PIs out of a sample of 3 residents (R1).</p> <p>R1 is care planned to be repositioned every two to four hours and facility documentation shows R1 was not being repositioned every two to four hours.</p> <p>Evidenced by:</p> <p>The facility policy, entitled Repositioning, dated 2013, states, in part: .</p> <p>Purpose: The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair- bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.</p> <p>Preparation:</p> <p>1. Review the resident's care plan to evaluate for any special needs of the resident .</p> <p>General Guidelines:</p> <p>1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief .</p> <p>3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .</p> <p>Interventions:</p> <p>1. Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure .</p> <p>Documentation:</p> <p>The following information should be recorded in the resident's medical record:</p> <p>1. The position in which the resident was placed. This may be on a flow sheet.</p> <p>2. The name and title of the individual who gave the care.</p> <p>3. Any change in the resident's condition.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Any problems or complaints made by the resident related to the procedure.</p> <p>5. If the resident refused the care and the reason(s) why .</p> <p>Reporting:</p> <p>1. Notify the supervisor if the resident refuses the procedure.</p> <p>2. If the resident refuses care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated .</p> <p>The facility policy, entitled Prevention of Pressure Injuries, dated 2020, states, in part: .</p> <p>Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors .</p> <p>Mobility/Repositioning:</p> <p>1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team.</p> <p>2. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines .</p> <p>R1 was admitted to the facility on [DATE], and has diagnoses that include MELAS syndrome (a rare genetic disorder that affects the nervous system and muscles), hereditary spastic paraplegia (a group of more than 80 rare or ultra-rare genetic disorders that cause progressive muscle weakness and stiffness in the legs), and immobility syndrome (a condition that causes joint contractures, or stiff and immobilized joints, in the lower extremities of people with paraplegia).</p> <p>R1's Quarterly Minimum Data Set (MDS) assessment, dated 2/16/24, shows that R1 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R1 is cognitively intact. Section GG: Functional Limitation in Range of Motion: Upper extremities- no impairment, Lower extremities- impairment on both sides.</p> <p>Mobility: Sit to lying, lying to sitting, sit to stand and chair/bed to chair transfer R1 is dependent on staff.</p> <p>R1's care plan dated 1/27/21, states, in part: .</p> <p>Problem: Problem Start Date: 1/27/21 Basic CNA (certified nursing assistant) .</p> <p>Approach: Approach Start Date: 7/26/21</p> <p>Devices: Bariatric WC (wheelchair), EZ stand .</p> <p>Skin: Reposition every two hours. Must be turned at least every 2-4 hours while in bed .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Problem: Problem Start Date: 11/18/16 . At risk for alteration in skin integrity r/t (related to) decreased mobility, incontinence of stool and supra pubic catheter use. DX: hereditary spastic paraplegia .</p> <p>Approach: . Approach Date: 2/7/23 Encourage R1 to be up in wheelchair/recliner only 2 hours at a time around meals. Must be turned at least every 2 hours while in bed. CNAs to document positioning schedule and DON (director of nursing) to monitor weekly. (Sheet to run Sunday to Sunday). Edited: 4/22/24 .</p> <p>Approach: Approach Start Date: 11/18/16. Assist with turning and repositioning with nightly rounds .</p> <p>R1's Repositioning Tracker Flow Sheets dated 5/5/24- 5/15/24 shows for the following dates and times R1 was not repositioned:</p> <p>-5/10/24 at 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, 12:00 AM</p> <p>-5/11/24 at 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 12:00 AM, 2:00 AM, 4:00 AM</p> <p>-5/12/24 at 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, 12:00 AM, 2:00 AM, 4:00 AM</p> <p>-5/13/24 at 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, 12:00 AM, 2:00 AM, 4:00 AM</p> <p>-5/14/24 at 6:00 AM, 8:00 AM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, 12:00 AM, 2:00 AM, 4:00 AM</p> <p>-5/15/24 at 6:00 AM, 8:00 AM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, 12:00 AM, 2:00 AM, 4:00 AM.</p> <p>Of note: Aprils Repositioning Tracker flow sheets not provided.</p> <p>On 5/15/24 at 10:18 AM, Surveyor interviewed R1 and asked how often R1 is repositioned. R1 indicated he is to get repositioned every two hours, but he is not. Surveyor asked R1 if there are nights repositioning does not occur and R1 indicated yes. Surveyor asked R1 how often that occurs and R1 could not recall how often but indicated it happens.</p> <p>On 5/14/24 at 2:00 PM, Surveyor interviewed CNA F (Certified Nursing Assistant). CNA F indicated there is paper copies at nurse station to document repositioning on R1. CNA F indicated if R1 refuses repositioning it will be documented on those paper copies.</p> <p>On 5/14/24 at 2:05 PM, Surveyor interviewed CNA G. CNA G indicated for R1 there is a sheet at the nurses' station that repositioning is to be documented on every two hours. CNA G indicated if R1 refuses repositioning it is expected to be documented on that sheet. Surveyor asked if R1 refuses repositioning and CNA G indicated no.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/15/24 at 9:50 AM, Surveyor interviewed CNA H and asked what the expectation is for a resident on a turning and repositioning program. CNA H indicated the resident to be repositioned every two hours or whatever the care plan indicates. Surveyor asked if repositioning is to be documented and CNA H indicated yes, there are sheets at nurses' station if a resident is every two-hour repositioning.</p> <p>On 5/15/24 at 4:12 PM, Surveyor interviewed DON B (Director of Nursing) and asked if a resident is care planned to be repositioned every two hours would you expect the repositioning to be done every two hours and documented. DON B indicated yes. Surveyor asked if a resident refuses, should that be documented, and DON B indicated yes. Surveyor asked if R1 is on a two-hour repositioning schedule and DON B indicated yes. Surveyor asked DON B when the facility initiated the repositioning tracker flow sheets for R1, DON B indicated in April. DON B indicated it is her expectation repositioning and resident refusals to be documented on those flow sheets. DON B indicated she educated all nursing staff on those forms and to fill them out and mark any refusals on them. Surveyor asked DON B if she monitors those flow sheets and DON B indicated she saw two of them and did see spots not completed.</p>